EXAMINING HIV/AIDS AMONG THE ABORIGINAL POPULATION IN CANADA
in the post-residential school era

By J. Kevin Barlow, 2003

Introduction

The purpose of this review is to examine current literature to determine whether there is a link between the legacy of residential schools and HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome); to outline how HIV/AIDS is affecting the Aboriginal population; and to identify what interventions are being made to combat this health issue, including best practices and challenges. It is difficult to state whether HIV/AIDS can be *directly* linked to the legacy of residential schools (herein referred to as the Legacy), as there is a lack of clear, direct evidence to support such a claim; although, it is clear that some residential school survivors (herein referred to as Survivors) are living with HIV/AIDS. Not enough is known about the extent to which this health issue is manifesting itself among Survivors and their direct descendants. An argument based on the intergenerational impacts can be made due to the multi-generational nature of both physical and sexual abuse and unresolved trauma. The loss of culture and the marginalization that Survivors, their descendants and other family members feel may also be contributing factors.

A significant amount of healing efforts have been funded through the Aboriginal Healing Foundation (AHF), reaching approximately 163,389 individuals and group participants (Scott, 2002). At least two AHF-funded projects funded an Aboriginal AIDS service organization to specifically examine HIV-related issues; one offered mentoring for Aboriginal youth to develop healthy sexuality and the other addressed therapeutic issues for Aboriginal clients. A third AHF-funded project was for a youth program that served gay, lesbian, bisexual and transgendered youth. This project addressed HIV as a peripheral issue, which dealt with Aboriginal youth who were questioning or struggling with their sexual identity, some of whom were being sexually exploited.

Methodology

This article can only offer an overview of some reasoned linkages between HIV/AIDS and the Legacy. A wide range of existing literature was reviewed, particularly for references or linkages to the residential school Legacy. This offered a broader knowledge base with respect to how and why the HIV/AIDS epidemic is unfolding and identifies gaps that exist to address this epidemic. Interventions regarding HIV/AIDS were also noted, especially in terms of identifying best practices. The Canadian Aboriginal AIDS Network and its affiliates were instrumental in identifying intervention-related resources, potential research of interest, as well as providing details on the history of the Aboriginal HIV/AIDS movement in Canada.

The Residential School Legacy

The establishment of the residential school system was a result of federal government policy and culminated in a formal partnership between the Roman Catholic, United, Anglican and other churches to educate Aboriginal children. Both church and state had significant roles in the lives of Aboriginal people.

For several generations, Aboriginal communities were struggling under two key avenues that contributed to disruptive changes: adverse social and economic conditions at the community level; and adverse impacts resulting from the residential school system. Through the introduction of new diseases, displaced roles (i.e., parenting), encroachment of traditional lands by European settlers, introduction of alcohol and other factors, Aboriginal communities were changing and not always for the better. Cultural strengths, such as the extended family-based system, also changed in their effectiveness to address the imminent threats commonly found within residential schools; namely, physical and sexual abuse. Thus, not only did Survivors experience trauma during their educational training, but these traumas have been multi-generational and extended to family members and friends.

Assimilation was a central goal of federal policy. In 1920, the intentions of the government was expressed in a statement made by Duncan Campbell Scott, then Deputy Superintendent-General of the Department of Indian Affairs: "Our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no question, and no Indian Department" (as cited in Gibbons and Ponting, 1989:26). Aboriginal people did not possess the power or means to resist government policy and Indian agents (government employees with wide-reaching powers), at times enforced by the RCMP.

Most, but not all, church-operated residential schools in Canada closed in the late 1960s: "Residential schools officially operated in Canada between 1892 and 1969" (Aboriginal Healing Foundation, 2001:7). The majority of residential schools ceased operations approximately a decade before the HIV/AIDS epidemic began in North America. The first Canadian death from AIDS occurred in 1983 (Health Canada, 2001), at a time when people succumbed much sooner after becoming HIV-positive.

With respect to the Legacy, at least two key areas have been impacted: damage to cultural identity, including loss of language, traditions and connection to family and community; and damage to the individual, resulting in shame, rage, lack of trust and engagement in negative coping patterns, including substance abuse, among others. Marginalization and isolation are further by-products of the Legacy. Isolation, coupled with negative coping patterns, may pose risks for HIV infection for some Survivors, as will be seen further in this study.

Rigid church doctrine, combined with many forms of punishment, led to conflicts and trauma for Survivors, which often remained unresolved. Unable to resolve these conflicts and trauma is partly because many Aboriginal communities were not in a position to adequately support their

psychological and emotional needs and because living conditions were (and still are) so impoverished in some communities. Christian teachings toward sex and sexuality, in general, were rigid and unbending. Aboriginal students were pressured to maintain abstinence until marriage. How confusing it must have been for the students to have been taught that sex is for procreation upon marriage, only to have some of these same people commit violent sexual acts against them. Damage to one's sexuality can often predispose a person to high-risk behaviours that could lead to HIV. One outcome for survivors of sexual abuse is confusion around their sexuality. This can be more confusing for same-sex abuse.

