

# The Canadian Aboriginal AIDS Network 'HIV/AIDS Community Building'



## HIV/AIDS Aboriginal Skills Building Forum

**1999**

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## ***Executive Summary***

*HIV/AIDS Community Building* was the theme for the Canadian Aboriginal AIDS Network's (CAAN) Skills Building Forum '99. This theme reinforces the need for many groups within the Aboriginal community to come together to share in the knowledge and experience of those working in the HIV/AIDS field and/or those who are affected or infected by HIV/AIDS.

By learning together, we can keep our communities strong and healthy and move forward in unity. We can also strengthen our ties to those in the non-Aboriginal community whose hard work and dedication to the cause of HIV/AIDS can further enhance our understanding of the disease and assist us in our need for better treatment and prevention.

The theme helps to integrate Aboriginal beliefs and healing practices, and fortifies the need to reconnect with the teachings and traditions of our ancestors.

CAAN has been incorporated since March of 1997. Part of its mandate, under the guidance and support of the HIV/AIDS Prevention and Community Action Program, is to plan and conduct a national forum that provides the Aboriginal community with the necessary skills to address HIV/AIDS. Delegates from across the country are invited to attend the forum in the capacities of presenters and participants. The need for such skills building was identified by the CAAN Board of Directors before CAAN's incorporation. Every effort was made to ensure that such a forum take place.

The goal is to raise awareness of HIV/AIDS as it relates to the Aboriginal community and give those, providing service and support, the tools necessary to deal with the issues.

The Skills Building Forum provided an excellent opportunity for recommendations to be brought to CAAN's attention, and help them to determine what matters should be addressed by the organization. One constant theme was, however, prevalent throughout the conference.

*That there is a need for widespread community building among Aboriginal peoples. It is time to look for solutions as well as identify the problems. These solutions need to come from us, and not from outsiders. All Aboriginal people must be involved, regardless of gender, age, belief systems, status, sexual orientation, profession, or political affiliation. Until we recognize that all peoples — drug users, sex workers, and prison inmates include — are part of our community we won't be able to heal completely.*

A great deal of planning and effort goes into preparing a forum like this one. The Canadian Aboriginal AIDS Network would like to take this opportunity to offer thanks for the work done by a dedicated group of individuals. CAAN thanks the staff at CAAN, Robert Friday, Cindy Deschenes, Derek Barnaby and Cindy Ashkewe who planned and organized the Forum. An event like this would be lost without a very special group of people, volunteers, who gave their time and their

selves to help make the forum a success. Their effort is greatly appreciated by the CAAN staff and conference delegates. We thank this group of volunteers in Ottawa and Toronto and send a special thanks to Darwin White.

The Canadian Aboriginal AIDS Network would like to thank everyone who helped to make our forum a success. Thanks for sharing your information, for showing strength of spirit, and revealing your hope. May we all meet again soon.

All My Relations.

## ***Conference Planning***

The Canadian Aboriginal AIDS Network's "Skills Building Forum '99" is the second of such events for the organization. The success of last years forum reinforced the ongoing need for such information sharing, and thus, preparations for a skills building forum for 1999 were made.

A committee of CAAN staff and Board of Directors was struck at a board meeting in November 1998. The committee determined the overall theme of the forum; *HIV/AIDS Community Building*. A CAAN staff member was appointed to be the skills building forum coordinator who would oversee the planning and implementation of the forum. Two additional staff members were hired on contract to assist in the development of the project. They enlisted a small group of volunteers from both Ottawa and Toronto to help carry out duties of the forum.

Registration forms, information posters, and scholarship applications were made available to all potential participants. Information was sent and/or faxed to CAAN's board member organizations, national partnership groups, national and regional HIV/AIDS service organizations, branches of Health Canada, individual and organizational memberships, past participants, and others contacts who expressed interest.

Some of these include:

- Atlantic First Nations HIV/AIDS Task Force;
- Two-Spirited People of the First Nations;
- HIV/AIDS Legal Network;
- Community AIDS Treatment Information Exchange;
- National Indian and Inuit Community Health Representatives Organization.

Health professionals, HIV/AIDS front line workers, national and regional organization representatives, traditional healers, media consultants, and those directly affected or infected by HIV/AIDS comprised the bulk of participants at the forum.

### **Scholarships**

The Canadian Aboriginal AIDS Network was able to provide some scholarships for those wanting to attend, as always, resources were limited. Scholarship applications were distributed with a closing date of February 5, 1999. Selections were made by a small committee comprised of: the CAAN Executive Director, one CAAN Board Member, the Skills Building Forum Coordinator and assistant

on February 10. Approximately 75% of the applications received were approved for scholarship. They were selected on the basis of region, gender, Aboriginal Person living with HIV/AIDS (APHA) status and availability of CAAN resources.

## ***Summary of Proceedings***

The CAAN Skills Building Forum was held at the Best Western Primrose Hotel, 111 Carlton St., Toronto, Ontario from March 4 to 6, 1999. There were 105 people registered for the forum.

Delegates were flown into Toronto on Wednesday, March 3 in time for registration Thursday morning beginning at 8:15.

The forum offered 19 different workshops on topics ranging from group specific (Women and HIV/AIDS, 2-Spirited components) to the practical (proposal writing) to the spiritual/emotional (“Psychology of Vision”, “Healing Through Humour”)

### **March 4, 1999- DAY ONE**

The morning began with an opening prayer. Darcy Albert of the Two-Spirited People of the First Nations acted as Master of Ceremonies. Sandra Greene, Executive Director of CAAN, welcomed everyone to the forum. Robert Friday, Skills Building Forum Coordinator, gave a briefing about the preparation and proceedings of the forum. Albert McLeod of the Manitoba Aboriginal AIDS Task Force addressed the audience as Key Note Speaker. The existing CAAN Board of Directors was introduced and a list of workshop presenters was read aloud.

After a brief coffee break three short presentations were made by:

- Laura Commanda of Health Canada;
- Renee Masching, CAAN representative for the National Aboriginal Reference Group on HIV/AIDS (NARGHA); and
- Mai Nguyen of the Laboratory Centre for Disease Control Working Group and Arlo Yuzicipi-Fayant.

A traditional lunch was held at the Council Fires Native Friendship Centre. The first three workshops began at 1:15 p.m.

The workshops included:

- *The Art of Proposal Writing* by Christine Smith;
- *Healing, Surviving, and Loving in the Meantime — The Emotional, Mental and Spiritual Aspects of HIV/AIDS* by Judy Weiser and Rodney Horne;
- a panel workshop with short presentations by Gary Carbonell, *How to Run Successful*

*Aboriginal Organizations*; Mai Nguyen on *HIV/AIDS Epidemiology*; and Skyler Webster on *Writing for Journals and Abstract Presentations*.

The conference was adjourned for the day.

Alex Archie hosted the APHA Caucus at 5:00 p.m. that evening.

### **March 5, 1999- DAY TWO**

An opening prayer was conducted, followed by announcements by Master of Ceremonies, Laverne Monette of the Ontario Aboriginal HIV/AIDS Strategy. Dean Moncayo of the Heiltsuk Cultural Education Centre presented a Key Note Address.

Morning workshops included:

- *The Psychology of Vision* by Edna Brillon and Ann-Marie Woodall;
- *The Effects of the Residential School System on Healthy Sexuality* by Doreen Sterling;
- *HIV/AIDS Program Delivery- The Community within a Community* by Tom Howe and Gabe Saulnier;
- *Assembly of First Nations (AFN) HIV/AIDS Research Projects Update* by Duane Etienne;
- *Non-Governmental Organizations*, presentations by the HIV/AIDS Legal Network, Community AIDS Treatment Information Exchange (CATIE), and the Canadian AIDS Society (CAS);
- *Two-Spirited Elder Speaks* by Nazareth Therriault; and
- a presentation on *The Red Road* by Art Zoccole and Alex Archie.

Lunch followed.

Afternoon workshops began at 1:15 p.m. and included:

- *Examining the Dilemma of HIV/AIDS Health Care* by Dean Moncayo;
- *HIV/AIDS Therapies and the Circle of Healing* by Ralph Wushke and Irene Peters;
- *The Psychology of Vision- Part II* with Edna Brillon and Ann-Marie Woodall;
- presentations on *Aboriginal Women and HIV/AIDS* by Margaret Horn (video presentation)

and Wanda Villanueva (discussion);

- *Aboriginal HIV/AIDS and Prisons* by Rick Lines and Laverne Monette; and
- *The Effects of the Residential School System on Healthy Sexuality* (condensed version) by Doreen Sterling.

### **March 6- DAY THREE**

A morning prayer opened the day, followed by Master of Ceremonies, Margaret Horn who made announcements. Alex Archie gave an APHA view as the Key Note Speaker.

Workshops included:

- *Educating Beyond the Basics* with Barbara Bowdeich;
- *Psychology of Vision- Part III* by Edna Brillon and Ann-Marie Woodall;
- *NARGHA Update* by Jake Linklater; and
- *Healing Through Humour* by Leonard Dick.