In describing cross-cultural relations, the term "ethnostress" can provide insight into the Aboriginal experience in residential schools. "Ethnostress occurs when the cultural beliefs or joyful identity of a people are disrupted. It is the negative experience they feel when interacting with members of different cultural groups and themselves" (Antone, Miller and Myers, 1986:7). This cultural clash can include normal human responses to abnormal situations. For example, if an Aboriginal child is repeatedly beaten and told their culture is savage, a normal response could be to start believing it. Ironically, forced assimilation succeeded only in creating conflict and confusion, because both residential schools and reserves segregated Aboriginal people from mainstream society.

It is difficult to say what would have happened if residential schools had not been formally entrenched in the lives of Aboriginal people. The fact that these schools operated for many generations and that institutionalized abuses occurred are factors for many, but not all, of the social ills felt today in Aboriginal communities.

Understanding Physical and Sexual Abuse

Two of the major abuses known in residential schools were physical and sexual abuse. It is important to note that not all Survivors fell victim to abuse nor did they all have the same negative experiences. Some experienced what is known as vicarious trauma, which is witnessing or hearing about the abuse and feeling powerless and too frightened to do anything about it. This powerlessness is a major characteristic of the residential school Legacy.

It is quite common for survivors of childhood sexual abuse to disclose their experiences only well into adulthood. As a result, the challenges faced are often complex and varied. Some issues that sexual abuse survivors can face include: "depression; poor self-esteem; sexual dysfunction; promiscuity; alcoholism or substance abuse; and extremely poor sense of boundaries" (Middleton-Moz, n.d.:2-27). Because of the importance of Aboriginal families, how well an Aboriginal community responds to these sensitive issues can often determine whether a victim eventually moves from unresolved trauma onto a solid healing journey.

One treatment model by Crowder (1993) describes the impact of sexual abuse on male survivors, of which many are likely similar for female survivors. Some of these impacts can increase the risk for HIV infection, and include: "Posttraumatic Stress Disorder (PTSD) and dissociation; difficulties with male [or female] gender identity; sexual orientation confusion and homophobia; abuse-reactive

perpetration and aggression; sexual compulsions and addictions; and interpersonal difficulties" (Crowder, 1993:22). Clearly, emotional challenges result when an individual experiences childhood sexual abuse. When these emotional difficulties are not dealt with, negative coping patterns may surface. For example, sexual compulsions and addictions can be areas that increase risk for HIV infections.

The effects of physical abuse mirror, in some ways, those of sexual abuse, because both behaviours often occur within dysfunctional environments. Alcoholism (or substance abuse) is a common factor associated with abuse, which creates difficulties due to the erratic and unpredictable behaviour of the abuser. As a result, some individuals with traumatic childhoods may also turn to alcohol and/or drugs as a means of coping.

Most of the documents reviewed did not examine whether the Legacy of physical and sexual abuse in residential schools is related to HIV/AIDS among the Aboriginal population, given what is known about the effects of physical and sexual abuse. However, it is safe to say that residential schools have been a contributing factor for some Survivors. This observation also applies to later generations. It is more likely that those individuals with severe unresolved trauma may be at greater risk for HIV/AIDS, based on whether certain high risk behaviours are present. Simply put, wounded children grow up to be wounded adults. Research studies, policy documents and educational materials that have some reference or relationship to residential schools are cited throughout this report.

In the absence of any substantive and direct evidence that links HIV/AIDS with residential schools, this study must rely on the chain of events that began generations ago and essentially set in motion a vicious cycle of multi-generational physical and sexual abuse. The closed climate, both within residential schools and, subsequently, in Aboriginal communities, also contributes to passing along generations of unresolved trauma.

The amount of grief work required to overcome such personal and cultural histories is immense, especially when considering inadequate support mechanisms or time to grieve before the next loss happens. In short, systemic discrimination, disruption, weakening of the family-based social system, internalized shame, combined with the multi-generational effects of physical and sexual abuse and addictions, can contribute to risk behaviours that lead to HIV infection.

As a result of lower socio-economic conditions over time, the health of Aboriginal people has suffered in general. Also, the overall health of Aboriginal people continues to raise questions about the best response to this concern. The list of maladies is seemingly endless, including higher rates of suicide, higher unemployment, poor housing conditions, lower education levels, higher rates of addictions, higher rates of sexually transmitted diseases and infections and higher rates of HIV/AIDS, among others. The poor state of Aboriginal health and social conditions, combined with individual traumatic histories (including residential schools), are likely key contributors to the significant spread and rise of HIV/AIDS among the Aboriginal population.

HIV/AIDS and Aboriginal People

HIV is an acronym for Human Immunodeficiency Virus, which is widely accepted as the cause of AIDS (Acquired Immune Deficiency Syndrome). AIDS is classified as a "syndrome" because when the immune system breaks down, infected individuals become susceptible to numerous opportunistic infections and cancers, which are the eventual causes of death. Thus, the term "syndrome" applies because it is not just one illness or infection that leads to death, but rather more than one disease that can eventually consume the body's defense.

HIV can only be determined through a blood test. The highest concentration of HIV is found in semen and blood, including menstrual discharge. There is also much less concentration of HIV in vaginal fluids, breast milk, tears and saliva. When a person has unprotected vaginal or anal sex with someone who is HIV positive, there is a high risk for infection. Blood is a highly efficient means of spreading HIV, which is also why injection drug use is contributing to many of the new and cumulative HIV infections.

AIDS develops after many years of HIV infection. Only a medical doctor can diagnose AIDS by determining whether the CD4 count is less than 200 and whether there is more than one of the AIDS-defining illnesses present. The CD4 count or T-Helper cells are the body's defense mechanisms for any imminent threats and usually attack as a viral or bacterial infection. In individuals with HIV, the CD4 count begins to drop and are unable to do their job of defending the body from infection. New anti-retroviral medications in various combinations now allow individuals to live much longer. Often, people with HIV can live up to fifteen years before the more serious threats become evident. The World Health Organization uses the following Modified Staging Model to measure the progression of the AIDS virus:

> Stages I and II are early disease stages and are largely characterized by being asymptomatic [no symptoms]. Stage III is associated with low CD4 count without a major opportunistic infection and Stage IV is usually associated with an AIDS diagnosis (Schneider, Hanvelt, Copley and Meagher, 1999:30).

Before providing epidemiological information, it is important to emphasize that the figures cited relate primarily to First Nations people and less so for the Inuit or Métis people. More importantly, significant gaps in information, as well as other factors, make it difficult to provide a precise description of how HIV/AIDS is affecting *any* of the three Aboriginal groups. Population size, regional variations, cultural differences, data collection practices and limitations, and incomplete or incorrect ethnic identifiers all affect what we know of Aboriginal HIV/AIDS cases.

According to Health Canada, "[a]s of June 2002 . . . 459 [AIDS cases] were reported as Aboriginal persons. In 1993, the proportion of reported AIDS cases with known ethnicity attributed to Aboriginal persons, was 2.0%. This proportion steadily increased until reaching a high of 10.0% in 1999" (Health Canada, 2003:1). When taking into account the Aboriginal population, which makes up 3.4% of the overall Canadian population, this means that there is a significant overrepresentation

of AIDS cases among Aboriginal people. The Centre for Infectious Disease Prevention and Control (CIDPC) of Health Canada also reports that: "Of the 459 AIDS cases among Aboriginal persons reported to June 30, 2002, 18 were identified as Inuit, 35 as Métis, and 372 as Native Indians (i.e. First Nations), and 34 as Aboriginal unspecified" (Health Canada, 2003:2). CIDPC further explains:

> Positive HIV reports from provinces with ethnicity reporting (British Columbia, Yukon Territory, Alberta, Saskatchewan, Manitoba, Prince Edward Island, and Newfoundland and Labrador) indicate that Aboriginal persons were over-represented among new HIV diagnoses, i.e. 19.2% in 1998, averaging 24.0% in 1999-2001, and peaking at 26.5% in the first six months of 2002 (Health Canada, 2003:3).

The Health Canada report indicates that HIV infections among Aboriginal people have been on a steady rise over the last decade or so. "An estimated 370 Aboriginal people in Canada are becoming infected with HIV each year - an average of more than one per day" (Health Canada, 2001a:2). Clearly, these figures are disturbing.

The greatest risk factor for HIV infection involves injection drug use (IDU), where needles are shared by more than one person. This practice also increases the risk of HIV infection for sexual partners. There is a pressing need for more prevention efforts in this area. In fact, the role of injection drug use raises a grim reality: "Injecting drug use is the predominant risk factor for HIV infections among Aboriginal populations representing an estimated 54% of prevalent infections and 64% of incident infections in 1999" (Health Canada, 2003:6). The following quote reveals trends over time where the increases are more noticeable:

> [T]he number of Aboriginal persons living with HIV has increased from 1,430 in 1996 to 2,740 in 1999 (91% increase during the 3-year period). The estimated number of incident infections among Aboriginal persons increased from 310 in 1996 to 370 in 1999. Although Aboriginal persons comprised only 2.8% of the general Canadian population in 1996, they accounted for 5.5% (2,740/49,800) of all prevalent infections and 8.8% (370/4,190) of all new infections in Canada in 1999 (Health Canada, 2003:6). [1]

The following table shows data on reported HIV tests by gender, age and exposure categories for Aboriginal and non-Aboriginal people. These data show some interesting variations between these two groups. While some community-based workers feel such comparisons further create stigmas and marginalization for Aboriginal people, such comparisons can better reveal critical information that can assist in designing interventions.