Workshops ended at 12:00 noon.

The first CAAN Annual General Meeting immediately followed. Those interested were invited to attend.

An official closing of the Skills Building Forum '99 was held at 2:30 p.m. in the Pearson Room. The newly elected Board of Directors was introduced, final announcements were made, and a closing prayer ended the forum.

All participants were invited to attend a social at 6:00 p.m. at the Native Canadian Centre with the serving of traditional food, and entertainment provided by the "Eagle Heart Singers."



## ***Goals and Objectives***

The overall goal of the conference was to provide a forum for Aboriginal people infected and affected by HIV/AIDS to identify their needs, voice their concerns, and share their experiences.

### ***Goals And Objectives***

- To bring together from across Canada Aboriginal Peoples affected and infected by HIV/AIDS. (Goal Met)
- To provide information and empowerment techniques to Aboriginal People living with HIV/AIDS. (Goal Met)
- To examine the needs and gaps around HIV surveillance and research issues among Aboriginal populations. (Goal Met)
- To recognize and reflect the cultural and traditional strengths and diversity of Aboriginal communities. (Ongoing)
- To implement and begin the consultations necessary to help agencies and individuals develop Aboriginal AIDS Strategies in their communities. (Ongoing)
- To provide delivery of the latest treatment/research issues and information. (Goal Met)
- To provide a forum for delegates who attend to share with one another issues not addressed in the conference agenda. (Goal Met)
- To provide an opportunity for AIDS organizations to network with one another and other Aboriginal Organizations. (Ongoing)
- To identify and make recommendations regarding issues surrounding Aboriginal community building and partnerships. (Ongoing)
- To provide information about developing culturally appropriate training and education materials to impact Aboriginal communities. (Goal met)
- To gain feedback and recommendations on CAAN projects. (Goal Met)
- To gain direction on the role of a national Aboriginal AIDS Organization. (Ongoing)

- To identify the need for and designing cross-cultural training with Non-Aboriginal service providers. (Ongoing)

# **Key Note Address**

Presenter: Albert McLeod

## **Objectives**

To share community experience in data collection, interpretation and application of these data in prevention and control programs for Aboriginal persons.

### **Aboriginal communities' viewpoint: Why do we need to collect HIV/AIDS statistics?**

- To raise awareness of the importance of the HIV/AIDS epidemic among Aboriginal communities.
- To have data relevant to Aboriginal people
- To justify applications for funding of Aboriginal research and support programs

### **Data relevant to Aboriginal people**

Compared to non-Aboriginal AIDS cases (n=12,237) Aboriginal AIDS case (n=303) are:

- Younger: 29.0% vs 17.7% less than 30 years of age
- More likely to be women: 16.5% vs 6.4% in adult persons
- More likely to be infected by injection drug use: 23.4% vs 3.9%

### **Data for public health action: Prevalence/Incidence studies**

1. Study among pregnant women in Manitoba
- Data:
    - prevalence rate was 0.7 per 10,000 in 1991
    - prevalence rate was 3.2 per 10,000 in 1994-95

When compared to previous estimates of HIV prevalence, the 94-95 prevalence rate was

higher than predicted.

- Recommendation: Screening pregnant women for HIV.  
Currently, the province is evaluating the outcome of screening policy regarding the detection of infected mothers and the treatment on time to prevent the spread to infants.
- 2. Study among injection drug users in Winnipeg (Winnipeg Injection Drug Users Epidemiology (WIDE) Study)

# ***Health Canada Presentation***

Presenter: Laura Commanda

## **Canadian Strategy on HIV/AIDS**

- For Aboriginal people living on-reserve and off-reserve.
- New Strategy released May 1998 is based on past successes and lessons.
- Community based infrastructure.
- Move from a federal strategy to a nationally shared approach, more team-building.
- Focus on education and prevention.

## **Six major goals:**

- To prevent the spread of HIV.
- To find a cure.
- To find and provide effective vaccines, drugs and therapies.
- Provide care, treatment and support for people living with HIV/AIDS, their care-givers, families and friends.
- Minimize the adverse impact of HIV/AIDS on individuals and communities.
- Minimize the social, economic factors that increase the risk of HIV infection.

## **Three major policy directions guiding the implementation of the strategy:**

- integration and sustainability;
- increased focus on groups most at risk; and
- increased public accountability.

### **Co-ordinating mechanisms**

- Ministerial Council on HIV/AIDS.
- Working Group on Aboriginal Issues.
- Increased inter-collaboration.
- Increased research co-ordination.
- Increased co-ordination of Aboriginal HIV/AIDS related activities.
- Increase co-ordination of annual priority setting and program planning process.

### **Current strategy highlights:**

- 42.2 million annually.
- No time-limit to this program.
- Permanent program of Health Canada.
- 15 member ministerial council that advises the minister.
- One million for community based research.
- New drug policies that focus on high risk groups.

### **Allocations**

- Prevention work: 3.9 million.
- Community development support for Non-Government Organizations: 10 million.
- Care, treatment and support: 4.75 million.
- Research: 13.15 million.
- Surveillance: 4.3 million.
- International collaboration: Three hundred thousand.
- Legal, ethical and human rights: Seven hundred thousand.
- Outreach to communities: 2.6 million.

- Competition monitoring and reporting: 1.9 million.
- Correctional Services of Canada: Six hundred thousand.

### **Stakeholder recommendations**

- Distinct approaches are needed, specific to Aboriginal control strategy.
- Dedicated funding for Aboriginal people.
- Increased funding for national HIV/AIDS organizations.
- Increase focus on research and surveillance.

### **Health Promotions and Programs Branch (HPPB): Allocations — HIV/AIDS Division**

- Prevention and community action: 100,000.
- Care, treatment and support : 100,000.
- Co-ordination: 100,000
- Community Development: 1.2 million.

### **Branches within the department**

- Medical Services Branch (MSB): Epidemiology and surveillance.
- Health Promotions and Programs Branch: Community development programs.
- Also have strategy dealing with Correctional Services of Canada.

### **Partnerships — Information sharing mechanisms within Health Canada on Aboriginal HIV/AIDS issues.**

- Ministerial Council.
- NARGHA.
- Ethnic Advisory Committee which is also working on Aboriginal issues.



# ***NARGHA Presentation***

Presenter: Renee Masching

## **National Aboriginal Reference Group on HIV/AIDS (NARGHA)**

- still in development stage

### **Membership**

- Assembly of First Nations
- Canadian Aboriginal AIDS Network
- Congress of Aboriginal Peoples
- Inuit Tapirisat of Canada
- Paktuutit
- Metis National Council
- National Association of Friendship Centres
- Native Women's Association of Canada
- 2 seats for PHAs
- Montreal Native Friendship Centre (transitional seat)
- Native Women's Transition Centre (transitional seat)
- Health Canada representatives

### **Terms of Reference**

- Still in draft form.
- Intent is to work in partnership with Health Canada and Aboriginal organizations that are

involved directly or indirectly in Aboriginal health issues and specifically HIV/AIDS.

### **Mandate**

- Advise Health Canada and help focus the Aboriginal component of the Canadian Strategy on HIV/AIDS on the issues that require attention. Obviously, these issues will change over time.

### **Work Plan**

- Define Terms of Reference
- Develop administrative guidelines for the urban and non-reserve funding dollars. This is aided in part by the National Round Table Discussions.
- Learning to work together. Learn from one another. Very positive process.

# ***LCDC Working Group Presentation***

Presenters: Arlo Yuzicapi Fayant and Mai Nguyen

## **Mandate:**

### **Bureau of HIV/AIDS, Sexually Transmitted Diseases (STD) & Tuberculosis (TB)**

- To conduct national surveillance and applied studies on the epidemiology and laboratory science related to HIV/AIDS, STD and TB;
- To investigate HIV/AIDS, STD and TB infections and outbreaks; and
- To develop recommendations for their control.

### **Our objective related to Aboriginal Issues**

- To more fully involve Aboriginal people in the design, implementation, collection, interpretation, and dissemination of HIV/AIDS epidemiologic information so that prevention and care programs for Aboriginal people may be better targeted and evaluated.

### **Our Activities**

- Supporting HIV prevalence and incidence studies;
- Hosting annual meetings for Aboriginal stakeholders;
- Coordinating the Aboriginal Working Group on HIV/AIDS Epidemiology and Surveillance (AWG);
- Enhancing the reporting system for HIV/AIDS among all Canadians, including Aboriginal people; and
- Disseminating information rapidly to Aboriginal communities.

### **Information dissemination**

- Information synthesis and dissemination is one of the major tasks of the Bureau of HIV/AIDS, STD & TB
  - List of Bureau's reports, publications and presentations

Solicit feedback on ways to improve our information collection and dissemination.

### **Bureau's reports and publications**

- Proceedings of annual meetings:
  - Aboriginal HIV/AIDS Epidemiology and Surveillance meeting
  - HIV Epidemiology meeting
  - HIV/AIDS Surveillance meeting
- Inventory of HIV Incidence/Prevalence Studies in Canada
- HIV Risk Behaviours Among Canadians: An Inventory & Synthesis
- HIV and AIDS in Canada, Surveillance Report
- HIV/AIDS Epi Updates and STD Epi Update Series
- Division Activity Report to May 1998

### **Feedback on ways to improve information dissemination to Aboriginal people**

- Opportunity to obtain your feedback:
  - content
  - format
  - language
  - access
  - frequency of dissemination

## **ABORIGINAL WORKING GROUP ON HIV/AIDS EPIDEMIOLOGY AND SURVEILLANCE**

### **Background of the AWG**

- March 1996: was initiated to provide guidance and advice to LCDC on priorities for information collection.

- During 1996-98: added a few more responsibilities to continue the work discussed between annual meetings (see the AWG's Mandate).
- 1998-99: developing ways for better use of HIV/AIDS statistics among Aboriginal people in prevention and care programs, as well as mechanisms to liaise its work with other governmental HIV/AIDS programs.

### **Current members of the AWG**

- Mr. Darcy Albert
- Ms. Arlo Yuzicapi Fayant
- Mr. Fred Andersen
- Ms. Linda Day
- Mr. Duane Etienne
- Ms. Sheila Genaille
- Ms. Sandra Greene
- Ms. Roda Grey
- Ms. Renee Masching
- Ms. Pauline Wood Steiman

### **Mandate of the AWG**

- To develop an ethical evaluation checklist;
- To review and solicit proposals specific to Aboriginal people;
- To plan for annual Aboriginal HIV/AIDS Epidemiology and Surveillance meetings; and
- To interpret data relevant to Aboriginal communities for national/international conferences.

### **CAHR 1999 paper outline**

- Background:
  - Evolvement of the AWG and annual Aboriginal meetings
  - Why the AWG is valuable to LCDC and Aboriginal communities.
- Objective 1: Ways for better use of HIV/AIDS statistics among Aboriginal people in research, prevention and care initiatives
  - roles and responsibilities of LCDC and the AWG

- mechanisms for disseminating timely information
  - efficient ways to follow-up once the data are released.
- Objective 2: Ways to liaise the AWG's work with governmental HIV/AIDS programs
  - mandate of different governmental programs and different advisory working groups
  - areas of autonomy and overlap between different advisory working groups
  - mechanisms for exchanging information
- Lessons learned
  - AWG's viewpoint
  - LCDC's viewpoint
- Conclusions

#### **Work in the process . . .**

- To forward ethical evaluation checklist and recommendations for Aboriginal identifiers to those who plan to collect HIV/AIDS data.
- To bring concerns to appropriate persons for action.
- To present findings relevant to Aboriginal people at different forums.

## **Workshop Summary**

There were 19 workshops offered over the three day period of the CAAN Skills Building Forum. Special focus was given to APHA's, who were offered a caucus to share their issues. The summaries that appear here are not meant to be complete. They are overviews only. Many of the workshops were intensely focused on healing. In these cases, we have tried to preserve the confidentiality of participants and the sacredness of the circle, and give an overview of proceedings only. If you are interested in finding out more about these workshops, contact the Canadian Aboriginal AIDS Network to find out when and where they may be taking place in your area.

**All workshops were recorded on video tape and transcribed to written notes later. Unfortunately, due to technical difficulties, several workshops were not recorded. These were;**

- I. *HIV Therapies and the Circle of Healing*, by Ralph Wushke.**
- II. *Presentation on Non-Governmental Organizations (NGO's)*, by The HIV/AIDS Legal Network, CATIE, and the Canadian AIDS Society.**

**For information on the content of these workshops and presentations contact the Canadian Aboriginal AIDS Network.**

**The National Indian and Inuit Community Health Representatives Organization (NICHRO) Video, *Keepers of the Earth* (presented by Margaret Horn), is available from the Canadian Aboriginal AIDS Network.**

**At the request of the presenter the workshop, *Healing, Surviving and Loving in the Meantime*, by Judy Weiser and Rodney Horne was not recorded for the participant report. For information on this workshop please contact the Canadian Aboriginal AIDS Network.**

***Disclaimer:***

***The views expressed in the forum workshops, and recorded here, are not necessarily the opinions of Health Canada. In addition, individual comments of participants and presenters are sometimes recorded verbatim and are not necessarily the opinions of CAAN and its member groups.***



# *The Psychology of Vision*

Presenter: Edna Brillon

The Psychology Of Vision workshop was a three day event based on personal and group healing with an Aboriginal focus. Much of the work done in this workshop was intensely personal to the participants, and out of respect for them and their own issues, much of what happened in these workshops must remain confidential. However, the guiding principle behind the workshop, and the format used, is recorded here for those who may be interested in attending one of Edna's Psychology of Vision sessions in the future.

Edna Brillon has traveled all around the world, making trust among people a reality. Her workshop is based on four principles. Integrity, Accountability, Love, and non-denominational spirituality.

According to Edna, we are now living in the native renaissance. All over the world people want to know us, and want to know our history. And though we are still in pain, we seem to forgive and heal more quickly than other people. One of our roles perhaps is to heal and forgive and teach others around the world how to do this as well.

One of the greatest issues with the native community is that we, as individuals, feel everyone else's pain. Children are especially sensitive. They take other's pain, the pain of their mother's and grandmothers, and swallow it. It is a shamanic gift, this, and a tradition in native communities. Except that Shaman used to swallow the pain and bring it back up again in great black balls and spit it out, to achieve healing of their subject. We have lost our ability to bring it back up, and so we walk around with the great black ball of pain in us. It is our ancestor's pain, and the pain of our families, friends and parents.

The goal of the Psychology of Vision is to begin to go in and heal this pain, to remove core issues and replace it with the universe. This pain stops us from being who we are, and once it is removed, we are free to live as we were intended to live. One of the ways to accomplish this is to bring people together to share their pain. The workshop works with group and group process. We can't deal with the pain alone. Over the three day workshop, trust and energy is built, and a willingness to heal is unearthed. A small group in a short time can do wonders.

The workshop is broken down into nine components. These are titled

1. Scout/Pioneer (exploration)
2. Relationships (without sacrifice)
3. New Level Of Communication
4. Chronic Problems

5. Heart
6. Spirituality
7. Abundance
8. Letting Go
9. Leadership

There are four parts to the human mind.

1. Conscious mind — smallest of these, less than four percent of our makeup.
2. Subconscious mind — is a little bigger, and is like a video tape recorder. It records everything that has happened to us from our birth onwards. We can access all emotion and feeling, everything that happened to us, through the subconscious mind.
3. Unconscious mind — the healing work of the workshop is done here. One issue cleared up here clears 10 in the subconscious mind and a 100 on the conscious mind. It is here that resides myth, story, legend, and metaphor. The old people of our culture, when they used to see someone in trouble, would not lecture them or tell them they were wrong. Rather they would tell a story. The unconscious mind is a great healing place.
4. Higher Mind — place of enlightenment and the higher miracle mind. The worst thing that colonization did to natives was take away a natural state of higher mind. Before contact, we resided here — whole and unfettered. Contact brought us down into the conscious and subconscious mind, which are fear based. Our consciousness was lowered.

When the clear, round circle of the higher mind is divided, becomes *subfractionated*, we become small, troubled, isolated, and lonely. Our *ego* wants us to be divided in this way, but our higher mind wants us connected. Each time in our workshops we clear up a core issue we erase a line that divides our higher mind. The removal or clearing up of our core issues begins us on a journey of wholeness back to enlightenment and the miracle mind. We are no longer working from a basis of fear. This is the goal, through group process and personal revelation, of the workshop Psychology of Vision.

For more information on these workshops call Edna Brillon at (604)254-5335.

## *The Two-Spirited Elder Speaks*

Presenter: Nazareth Therriault

When the four races were made, the creator gave each one a direction. Our people were the last to leave because they didn't want to leave Creator's side. The Creator gave each one a clan, a democracy for their lives.

Seven Clans:

Fish Clan - philosophers and thinkers

Loon and Crane Clans - leaders and chiefs

Bear Clan - guardians and herbalists

Martin Clan - warriors, strategists

Deer Clan - peaceful ones, reconcilers

Bird Clan - spiritualists, knowledge seekers

Man and woman were created, also the creator made two-spirited people to compliment the man and woman. When we pray we pray for all of life, not just straight people. Two-spirited people are a part of the whole community.

There were different roles and functions for two-spirited people before the Europeans came here. Two-spirited people were mediators, shamans, healers, craftspeople, matchmakers, and gave power names to the men of our communities.

The present chaos and disorder brought on by ignorance and intolerance turned a once proud and dignified people into a misunderstood subculture. Our own kindness hurt us. We lost our whole island because of our kindness.

Europeans brought their hate and persecution with them from their countries. They thought they were escaping it, but they put it on us in their religion and state. When the church and state came here they saw our life as pagan. Those who were two-spirited got even worse treatment because they were seen as horrid and unnatural in European culture, whereas in the Native cultures they occupied a position of respect.