[1] According to Statistics Canada in the 2001 Census, the Aboriginal population has grown to represent 4.4% of Canada's total population and was previously 3.6% in the 1996 Census data.

Table 1: Gender, Age and Exposure Categories Among Reported HIV Tests, Aboriginal vs. Non-Aboriginal Persons in Provinces with Reported Ethnicity, 1998-June 30, 2002**

	Aboriginal	Non-Aboriginal
GENDER	**n=688**	**n=2,267**
Female	45.3%	19.9%
AGE (years)	**n=691**	**n=2,283**
20-29	27.9%	19.6%
30-39	39.5%	39.7%
40-49	22.3%	26.1%
EXPOSURE CATEGORY	**n=677**	**n=2,166**
MSM	7.7%	35.7%
IDU	60.6%	30.8%
Heterosexual	26.4%	28.8%
**British Columbia, Yukon, Alberta, Manitoba, Saskatchewan, Prince Edward Island, Newfoundland and Labrador. Subtotals differ due to unknown gender, age and exposure in some reports.		
Source : Health Canada, 2003:4		

To better explain the figures contained in the table above, the majority of Aboriginal HIV infections (39.5%) fall into the 30-39 age range, which would be the lower end of the age group that Survivors could fit. This is followed by 27.9% in the 20-29 age range and 22.3% in the 40-49 age range. With respect to how Aboriginal people are being exposed to HIV, slightly more than sixty percent (60.6%) are injection drug users compared to 30.8% among non-Aboriginal people. More than one-fourth of the HIV infections among Aboriginal people are through heterosexual contact (26.4%), which is similar to non-Aboriginal people (28.8%). Slightly less than ten per cent (7.7%) of the Aboriginal HIV infections are men who have sex with other men (MSM), compared to about a third (35.7%) for non-Aboriginal MSM.

The Role of Injection Drug Use

Sharing needles represents the main risk factor for injection drug users because of several factors that increase the risks for HIV infection. First, many of the drugs used are highly addictive (i.e., heroin and cocaine). Second, because these types of drugs also create intense, elevated feelings of euphoria, followed by a steady decline, addicts must increase the frequency of their injections to maintain this altered state. Third, with prolonged use, addicts need more and more of the drug to reach the desired state. Fourth, when needles are shared, there is a direct entry for HIV into the bloodstream because blood enters the syringe each time it is used. This is one of the most efficient way to spread HIV, as well as other diseases such as Hepatitis C.

These factors become more pronounced when HIV infections reach a benchmark among the injection drug using population. "Experience in other large cities has demonstrated that once more than 10% of the drug-injecting population is infected with HIV, prevalence of infection may increase rapidly " (Elliot, Blanchard, Dawood, Beaudoin and Dinner, 1999:v). Because injection drug use (IDU) is a key exposure category for Aboriginal people, a critical reason why IDU continues to increase is because IDU populations reach or exceed that ten per cent benchmark.

The following cites highlights from a needs assessment conducted by a needle exchange program operated through a Native Friendship Center in Nova Scotia. Although this study represents a small sampling for people of Aboriginal descent, some insightful findings included: "67% . . . of those asked said yes their parents were alcoholics; sixty-nine per cent (I) of those interviewed told us they had been abused physically, 64% described the abuse as mental and 28% said it was sexual abuse" (Grandy, 1995). Clearly, a large number of people may be predisposed to addiction simply because of the environment they were raised in, which could have similar implications for Survivors of residential schools.

Aboriginal Men Who Have Sex with Men

Men who have sex with men (MSM) represent a significant percentage of the HIV infections among Aboriginal people. The phrase, *men who have sex with men*, is preferred because the term *gay* is not always applicable to those who would fall into this category. For example, a fair number of young male sex-trade workers who sell their bodies to other men do not classify themselves as gay and rely on the sex-trade as a matter of survival. Some may be gay, but not all are. The same holds true for married men who have extra-marital sex with men. The following table shows the estimated distribution of prevalent and incident infections among Aboriginal people through different exposure categories.

Table 2: Estimated Exposure Category Distribution Among Prevalent and Incident Infections Among Aboriginal People in Canada, 1999

Exposure Category	Prevalent Infections (n=2,740)	Incident Infections (n=370)
IDU	54%	64%
Heterosexual contact	15%	17%
MSM	23%	11%
MSM/IDU	6%	8%
Source : Health Canada, 2003:6		

Injection drug use among Aboriginal men who have sex with men (MSM) is also a contributing factor to the number of HIV infections in this group. As stated above, MSM accounted for 23% of prevalent infections and 11% of incident infections. When injection drug use was included as a contributing risk factor, another 6% of prevalent infections and 8% of incident infections were found.