Church and state brought homophobia to us. They gave us their garbage to carry around in our culture. We don't have to do that anymore. But in the past we did. In order to survive we went underground to seek protection, disguise, silence and isolation. We began to forget our teachings, ceremonies, histories and traditions.

Now we have to start learning again. We have to learn to see messages in nature and around us and

see their real meaning and power. Turtle shells, pipes, medicines, crystals, bear claws and turtle claws. These are the possessions of a lifetime of seeking. Time must be taken to build understanding as we wait for a proper time to use everything.

The four races have come together here, but the other races have forgotten their teachings. We didn't lose them, we put them aside for a while, but now we are taking them up again. Retracing our steps and taking up our bundles again. The four races got lost somewhere and we are coming together again here.

Each race has a responsibility. We look after the land. We need to learn to live as a healthy happy nation again. We have important work to do. Even if we just come here to listen, we go home and share the message there.

Four things we have to do to bring our lives together:

- keep your house clean, not just fiscal, but your body too, what you put in your body.
- Always wear clean clothes, appearance is important. You are not just dressing yourself, you are dressing your spirit and it must be kept clean.
- Never gossip. Even lending an ear is gossiping.
- Respect yourself and those around you, even when you think someone has nothing to say, listen. Give respect and it will come back to you.

# ***The Red Road***

Presenters: Alex Archie and Art Zoccole

Ten years ago there were not a lot of Aboriginal people involved in HIV/AIDS conferences. Today there are a large number of Aboriginal groups undertaking work in HIV/AIDS issues.

In British Columbia there are 19 groups funded by the Aboriginal Health Division of the Ministry of Health, 3 of which carry a provincial mandate. They are: Healing our Spirits British Columbia First Nations AIDS Society, British Columbia Aboriginal AIDS Awareness Program, and The Red Road HIV/AIDS Network. The other groups have HIV/AIDS strategies as a part of their mandates.

The Red Road group has 36 seats which allow a chance to partner up with provincial and national governments. This allows for multiple government departments to be involved. It also includes APHAs, two-spirited, Injection Drug Users (IDU), and women. All groups are represented, even the children were not forgotten, although not on the board.

What is a strategy? Why do we need a strategy? This strategy is unique because it is for on and off reserve people. This is unique in Canada.

In the beginning Aboriginal people were severely under-represented in AIDS task-forces. There are so many groups within the population: on-reserve, off-reserve, corrections, drug users etc.

There is a network of Aboriginal People in British Columbia who are providing AIDS related services. Part of the goal of this group was to ensure that they are not all providing the same services to the exclusion of other services. There is a need for a mediator between the organizations that can ensure they are sharing responsibilities for services.

## **Communication**

It is important to get a communication strategy in place. We need to examine how we can reach more people. Not all people have e-mail, fax, and phones, so it is good to use the mail for sharing information. But use the technology you have access to as well. Another place for sharing information is in conferences and information tables set up at conferences.

## **Statistical Highlights**

- In British Columbia the number of Aboriginal people tested HIV positive in 1995-1997 was 16%.

- In that same 3 year period approximately one hundred Aboriginal people per year tested positive.
- 50% of those HIV positive diagnosis were of people who fall into the 30 to 39 years of age range.
- 40% of new Aboriginal HIV infections are women (1995-97). In Non-Aboriginal people the rate is 17%.
- 60% of Aboriginal people diagnosed HIV positive identified injection drug use as a primary risk factor.

## **Barriers**

Barriers to treatment, education and prevention in the community include:

- lower levels of education
- illiteracy
- low incomes
- lack of information about service providers
- lack of respectful, cultural sensitive or appropriate services (one solution here has been the creation of a resource directory)

There were eight consultations done with the draft report. A commonly asked question was — we have this information, now what do we do with it.

## **Recommendations**

The Red Road Report includes 50 recommendations. What follows is a brief summary of some of these.

- Building healthier communities.
- Increase STD prevention services available, particularly in rural communities.
- Raise awareness of HIV/AIDS.
- Continue HIV specific prevention efforts for youth.

- Design programs for adults ages 30 to 50 years of age.
- Preventing transmission of HIV/AIDS through harm reduction programs.
- Ensure harm reduction programs include non-judgmental services.
- Diagnosis HIV infection and start treatment early.
- Maintain the health of APHA by improving referral methods within and across regional health authorities.
- Increase levels of access to home based care in rural and remote communities.
- Securing funding for Aboriginal HIV/AIDS services.
- Increase development for Aboriginal drug and alcohol treatment programs, particularly those targeted to women and youth.
- Set standards of training for those working in the HIV/AIDS education community. So they can provide the most up-to-date information when they go out to their communities.
- Identify what types of research needs to be done in the Aboriginal HIV/AIDS field and how to get the findings to work in the community.



## ***The Healing Power of Humour***

Leonard Dick conducted his healing power of humour workshop to repeated gales of laughter. With clever jokes, word games and an Aboriginal focus, Leonard teaches us that humour can be an antidote against despair and a useful tool to dealing with the stress of this disease and our work in the community. It eases tensions, creates perspective, and balances out the sadness of our lives with laughter. Those who attended Leonard's workshop came out, as usual, with big smiles on their faces.



# ***HIV/AIDS Epidemiology and Surveillance***

Presenter: Mai Nguyen

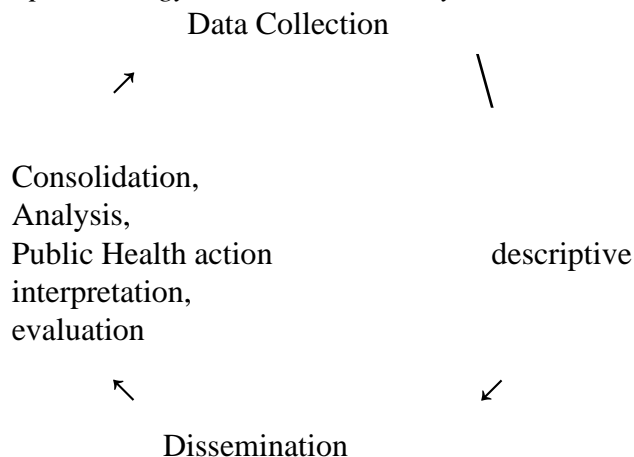
Notes © Bureau of HIV/AIDS, STD and TB, LCDC, March 1999

## **Objectives**

- To describe the working context of Bureau of HIV/AIDS, STD and TB.
- To explain the process of information collection as it relates to public health action.
- To share our experience in data collection and applications of these data in guiding prevention and control programs.

## **Mandate: Bureau of HIV/AIDS, STD and TB**

### *Epidemiology and Surveillance Cycle:*



## **Epidemiology: Definition**

- Study of distribution of disease frequency and its determinants to help us understand who is being infected over time.
- Leads to the estimates of:
  - HIV prevalence = the number of people who are living with HIV
  - HIV incidence = the number of people who are newly diagnosed with HIV

## **Surveillance: Definition**

- Ongoing, systematic collection, analysis and interpretation of health data essential to planning, implementation and evaluation of public health practice.
- Closely integrated with the timely dissemination of these data to those who need to know.
- Application of these data to prevention and control.

## **Surveillance versus:**

### *Epidemiology*

- targeted and one-time projects to answer questions not answered by ongoing surveillance data.

### *Research*

- data are collected for specific purposes; not necessarily timely; may not have appropriate dissemination or links with public health action.

### *Health Information System*

- may not be ongoing, may not have timely dissemination, or not specifically applied to prevention and control.

## **Bureau of HIV/AIDS, STD and TB's viewpoint: Why do we need to collect HIV/AIDS statistics?**

- *To monitor the HIV/AIDS epidemic.* Who? Where? Why? What are the trends over time? What are the population sizes of groups at risk for HIV infection?
- *For Control.* Detect epidemics early and possible outbreaks.
- *For Action.* To plan and set priorities. Guide and evaluate control and prevention programs.

## **To monitor the HIV/AIDS epidemic among all Canadians: How?**

- Since 1982, AIDS Case Reporting Surveillance System has been the mainstay.

- Supplemented by epidemiology studies and mathematical modeling and projections to estimate HIV prevalence and incidence.
- In 1995, creation of a national HIV database based on HIV-positive test reports.
- Further on, creation of a network of clinical databases.
- Since 1998, integrated HIV/AIDS surveillance. Data are obtained from 3 sources (HIV testing data, HIV strain surveillance, and HIV case reporting).

### **To monitor the HIV/AIDS epidemic among Aboriginal people: Challenges**

Studies with Aboriginal identifiers (First Nations, Inuit, Metis)

- non-standardized definition of Aboriginal identifiers
- variation in completeness of ethnic status reporting
- limited data
- not representative sample
- potential voluntary bias in HIV testing and clinical data.

Studies among Aboriginal people.

- Sioux Lookout Study
- Saskatchewan Study of Pregnant Women
- BC Study among Pregnant Aboriginal Women

### **Synthesis of information**

- Tabular
- - case counts
- Graphs
  - to characterize temporal trends (epidemic curves)
- Maps

- for geographical distribution
- Mathematical analyses
  - to detect changes in trends, to characterize historical trends, to characterize where epidemic might go.

### **Dissemination of information**

- Immediate:
  - to those who are the source of the data
  - to those responsible for taking action
- Periodic reports
  - Epi Updates, surveillance reports, Inventory
  - stakeholder meetings
- Other forum
  - national/international conferences and skill building workshops

### **For control: to detect epidemics early and possible outbreaks**

- Ex. 1: Vancouver IDU epidemic
- Ex. 2: Nova Scotia cluster investigation.
- Ex. 3: National HIV estimates — shift of the HIV epidemic from men having sexing with men (MSM) to IDU.

### **For action**

- Process of collaboration, consultation and action begins right away to control and confine the spread of the disease
- Things to consider
  - Disease itself
  - Players

- Resources
- Leadership
- Accountability
- Sensitivities
- Communication plan

### **Who to collaborate with?**

- Anyone who's day to day work, mandate or lifestyle might be impacted by work you do
  - Affected population
  - Impact (short and long term)
  - Mandates
  - Program and policy makers
  - Local, regional, provincial, federal levels

### **Conclusion**

- Ensure epidemiology and surveillance cycle is on-going
- Challenge is to balance the need for complete data with the need for timeliness to ensure appropriate public health action
- Collaboration is key to successful interventions
- Overall purpose: To understand the current status of the epidemic and its likely future direction to guide public health action.



# ***The Effect of Residential Schools on Healthy Sexuality***

Presenter: Doreen Sterling

Since the colonization of Aboriginal communities in Canada there has been only silence. Aboriginal people in this country have suffered from an inability to talk and express the negative things that have happened to them. Everything is hush, hush with us. We don't want people to know.

Back before the colonization of our peoples and our lands, we lived in circles. We had circles for everything, and our entire make-up was circular. There were four directions in the circle, and there were four aspects to each of us — the physical, the spiritual, the emotional and the mental.

Once colonization began our circles were broken, and we began to live in cubicles. These united aspects of ourselves were broken, isolated, and we have lived that way ever since. Residential schools played a large part in achieving this isolation among Aboriginal people.

Before colonization, Aboriginal people made a journey in their life around the medicine wheel. Most of us, due to the problems that have been thrust upon us, don't make it now. We don't live as long as we used to. Our own ceremonies, our own medicines, helped us in pre-contact. Contact brought us to a different world.

The first thing we must know to examine the effect of residential schools upon our culture and peoples is to remember that the schools were created not to educate us but to eliminate us. It is documented that Residential schools would eliminate Aboriginal people within twenty five years of their operation and their would be no more Indian question. We can begin, with this knowledge, to understand our own pain.

In the first year of residential school, 10,000 children between the ages of 5 to 15 were taken from their families and placed in the schools. These children never learned to communicate with their families, and their is a legacy of that in our own families today.

These children were also separated by gender and age. Why? Because if the intent is to eliminate a race, then you start by separating the genders. Then there can be no babies, and what babies are made will be unhealthy. There will be neglect and abuse, by people who have never learned parenting skills, effective communication, or how to have relationships.

In trapping families in Manitoba, the children were taken even earlier, at the age of three, because

officials knew that the families may migrate for several years before returning to their reservation, and they wanted to make sure these children were subjected to residential schools early.

In residential schools there was one supervisor for two hundred children. These supervisors were usually priests or nuns, practicing an unnatural celibacy. They were over-worked, often angry violent and abusive. No wonder our sex got dirty. In the long house, sex was a natural healthy part of our lives, and not dirty. But we lost that with residential schools. Children were not taught about sex, and developed unhealthy attitudes towards it. They were also not taught parenting skills.

The legacies of this still echoes in our communities. We often get angry about it, and ask why? We wonder why there is still abuse in our families, without understanding that abuse is cyclical. That an abused child will grow up to be abusive. Alcohol and drugs is one way some of us have chosen to deal with the pain. It's magic loosens us — our arms and legs and tongues. But it also brings with it more pain, and endangers others.

We have to, as Aboriginal people, not only study the effect of residential schools on our communities and express our rage about it, but we must talk about it. Examine it. Talk and share our experiences and fight the silence. The next step for Aboriginal people is to not let it happen again. We must mobilize ourselves, re-connect ourselves and re-create our circles. Once we have discovered what we have lost as a result of colonization and residential schools we can begin to look for it again.

## ***Assembly of First Nations Research Projects***

Presenter: Duane Ettiene

In the last few years, in a response to the AIDS epidemic in the Aboriginal community, AFN has conducted several research projects across Canada in an attempt to identify the issues facing Aboriginal people in relation to HIV/AIDS. Duane Ettiene presented on two of these projects. One was a longitudinal study of HIV/AIDS issues among Aboriginal people in Canada, including 151 participants. The other was a study of youth in four cities across Canada including 249 young participants with a median age of 24.<sup>1</sup> The areas of difficulty revealed among participants in these studies are:

- There is a problem with national reporting methods. 41% of testing sites have no ethnic identifiers. Under-reporting is common in the Aboriginal epidemic, and we have no true idea of how many Aboriginal people are truly infected. The numbers available, however, indicate that Aboriginal people have much higher rates of infection than mainstream communities.
- There is no national database of Aboriginal people infected with HIV.
- Anonymous testing not available or reliable on many reserve testing sites. For this reason many people don't get tested.
- There is lack of confidentiality about this issue on reserve. This is another reason why people won't get tested.
- There is a shortage of information about these issues on reserve. Mis-information and prejudice makes disclosure for those who are infected a terrifying experience. Many do not disclose, and therefore do not receive the help they need, because of this fear.
- The cost of treating and helping someone with HIV is high. A recent Canadian study revealed that \$153,000 dollars can be estimated to be spent per lifetime of each person who is infected. The earlier the disease is discovered, the easier it is to keep these costs down. Because so many Aboriginal people are not being tested, it is almost impossible to estimate future costs to the community.
- Prevention is difficult because of under-reporting.
- 7 out of ten young people studied have unprotected sex.

<sup>1</sup>For detailed study breakdowns, contact AFN at (613) 241-6789

- only 10% of those studied use condoms.
- 63% of those studied are involved in injection drug use.
- most youth want information from their schools first, and secondly their doctors and clinics.
- There is rampant misinformation about HIV/AIDS among the Aboriginal young people in this study. Many did not have a clear idea of HIV is contracted, and put themselves at risk without knowing it.

## ***Examining the Dilemma of HIV/AIDS Health Care***

Presenter: Dean Moncayo

The issue of health care in the Native community is a very challenged area. There is a shift taking place in Native communities right now that is different from anything that any of us have ever lived through. It is coinciding with two things: the HIV/AIDS epidemic (a coincidence) and a Native Renaissance, a global desire to have an idea of what is going on with Native people and see how they deal with things.

This puts us in a unique position right now because there is a lot of interest in how we are dealing with HIV/AIDS. A lot of opportunity is being given to us to craft a voice. Transformation occurs as a result of an interest and a desire in wanting to change. You need to learn to be careful what you ask for. You need to ask for guidance in your work.

The desire is to begin at a place of healing and transformation. The greatest amount of love, the greatest experiences, the greatest amount of work have all come out of times in our lives when there has been transformation. This is based on my experience, an experience that has taught me that when I engage the spirit I will be shown the way. Possibilities exist any time someone is open to healing.

Trust is an issue. The circle has to be a place where there is confidentiality and you can trust. Look at the work of Edna Brillon (Psychology of Vision Workshops) and see how she is going out into communities and making trust a possibility all over the world. There is a power, of the land, the universe, whatever, in her work that speaks of transformation.

With healing and trust we can transfer meaningful information. Not just data collection and surveillance. That process of data collection has been challenged because it has no trust, no confidentiality. In order for the data to be meaningful there is a certain level of healing that must occur. Right now there appears to be a desire for that kind of healing.

**What is it like in the communities? What is it like to share? What is it like to talk about HIV/AIDS there?** (Responses from the circle)

- People have phobias and stigmatism, but workshops have good turn-outs. One-on-one discussions are important too, they show that people are aware of what is happening. Participation is limited as far as volunteering for working to raise awareness in the Native community. Perhaps because of the perceived shame of the disease by family and friends.

But with support, from elders and the people, participation should increase.

- There is a silence that follows mention of HIV/AIDS and the risk behaviour still happens so frequently. The youth are informed and have assimilated it into their lives. Testing is available, but confidentiality is such an issue in a small community. Need to force people to talk about it. Process is slow, but important to keep at it.
- There is not much support in the community. Access is a problem because of isolation. Information needs to be made available in these small, isolated communities to combat the ignorance.
- Develop the mind and the spirit to keep going in this field. Healing is difficult in some situations, but it is so important to find the balance.
- There is still a negative attitude about HIV/AIDS, there are still people who see it as a gay disease. Programs are coming into reserves through Health Canada but participation still varies so much. Some embrace the chance for education while others remain isolated. Proximity to larger centres is still important in access to resources.
- But a distance from a prevalence of HIV/AIDS cases in urban areas gives people a false sense of security in that they feel that it is so far away and will not reach their community.
- There is a need for programs to provide support for family members of APHAs. There are too many barriers to setting up education programs in community.
- Need to build a sense of compassion and understanding in communities.
- We all learn together. There are so many issues to address as a precursor to HIV/AIDS education: healthy sexuality, abuse, etc. Taking responsibility and focusing on healing, not blaming are a part of the process.