Aboriginal gay males in large urban settings were among those first affected by HIV/AIDS. Homophobia, felt to be a key barrier, continues to factor into prevention efforts. The Ontario AIDS and Healthy Lifestyle Survey found that: "The majority of respondents felt homosexuality was wrong, and perceived their family and community to support this view" (Myers, Calzavara, Cockerill, Marshall and Bullock, 1993:42). Approximately 80% of respondents in each of these groups held negative views toward homosexuality.

Aboriginal Women

Table 3 shows the number of reported AIDS cases for 2001 for Aboriginal and non-Aboriginal women. These percentages indicate that young Aboriginal women account for almost three times more AIDS cases than non-Aboriginal women. Injection drug use (IDU) as a risk factor is almost six times more likely for Aboriginal women than non-Aboriginal women.

Table 3: Gender, Age and Injecting Drug Use Among Aboriginal and Non-Aboriginal [Females] Reported AIDS Cases up to June 30, 2002

	Aboriginal		Non-Aboriginal	
Gender: Female	n=458	23.1%	n=15,237	8.2%
Age (years): <30 years old	n=459	24.6%	n=15,253	16.5%
Exposure Category: IDU	n=446	35.9%	n=14,874	6.3%
Source : Health Canada, 2003:2				

Available data suggest that an increasing number of Aboriginal women are becoming infected with HIV largely through heterosexual contact and also that more Aboriginal women are becoming involved with injection drug use, compared to non-Aboriginal women. However, there are gaps that still remain in the HIV/AIDS data, especially with respect to Aboriginal women living with HIV/AIDS.

Some Aboriginal women, who are sexual partners of injection drug users, also face high risks when unprotected sex occurs. When an HIV-positive woman becomes pregnant, there are real risks of infecting the unborn child at birth. Provided the woman knows she is HIV-positive, seeks medical attention and takes medication, the risks for infecting the child are reduced.

A study done by Shipp, Norton and Roussil revealed the most direct evidence of a link between residential schools on an intergenerational level where personal histories of physical and/or sexual

abuse were present. This study notes: "Most of the [HIV] positive women we interviewed told us that they come from families where one or both parents had gone to residential schools and alcoholism was a problem in the family. Eight [HIV] positive women admitted that they had been victims of sexual abuse as children and three women had been involved in abusive relationships either with a spouse or partner" (1999:24).

Sexual violence can result in risks for HIV infection when the attacker has HIV. It is a reasonable assumption that during any act of sexual violence, a male sex offender would not take the time or concern to wear a condom. This assumption is evident because the attacker would likely be rushed so as not to get interrupted by someone who could identify them. Sexual violence is defined as "any unwanted or non-consensual sexual touching, act or exploitation achieved through physical force, threat, intimidation and/or coercion" (Health Canada, 2001b:1). However, not all acts of sexual violence carry the same risks for HIV; for example, forced oral sex is believed to carry less risk unless there is broken skin in or around the mouth. This is not meant to downplay the trauma and violation that occurs as some risk may be present if the attacker has HIV. Sexual violence that could increase the risks for HIV include: "sexual assault; historical sexual assault (childhood sexual abuse and repeated sexual assault); [and] partner abuse (sexual assault and other acts of sexual violence against women in their relationships)" (Health Canada, 2001b:1).

Aboriginal Offenders

Institutional homosexuality occurs when the offender (usually a heterosexual prior to incarceration or when not incarcerated), engages in same-sex behaviours while incarcerated. Percentages vary and evidence suggests that the numbers are significant. "The findings of studies on sexual conduct in prison are quite consistent. The Montreal medium security prison study found that 6.1% of men and 6.8% of women report having sex in prison. Similarly, the CSC [Correctional Services Canada] survey found that 6% of inmates report sex in prison. The New Brunswick study found a rate of 9%. Condom use was reported by only 33% of inmates in the CSC survey" (Canadian Aboriginal AIDS Network, n.d.:28). Because sex between inmates is prohibited within a correctional setting, this may lead to unsafe sexual practices.

With respect to injection drug use, needles often are used so many times that they become dull, causing more damage to the skin upon injection. Inmates also may not clean the needle with bleach and water before the next inmate uses it, because both possession of drugs and the injection equipment are illegal. Homemade injection equipment is used, such as pens, which are so crude they cause significant skin damage upon injection. Because a number of inmates may pass around one needle, HIV and Hepatitis can easily be spread. As this indicates, clean or unshared needles are viewed as a major aspect in harm reduction against HIV. "Drug use within the penal system is a fact of life, but there is no program for providing clean needles in prison. Thus while in prison, Aboriginal IDUs are unable to protect themselves against HIV infection" (CAAN, n.d.:i).