# ***Aboriginal Women and HIV/AIDS***

Presenter: Wanda Villeneuve

Much of the workshop, *Aboriginal Women and AIDS*, was held off camera, at the request of the presenter. For more information of this workshop, please contact CAAN at 1-888-285-2226.

The issues that the group raised near the end of the workshop were recorded, as the presenter felt that these issues need to be addressed by CAAN and the Aboriginal community as we move into the year 2000. The areas of importance, raised by the group, are:

- We must build a strong supportive network on-reserve for women.
- We must address family violence issues.
- We must have a safe place on-reserve for women to talk.
- We must have elders that are willing to deal with HIV/AIDS issues for women.
- Among our on-reserve health workers, we must have commitment to the issues. This kind of work is not just “a job.”
- We must remember the children, and help them. We can do this by having nursery programs, and bridging generational gaps.
- We must start community building by addressing the issues of single mother families in our traditional circles.
- We must have positive role models for children and adults alike.
- We must look at violence against women. If a woman’s life is not safe, our community is not safe.
- We must look at the issues of male responsibility towards women. This is a difficult subject, but one that can be dealt with if we try.
- We must look at the role of 2-spirited people in women’s issues. 2-spirited people can help us build a healthy Aboriginal community.
- Communication at all levels of our community is important.

- We must have more workshops and conferences that focus specifically on Aboriginal women's issues.
- There is a need for holistic living among Aboriginal women
- We must identify gaps — language, generational, gender, others — in our communities.

When we have a circle, everyone is supposed to fit in — women, men, elders, children, 2-spirited, drug users and prisoners. If violence against women doesn't stop, we will never have a healthy community. By the year 2000, many more women will be infected by HIV/AIDS, and women, after they contract HIV, don't seem to live as long as men. This workshop, limited by time, does not begin to touch these issues. Much more could, and should, be said.

## ***Aboriginal HIV/AIDS in Prisons***

Presenters: Laverne Monette, Ontario Aboriginal HIV/AIDS Strategy (OAAS) and Rick Lines, Prisoners with HIV/AIDS Support Action Network (PASAN)

The Aboriginal prisoners and HIV/AIDS workshop began with a general introduction of facilitators and participants. Laverne Monette is the Executive Director of the Ontario Aboriginal HIV/AIDS Strategy in Toronto, and deals with the issues of Aboriginal prisoners as one component of her work. Rick Lines works with Prisoners with HIV/AIDS Support Action Network (PASAN).

PASAN is a new organization. One of the great tasks that PASAN faces is to make people understand that prisoners are a part of our community. All of us have a responsibility towards a person in prison both while they are incarcerated and when they return to their community.

Prisons have higher rates of HIV/AIDS and Hepatitis C (HEP C) infection than practically any other community. This is not because they are inherently at higher risk but because they are forced to live in a high risk environment. What makes the prison environment high risk is

- limited choices for prisoner about health and safety
- regulations prohibiting drug use make it logical to inject rather than choose safer methods

People who end up in prison are usually marginalized to begin with. Statistically speaking, prison populations come from poorer families and communities. Access to health systems among poorer populations is limited and such people face a wide range of social issues — from poor nutrition to various types of abuse.

In order to work effectively in prisons we must have a high level of awareness among community workers. Effective work is about building relationships . This sounds simple but is very challenging. To begin with, community workers face many roadblocks. Even getting into the prisons can be difficult. The walls are sometimes as effective in keeping community workers out as they are at keeping prisoners in.

Once a community worker does get inside the prison to work with populations, there are still many obstacles. Most prison inmates, male or female, have major trust issues. They generally mistrust authority, families, school, police, and health systems. They have been repeatedly told they are not valuable. They are actively discouraged, in prison and in society, from using their voice. They are told that they are not worthy and have been marginalized. Their trust has been violated repeatedly. In order for an HIV/AIDS community worker to effectively help a prisoner

some of these barriers must be overcome. This is not easy, and requires much time, dedication and awareness from those of us doing this work.

## ***TRUST***

Building this trust is of paramount importance in prison work. It must be built one person at a time, but each time we succeed, the trust expands exponentially. Prisoners will pass onto other prisoners the news that we can be trusted, and others may come to us as a result.

Once this kind of trust has been gained, we cannot take it lightly. A community worker helping an inmate may be the primary care giver in this situation. They must follow through and do all they say they will, while at the same time being honest about their limits. It is important not to set up false expectations, and to never violate the confidentiality of a prisoner.

### ***Some of the things community workers in prisons can do for inmates.***

- Give APHA's voice
- provide skills for inmates to participate in their own care
- provide knowledge and information
- provide outreach
- help teach effective communication skills

PASAN works with 200 HIV infected prisoners across Ontario. They get most new clients through current client referrals. There has been a real validation of work at PASAN. A level of trust among prisoners has been established .

There is another kind of trust that must be considered when community workers wish to outreach to prisons. That is the trust between your AIDS organization and the prison itself. Our organizations must have a relationship with the prison officials that allows us to get in the door. It must be based on mutual respect. However, our organization cannot allow itself or its community workers to become too close to the prison authority and bureaucracy, for it will destroy the trust between us and prisoners. There is no trust at all between prisoners and the institution. If prisoners perceive that you are too close to the institution authorities, they won't talk to you. Also, being too close to the institution compromises your ability to advocate on behalf of your client.

There must be balance between your relationship of respect and trust with the institution and your relationship with the prisoners. We must maintain certain boundaries on both sides.

The solution for both of these issues is to concentrate on **effective programs for prisoners**. If your programs are effective it gives your organization power when dealing with the institution and allows prisoners to place their trust in you.

### ***HIV/AIDS WORK IS AN OPPORTUNITY TO DEVELOP A RELATIONSHIP BETWEEN VARIOUS PRISON POPULATIONS***

Traditionally prisons have had widely divided populations among which there is little trust or effective communication. Health issues, and especially HIV/AIDS issues, cut across all these lines — health, race, geographic, and linguistic.

Community workers should always remember that prisoners are more aware of risk of HIV/AIDS than general society. Partially this is because of the close quarters and the relative ease of disseminating information in such a closed environment. Mostly, however, it is because there is such a risk for contraction in prison that most prisoners take the risk seriously.

### ***ABORIGINAL PRISON ISSUES***

Aboriginal communities, as much as main stream communities and perhaps more, have a tendency to forget that Aboriginal prisoners are a part of our society. Aboriginal prisoners that have been diagnosed HIV or HEP C positive are especially ignored. They rarely get visits and must rely on outside people — info sessions, education groups, other agencies — for support. How many of our communities are equipped to deal with an HIV positive ex-inmate once they get out? We don't think about it. As it stands First Nation communities don't have the services to maintain the emotional, physical and spiritual needs of Aboriginal prisoners once they are released.

Traditionally, the corrections system in Canada has not been good at dealing with high risk activities in prisons. To date there is no needle exchange or methadone projects available in prisons. Pilot projects have not even been approved. There has been no commitment to a harm reduction as philosophy in the corrections system, and as a result, prisoners are at high risk for HIV/AIDS.

Aboriginal people appear in high numbers in prisons. Their issues are the same inside as out, for whatever our attitudes are outside they exist inside — AIDS phobia, homophobia, racism, etc. These all contribute to HIV/AIDS risk. Surveys in prisons reflect that many prisoners will admit to high risk injection drug behaviors, but will not admit to high risk sexual behaviors. There is still a lot of homophobia in prisons.

The institution itself sustains these attitudes. It has too many policies, programs, and rules which promote phobic attitudes. Aboriginal people inside and out of prisons are at higher risk for HIV/AIDS because of colonization, oppression, lack of voice, and lack of tools. But one of the major problems for

Aboriginal people in prisons is the lack of tools and resources when they are released. Some prisons have traditional ceremonies for Aboriginal prisoners — sweats, brotherhoods, sisterhoods. These are things some Aboriginal prisoners may not have had their entire life. Yet when they get out, they may not have access to these things in their own communities. There is little support. Traditional healers and elders are sometimes not available, particularly in urban communities. Even if they are, a lot of traditional ceremonies require abstinence from alcohol and drugs to participate. Some released Aboriginal prisoners who are looking for ceremonies may not be clean. In this case, where does a person using drugs or alcohol, just released from jail, get traditional services? In addition, their offence may have alienated them from the community. This is why people keep going back in, and can't integrate. We need to go in and help by setting up support systems in the community when they come back out.

We must, as community support workers, talk to people about the prison environment — the lack of control, the lack of voice, being told what to do. The lies have to be faced. We must find out what really goes on in prisons and we must change attitudes about Aboriginal prisoners in our community.