Furthermore, it is widely believed that bleach and water does not kill the Hepatitis C virus. "Hepatitis C is a stronger virus than HIV and can not be killed by cleaning needles with bleach. In

Vancouver, 90% of the IDU community is infected with Hepatitis C" (CAAN, n.d.:20). While using bleach kits (provided within federal institutions) is better than not using anything to clean needles, it may do little to control the risks of infection for Hepatitis. Until the system changes to allow needle exchange programs within correctional facilities, more infections will occur. Also, tattooing with unsterilized equipment increases the risk for HIV infection.

Other Concerns

Many stigmas and fears exist that impede prevention messages. Even when someone is HIV positive, these negative attitudes can affect how they access proper medical attention, care and support. The following provides some insight into how fear and isolation can affect someone living with HIV or AIDS. "In the FN-CHRP [First Nations - Communities Health Resources Project] supplemental, the question, 'When you are back home, how comfortable do you feel telling people you are HIV+?' was asked. Of those who responded, 40 of the 63 respondents (63%) stated that they were either 'Somewhat Uncomfortable' or 'Very Uncomfortable'. 30 of the 40 negative responses were 'Very Uncomfortable' " (Schneider, Hanvelt, Copley and Meagher, 1999:8). Thus, one can see how difficult it may be to gain a more accurate assessment of how prevalent HIV/AIDS is among the Aboriginal population.

Aboriginal youth are also a particular concern. Available data indicate a significant proportion of Aboriginal people are becoming infected at younger ages than in the mainstream population. The rates of teenage pregnancies and levels of sexually transmitted infections among Aboriginal youth in some areas support this concern. For example, the BC Centre for Disease Control also found higher rates of HIV-positive testing:

> The increased vulnerability of First Nations populations is based on reports to Health Canada which shows levels of venereal disease (V.D.) such as gonorrhea, syphilis, chlamydia, trichomonas, genital herpes, etc. among First Nations, are higher than the national averages. Reports also show that the rate of teen-age pregnancies is higher than the national average, indicating young people having sex without condoms (Schneider, Hanvelt, Copley and Meagher, 1999:11).

One concern is that sexually transmitted infections (STIs) increase the risk for HIV infection, in part, because of open sores, in part, because of their impact on the immune system. The other concern centers around the levels of unprotected sex, demonstrated by the increasing number of teen pregnancies. It is critical to get the message across that HIV is a preventable disease.

The argument for supporting more prevention efforts is strengthened when the costs of treating this disease are examined. The economic burden is high. Drug therapies range from $6,315 to $12,205 per individual for the most common drugs being prescribed, with the highest costs being associated with an extended hospital stay in the last three months of life (Schneider, Hanvelt, Copley and Meagher, 1999). "A recent Canadian Study has made an estimate of $153,000 for the lifetime costs of treating someone with HIV and AIDS. This includes the cost of expensive drug therapies . . .

also include taking time off work and providing for child-care" (Schneider, Hanvelt, Copley and Meagher, 1999:10). An explanation on how costs are measured is given by Schneider and others: "Economic costs include all associated activities in caring for persons living with HIV and AIDS, that could be used for other valued activities" (1999:12). These are broken down into two main categories, direct and indirect costs and are summarized as follows:

> Direct costs can include such items as: medications; hospitalizations, medical contacts & procedures; health professional services; support services (nutrition, housing, counseling, personal care) and so forth. Indirect costs can include such things as: lost productivity; care, treatment & support given by volunteers and family members; lost contribution to society; lost contribution to household & family, etc. (Schneider, Hanvelt, Copley and Meagher, 1999:12).

According to Health Canada, "the number of persons newly infected with HIV was about 4200 per year" (Health Canada, 2001a:1). This equates to roughly eleven people per day. If an additional eleven Canadians become infected with HIV per day, multiplied by estimated lifetime care costs of $153,000, one can expect a minimum of $1,683,000 for every 11 cases found. Therefore, it could cost Canada over $50 million each month to care for those who become infected with HIV. There is some evidence to suggest that "First Nations persons living with HIV in Vancouver are accessing combination drug therapies at a **rate significantly lower** [emphasis added] than non-First Nations men who have sex with men" (Schneider, Hanvelt, Copley and Meagher, 1999:11). Thus, increased rapid disease progression, including more complications, may be more likely for Aboriginal people living with HIV/AIDS.

Best Practices

Very little research is available on best practices for addressing HIV/AIDS, especially with respect to Aboriginal people. Although the Canadian Strategy on HIV/AIDS undertakes regular evaluations, it appears that no major evaluation on efforts to combat Aboriginal HIV/AIDS has occurred. Individually funded initiatives generally implement evaluative measures, yet no large-scale effort has taken place. A literature search revealed only two sources that identified best practices.

The Atlantic First Nations AIDS Task Force developed a Best Practices Model on Child Sexual Abuse and HIV/AIDS. The primary reason for developing the model occurred when the agency had: "come across two recent cases in a 1st Nations setting where a confirmed HIV positive individual had been formally charged with a criminal offense for sexually abusing a child" (Atlantic First Nations AIDS Task Force, 1997:1). The agency mainly focused on HIV/AIDS prevention, education and training, and was caught off-guard when these situations became known and needed to assume a crisis management role. The model highlights approaches in dealing with child sexual abuse commonly found in other literature. The key challenge is that, unless the pedophile is known to be HIV positive, police are limited to prosecuting for sexual abuse only and not for exposing a child to a life threatening virus.

Also, there are multiple emotional aspects, especially when the community becomes aware that HIV is involved and there may be subsequent alienation toward the child because they are deemed to be HIV-positive, even when they are not. A series of discussion questions were developed to help address the fear that may prevail. They were aimed at clarifying values and prompting individuals to look beyond the initial fear and reaction.

The other resource on best practices is a report of the Federal/Provincial/Territorial Working Group on Aboriginal People and HIV/AIDS. Contributors to the report self-identified forty-one examples of what they felt were best practices. These are categorized into eight key areas:

Category:	**Best Practices Examples:**
Advocacy	AIDS Walk 98 and Aboriginal AIDS Awareness Week.
Band Council Resolutions	Union of Ontario Indians.
Capacity-building	Community Development Model; HIV/AIDS Skills-Building Forum and Strengthening Community Based Organizations.
Harm Reduction	Needle Exchange Program - Yukon; Aboriginal Harm Reduction Model.
Inter-jurisdictional Strategies and Models: (Regional, provincial or national level)	Alberta Aboriginal HIV/AIDS Strategy; BC Aboriginal HIV/AIDS Task Force; Quebec Provincial Aboriginal AIDS Coalition; Ontario Aboriginal HIV/AIDS Strategy; Aboriginal HIV/AIDS Working Group; Alberta Aboriginal Committee on HIV/AIDS and Atlantic First Nations AIDS Task Force. Community Level: On-reserve services provided by STD staff; Mobile HIV/AIDS Sexual Health Team; and Beardy's HIV/AIDS Sexual Health Team.
Prevention, Awareness and Education	Tree of Creation; Youth Supper Club; BC Aboriginal AIDS Awareness Program; "Showing the way" television ad series (PSAs); Elders Counselling Youth; SPYLING Awareness Program; Traveling Prevention and Awareness Program; Educational Program Alcohol/Drug Centres; HIV/AIDS Education Workshops On-reserve; Peer Leadership and Education; Family-Based Support Model; School Based HIV/AIDS Educational Program; AIDS 101 Posters; and First Nations Youth HIV/AIDS Educational Manual.
Service Delivery Models	Feather of Hope; Street Connections; Community Resource Worker; Living Room Program; Integrated Social Services, Conn River; 1-800 AIDS Information Line; Big Cove Reserve Testing Clinic; All Nations Hope AIDS Network and Calgary Urban Outreach Project.
Surveillance	Anonymous testing and pre-natal blood testing.
Source: Lemchuk-Favel, 1999.	

The term *best practice* is not always applied in the same sense and there may even be a shift toward using *preferred practices*. A best practice usually has solid evidence that certain approaches achieve desired results. Best practices describe ideal models and provide recommendations on policy and procedures. While the above-mentioned examples were stated as best practices, some may in fact be

good practices. Without the opportunity of doing further research into these examples, it is difficult to confirm whether they are, in fact, best practices.

Challenges

HIV/AIDS remains a major challenge and there is a constant need to have accurate and timely information that can support the use of any best or preferred practice. Injection drug use continues to grow as a key exposure category, increasing the number of new and cumulative HIV infections. Unprotected sex follows next as a key exposure category, and men who have sex with men share both these risks.

Although funding has been provided for Aboriginal HIV/AIDS programs, there remains a need to use these resources efficiently because they may not be sufficient in meeting the growing demand. Until living conditions improve, Aboriginal people will continue to experience poorer health status that includes HIV/AIDS. Many Aboriginal people living with HIV/AIDS may not be accessing new medications, which can cause their health to deteriorate more quickly.

Advancements have occurred in overcoming funding barriers, yet there is still a growing concern with respect to both HIV and Hepatitis C, especially within correctional settings where a disproportionate number of Aboriginal people are incarcerated, as well as among injection drug users and their families. Greater efforts are needed to divert Aboriginal people away from incarceration through alternative justice methods and to work within various release options, such as correctional healing lodges. Offenders being released and returning to their communities may need education and support in dealing with the potential risk of having HIV and/or Hepatitis C infection resulting from any related risk behaviours while incarcerated.

Other individuals that may feel marginalized (i.e., men who have sex with men, injection drug users, inmates, sex-trade workers, etc.), from their own community, require on-going and additional attention. Without increased focus in these areas, HIV may continue to grow within the Aboriginal population. Greater efforts to evaluate HIV education and prevention programs are needed and programs should be targeted to groups that engage in known high risk behaviours.