***PRISONERS ARE NOT SUPPOSED TO BE SENTENCED TO CONTRACTING HIV/AIDS OR HEP C. BY NOT PROTECTING PRISONERS AGAINST THESE DISEASES, THE CORRECTIONS SYSTEM SEEKS TO PUNISH MORE THAN SOCIETY ALLOWS. WE MUST BE VIGILANT ABOUT PRISONERS RIGHTS, AND ENSURE THEY ARE NOT BEING PUNISHED MORE THAN ALLOWED.***

Some difficulties particular to Aboriginal prisoners are.

- It is difficult for Aboriginal people to get probation. They may not have the tools deemed necessary by the parole boards to prove rehabilitation. We must work with the national parole board to help, work with, and support Aboriginal prisoners.
- Native support workers are stressed out. They face a huge system of bureaucracy and rules. They may not have a good understanding of people living without choices, such as many Aboriginal prisoners are.
- Alcohol and drug abuse is a problem. The kind of pain that many Aboriginal people feel sometimes requires drugs and alcohol to deal with. Value/attitudinal work in the communities must be done to sensitize leaders/healers to this important issue.
- Among leaders and elders in our community there is rampant homophobia, AIDS phobia and drug and alcohol phobia. These are the very issues that many Aboriginal prisoners are dealing with.
- Inter-generational pain must be dealt with.
- Some prisoners, past and present, turn away from self-esteem and pride in their cultures

because of the prejudice of elders and community leaders.

- Lack of positive images of Aboriginal people in the media.
- Not enough money to deal with the problems of Aboriginal people.

Question: How do we go about bringing Western medicine and holistic medicine together?

Answer: Not all elders are homophobic and drug phobic. In fact, true elders are not. We must remember that much Aboriginal healing is done holistically, and the effects are different based on individual belief systems. There is a current mistrust of western medicine due to bad health care experiences among the Aboriginal community. We have had many racist doctors and professionals in our past. And many of our people still haven't dealt with the other epidemics — tuberculosis, for example.

Ours is not a new problem. There have always been problems with compliance, poverty, housing, etc. So many issues face Aboriginal people and Aboriginal prisoners — HIV/AIDS is an added crisis. The solution comes in small steps — individual by individual — and at the community level. It is there that we will do our healing.



# ***Educating Beyond the Basics***

Presenter: Barbera Bowdeich

## **The ABCs of Prevention**

### **A**lternatives

“Just say no” is not enough. It is not acceptable or fair that HIV/AIDS means “no sex”. Not in the real world. Some people choose abstinence as a way to avoid risk. But in the real world it is not always like that. People have sex and use drugs. There is an alternative. There is more beyond sexual intercourse.

### **A**ssertiveness

Being able to express your boundaries.

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#### ***Tip for discussion groups . . .***

You can use this ABC listing method as a way of beginning to talk about prevention with any age group. Let them call out the ABCs and identify their issues.

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### **B**eing Responsible

Often we see young people as being not responsible. Being responsible is having the ability to respond. We respond based on our experiences and we want to have healthy choices. We have to give them the skills so they can respond.

### **B**eing Respectful

Of self and partner. That can help keep you safe.

### **B**oundaries

Personal, body boundaries. This begins with safe touch issues. What we are willing and not willing to do. We can establish boundaries at any age. For example: How much alcohol will I consume? This may include survivor issues or not.

## **C**ondoms

Absolutely essential. Don't skip over it just because it is a "basic" thing. Some people still don't understand all of the issues. Also implies that both partners have equal power in the relationship. This is a bigger issue. It involves power issues, esteem issues and relationships.

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### *Tip for discussion groups . . .*

In discussions it is sometimes useful to divide people into two groups and ask each group to come up with either ideas to use condoms or not to use condoms, then bring them back together and compare the lists.

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## **C**ommunication, Caution

Knowing how you can get Sexually Transmitted Diseases and what you can do to prevent it. Need to talk about HIV/AIDS and be available to answer questions and provide information.

## **C**ommitment

Talking about commitment and the development of a good relationship.

A young person's idea of a long-term relationship is one week. We all have jumped from spring to winter in our relationships. What we need to do is show young people how healthy relationships develop (see discussion tip on next page).

There is a need to plan, observe, and evaluate a relationship before engaging in sex. That is what commitment is about. Casual sex is a different thing and there is no judgement on that. Commitment is about belonging.

### **Looking at Healthy Relationships and Living — A season model**

Compare relationships to the four seasons:

Spring	first meet someone, first physical attraction, beginning, introductions.
Summer	take time, build some trust, laid back.
Fall	getting ready for the coming season, interdependence.
Winter	become intimate, giving back.

Life carries over into these seasons as well, our youth is spring, Summer is our young adult years. Fall comes with 35 to 50 and winter is our time for giving back, the years over 50.

But the cycle is also present in smaller versions throughout our lives. In developing relationships, inside the relationship itself there are cycles of seasons. Even in our health these

seasons are present.

E.g. Seasons in HIV progression:

Spring	diagnosed.
Summer	HIV asymptomatic.
Fall	showing symptoms.
Winter	AIDS.

The message that you don't belong can interrupt any of the developments of the stages of the seasons. That is why self-esteem is so important and that is why we have to start looking at the children of today right now. We can't risk losing their generation to the cycle of abuse that exposes them to behaviour that puts them at risk for HIV/AIDS.

Learn to recognize the gifts of these children and start to build their self-esteem with comments and actions that will help to build their esteem.

Our language even builds this cycle of poor self-esteem. Perhaps we need to change the language. Instead of using terms like "junky" perhaps we should use language that is not so full of personal judgement. With drugs and alcohol, instead of putting the judgement on the person for abusing the substance, we need to see the behaviour, the misuse, and not label the person.

People are afraid of HIV/AIDS because of lack of information. Like it used to be with cancer. You need to make the information available. People need to see the risks in different things. Even without speaking about sex, discussing the transmission of HIV in different body fluids is possible. Again, you can gauge this to the age of the people you are working with — from children to adults.

Education does not stop at the time of infection. Prevention takes place prior to infection and after infection. Both are equally important. You need to educate family and friends of people who are infected. Treatment option education is another aspect of education for people who are infected.

### **The Role of Educators**

Our role as educators is not to change behaviours, but to get people thinking about the issues that you are teaching and learn to see things differently. You're not an expert, you're just sharing information. Don't try to say you understand everything, because you can't. Situations are different for every individual. Be open to their experiences, but don't assume that you know all of the experiences.

Every educator is different. There is no right or wrong way to do education. You're taking your knowledge and translating it for the consumption of others, so you get to define how it will be done.

- Don't leave evaluations to the last minute.
- Let people know they are coming and what to look for.
- Keep evaluations simple and allow time for completion.
- Consider giving out the evaluation forms at the beginning of the presentation so participants know the level of analysis that will be required in them.
- Handouts can be distributed as needed instead of all at once. This keeps people from shuffling through them during the presentation. It also is one less thing to pull away their attention from what you have to say.

# ***The Art of Proposal Writing***

Presenter: Christine Smith

Whether your group is small and just starting out or established and seeking specific funding, the need to have a firm knowledge of your subject is key. Research is the place to begin your proposal process.

## **General Tips on Proposal Writing**

- Start with a clear mandate.
- Focus on the largest possible target population.
- Keep your proposal short and concise.
- Use clear language.
- Avoid jargon when dealing with non-government funders.
- Be sure to use proper grammar and spelling. **PROOF READ.** Your writing style does not have to be academic.
- Be positive, even if the issue isn't. Focus on achievements, staff, volunteers and past triumphs of your organization where possible.
- Don't make promises you can't keep. Talk about achievable goals.
- If your proposal is too fancy it may lead funders to think you have too much time and money already.
- Avoid requesting deficit funding. No-one wants to fund a project that has already been done.
- **FORMAT REQUIREMENTS VARY.** Check the funding agency for specific format requirements.

## **Finding Funding**

Information about where to get funding is easier to get these days. This makes it harder to get

funding though because there are more groups going after the same funding. Lists of funders are available at a cost, but there are other routes to finding the funders. Look at organizations who are funding similar projects in similar organizations to yours. Don't miss any opportunities. Keep an eye on local businesses, know who to ask for funds/sponsorship and when to ask. Some other sources of information are:

- Local business directories. (Use mail-outs to keep your organization in the thoughts of businesses.)
- Reference books in your local library: Directories of Canadian Foundations, Service Club Directories.
- National Government Grants.
- Internet.
- Yellow Pages.
- Crown Corporations Listings.
- Municipal Grants.
- Social Service Grants.

### **Getting Ready**

*The Funders* — Do your homework on the funders. Find out contact names, departments, history of projects they have funded in the past, deadlines and restrictions. If you are unsure, call the funder. Maybe they are looking for new ideas.

*Criteria* — Play with the criteria a bit. Putting a new slant on the criteria may get you funding you aren't normally eligible for. Be creative. How can you do what you want to do and still access this funding inside the criteria you may not normally work with?

*Partnerships* — Remain open to the possibilities of partnerships. Partner with a group to get joint funding. Don't be afraid to share and be open.