Conclusions

This brief overview sought to determine whether there is a link between the Legacy and HIV/AIDS; to outline how HIV/AIDS is affecting Aboriginal populations; and to identify and describe interventions, including best practices and challenges. Research indicates that there is a clear and disproportionate over-representation of Aboriginal people in both prevalent (cumulative) and incident (new) HIV infections. AIDS figures also reveal a similar over-representation. Although gaps in data exist, certain trends are noticeable, such as the exposure categories that contribute to how Aboriginal people are becoming infected with HIV/AIDS. Unprotected sex, whether heterosexual or homosexual and, more so, injection drug use, account for a large number of HIV/AIDS infections.

In terms of a link to the Legacy, there is little direct evidence that accurately describes the extent to which Survivors and later generations are infected and affected by HIV/AIDS. However, there is evidence that some Survivors have become infected. As stated earlier, one study by Shipp, Norton and Roussil (1999) revealed that there were a significant number of Aboriginal women, from homes where at least one parent had attended a residential school and alcoholism was an issue, were HIV-positive. Many of these HIV-positive Aboriginal women also disclosed personal histories of sexual abuse and some had been in physically abusive relationships. The study, however, stated limitations to their sampling size and described their report as exploratory. This is perhaps the most direct evidence found for intergenerational impacts. Primary research would have determined a greater understanding of these issues and the extent to which they are present.

In regards to underlying factors, the impact of government policy in the operation of residential schools, the role of the church and its doctrine, ethnostress, as well as other specific impacts from physical and sexual abuse, provide a reasonable linkage between the Legacy of residential schools and HIV/AIDS. Government policy was based on assimilation goals that weakened the foundation of Aboriginal communities, essentially family-based social systems. Due to multi-generational effects from assimilation, new-found illnesses and other factors, family structures weakened, especially with the establishment of residential schools that operated for over 130 years.

Residential schools were more than just a place of loneliness for many Aboriginal children who were separated from their parents and community. They were a formally entrenched system that sought to ensure assimilation goals would be achieved. This resulted in change, which is seen as negative by many Survivors and Aboriginal communities. Many individuals have passed through the doors of residential schools, resulting in several generations of negative impacts and cumulative losses. When institutional abuse occurs, it increases the burden for Survivors, because they had little or no recourse to question those in authority. The most devastating types of abuse known are physical and sexual abuse. With the added cultural and language losses, it is easy to understand how too many individuals were wounded.

Ethnostress further created conflict and confusion for Aboriginal communities, and many did not have the full capacity and resources to effectively respond to the needs of individuals who were

physically and/or sexually abused. Social ills, such as addictions and family violence, kept the abuse hidden. This increased the grief and loss work that is required to overcome the Legacy of physical and sexual abuse in residential schools, including intergenerational impacts. HIV/AIDS data clearly show the role of injection drug use as a risk factor among the Aboriginal population, which means that substance abuse is a common, yet negative, coping pattern being used. This fact leads to a reasonable assumption that there can be a link to the Legacy, when one considers that some Survivors with unhealed traumas may be among those that inject drugs.

One must also consider the impact of physical or sexual abuse on an individual. It is both plausible and possible that the Legacy can play a role for HIV/AIDS among certain segments of the Aboriginal population, perhaps more indirectly than directly. It is a reasonable claim that the Legacy has been a factor in the spread of HIV/AIDS among the Aboriginal population, however, the real question is: to what extent? A study cited earlier, on injection drug users (Grandy 1995), revealed troubled homes and childhoods where physical, sexual, mental and emotional abuse were common factors. This further confirms a relationship between troubled childhoods and homes, with subsequent self-destructive patterns in adulthood. When this self-destructive pattern is injection drug use, there are high risks for HIV. Another study referenced earlier that specifically targeted Aboriginal injection drug users (CAAN:n.d.), also found physical and sexual abuse common for both male and female study participants. Finally, data from Health Canada confirm injection drug use as a key exposure category for Aboriginal people in regards to HIV/AIDS.

This review suggests that a link, although tenuous, can be drawn when we consider: the impact of physical and sexual abuse; significant risks associated with injection drug use for HIV; and the high level of injection drug use as it contributes to HIV infections among the Aboriginal population. Negative results from government policies of assimilation have led to significant changes in Aboriginal communities. These changes include: loss of traditional economies, new illnesses, and damaged individuals and communities. Residential schools are among the key influences that have helped shape Aboriginal communities. These cumulative traumas and troubled personal histories, combined with low socio-economic conditions, affect the ability of Aboriginal people to overcome adverse situations such as HIV/AIDS. It is this current state of affairs that is believed to be contributing to many of the negative situations Aboriginal people face. HIV/AIDS is simply one of the newer issues being raised. Efforts must continue so that HIV/AIDS remains a preventable disease.

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