*Possibilities* — Don't ignore the chance to work with other groups. There could be the chance to make a local project regional or a regional project national if you are open to it. More funding may even open up if you explore these possibilities.

### **Dealing with Funders**

There are different ways of dealing with different types of funders.

*Health Canada.* Their impetus for funding comes from their mandate to look after the health issues of Canadians. Funding HIV/AIDS projects is their responsibility. To a degree, you are right in expecting their co-operation and help with your projects. Remember that as a part of the government, Health Canada is ultimately responsible to you as a Canadian citizen.

*Businesses.* This is a completely different relationship. With businesses you want to show them right off what funding your program can do for their business. Include the possibilities of recognition in the proposal (for example media attention, or special thanks in distributed materials).

*Foundations.* They want to speak to the charitable community. Speak to them in friendly terminology. They may not be experts at what you do, but they do know what they are looking for in a proposal. Show them what they want to address and how they can do it through sponsoring your program. Show how they can help you. Focus on partnership.

## **PREPARING THE PROPOSAL**

### **Cover Letter and Proposal Summary**

Identify the target population. Look at the issues in the group. Discuss it fairly widely where applicable. Find how your project can have a broader impact on larger populations. Indicate why your organization is best for the project funding. Emphasize connections to the community.

Briefly introduce the organization and workers. Emphasize partnerships, community volunteers, and involvement with the target group. Be positive and committed while remaining credible and realistic.

Proposal Summary should be about half a page long. Keep it clean and easy to read. Specific details go inside the report.

### **Goals and Objectives**

What is the specific program? The goal is your destination and the objectives are the points that will bring it together. Be clear and list all of your goals and objectives. Objectives must be linked to the goal and later tied to the budget and time-lines. Keep your goals and objectives credible. Include background information on organizations, individuals, and work needed to show that you have thought them through. This is a good place to show some evidence of your research and background work. Use references. Stay focused on the topic, don't get too broad. Keep it short and succinct. Keep in mind that the funders may not have the knowledge you have. Don't talk down to them, but don't assume anything either.

## **Time Lines**

Government proposals require time lines for each phase. This is becoming the norm for proposals. They are useful in keeping you on track and on budget when you start your work.

## **Budget**

This is very straight-forward. Include all expenses to carry out the project. Planning is important and this is where you tie in to your objectives. If your objectives are clear they will provide a good basis for covering all of the bases in budget planning. Note that multiple funding is becoming more appealing to funders. If there are multiple funders, break it down in the budget. There is no such thing as miscellaneous in a budget. Avoid using the word, funders don't trust it. Instead take the time to plan properly and make sure all eventualities are covered in the budget.

## **Budget Summary**

This is a listing of the specifics of grouped costs from the budget. Breakdown salaries and expected costs. Use this as a chance to explain you calculations of specific items.

## **Attachments**

Terminology and glossaries: may be useful when technical terms and acronyms are used.

Check the guidelines for specifics, but they may include:

- board of directors list,
- financial statement for the organization,
- charitable status,
- agency biography, and
- supporting documentation and letters of partnership.

## **New Groups**

New groups applying for funding for the first time may require:

- mission statement.
- general statement of goals.

- description of programs and services.
- staff and volunteer information.
- description of physical facilities.
- governance information.

### **Checklist**

- Cover Letter
- Proposal Summary
- Goals and Objectives
- Time Line
- Budget
- Budget Summary
- Attachments

### **ONCE YOU GET FUNDING**

- Your record keeping system helps in planning future programs.
- Always works towards enhancing the credibility of yourself and your organization, in the eyes of funders and the community.
- Use your time lines and budget. You put the time into their creation for a reason.
- Develop tangible objectives to work towards.
- Increase your knowledge of program areas. This is the source of your research for future project proposals.

### **Evaluation**

- Keep it simple. A good evaluation doesn't need to be complex.
- Evaluate as you are going along.
- Get participants involved in the evaluation. Measure difference before and after in the target groups.
- Make a checklist from your work plan and mark off when objectives are met.
- Note what went wrong in meeting objectives.

- Complications and variations in outcome are not necessarily bad.
- Keep notes. Share what you are doing with your co-workers as you go along. This way the evaluation won't be as difficult.

# ***How to Run Successful Aboriginal Organizations***

Presenter: Gary Carbonnell

The key to good management is good employees. Trust is important in avoiding a disaster in management.

## **Do I Have the Capability to Be a Boss?**

You are the boss, you know it, they know it, why keep hounding on it? Everybody has a title. Not everybody has the abilities to be the boss. Ask: do I have the capability to be a boss? There is no shame in not being boss material.

Boss must be able to:

- motivate
- improve moral
- be positive
- focus on strength of employees
- referee
- problem solve
- fight for your employees
- delegate

Boss has to be familiar with all of the jobs. Your employees are the experts, but you need to know enough to get by in any task.

You need the trust of your employees. You have to be a good coach to get everybody to work together as a team. Team building is tough.

**Employees** Know you employees. Identify their strengths. The mouse-type employee type will work away in their corner, say nothing. You have to pry ideas out of them. The sheep-type

employee will do whatever the others are doing. The elephant (or lion) type will charge forward, make decisions. You need to find a medium with such an employee, but usually this person is the best employee, you just need to control the reins. The bird (eagle) type soars all over the place — find what they need and take it back to put it in useful places. This has to be you. You have to be flexible, you have to have the room.

You must surround yourself with knowledgeable employees. You may have to switch employees around. These may be tough decisions, but are for the best of the organization.

### **Communication**

A good boss is open and honest. You have to make your employees a part of the decision making process. Let them tell you what is going on.

Communication needs to be clear. Objectives and deadlines must be clear. Don't assume that everyone knows what you are saying. Be precise.

### **Criticism**

Even as a boss you must be able to receive criticism. You also have to be able to make constructive criticism. Know that your staff is going to talk about you. Understand that this is the nature of employees. Take this criticism and actually hear what the employees are telling you with it.

Total employee involvement works. Let them know what is going on. They may have some useful input if they are in on all of the details.

### **Action Plan**

Plan your work and work your plan. List work according to importance — look at goals and objectives as you do this. Short-term and long-term goals give you something to evaluate your employees with. But do not do their work for them. Let your employees do their own action plans. They will say, "Boss, this is what I can accomplish."

Acknowledge your employees' performance — good in public, bad in private. You can't treat all of your employees the same way. This ties back to knowing their strengths and weaknesses.

Venting sessions. Take off your titles and let people talk about how they feel without fear of reprisal. Deal with the problems there.

### **Control**

Because of your employees you are successful. Give them ownership, discussions and control.

Surround yourself with key people and put them in key positions, give them control, do not assume it yourself. Let them have access to information. They need to know the budget, the internal problems, scheduling problems, even your own problems. The key is O.C.A.

**O**wnership  
**C**ontrol  
**A**ccess to information.

Personnel Files belong to the employee. Let them see it when they want. If you limit access, right away they assume you have something to hide. It is about getting them to trust you too.

## **Internal**

You must have good guidelines. You need good structures, but in Non-Profit Organizations they are only guidelines. They are flexible and must reflect human compassion.

Charter deals with mandates, roles, titles, how to fill vacancies, etc. They are all just guidelines.

## **Boards**

Boards are made up of volunteers, working to make the organization effective. They need guidelines, or else you end up with a group of people working in a bunch of different directions. They need to see that they are a team with a need for some guidelines to work with.

**Personnel Policy** — An absolute must in fairness to employee and employer.

**Financial Policy** —Set out limits, authority, capital.

**Job Descriptions** — Most important thing is the signature of the employee.

If you think small, you will stay small, so plan for a time when you are going to be a larger office.

## **Procedures and forms.**

Checks and balances are important. Have procedures and forms for long distance calling, purchase orders, signing checks etc. Time sheets and overtime policies are important. An understanding of the policy is important. Instructions on how to use the forms are a must. So even when you have moved on from the organization the forms are still useful.

## **Service contract**

Important in protecting organization and contractee. Title, contract, supervisors, duration, remuneration, language, goals, agreement of works and deadlines.

Too many employees can be a problem. As employees we will all try to get away with as little as possible in the workplace, so make sure you have the right number of employees for the work being done.

**Problem solving.**

1. Identify the problems.
2. Analyze the facts.
3. Identify possible solutions.
4. Evaluate best alternatives.
5. Select best alternative.
6. Implement decision collectively.
7. Follow-up.

If you are honest and open with your employees then your organization will work well.

- Motivation Not Control
- Trust Builds Trust
- Praise in Public, Criticize in Private
- Participation Promotes Motivation
- Communication Not Confrontation
- Achievement Encourages, Fear Inhibits
- Power Through People, Not Power over People

# ***Writing for Journals and Abstract Presentations***

Presenter: Schuyler Webster

## **Community Based Articles**

Description of program and its services, no bibliography, not a research paper.

- Small Abstract — written after the article, brief summation of what the article is about. One or two lines.
- Introductory statement — three paragraphs, describes program, philosophy. Goals of the program.
- Talk about particular part of the program. Initiatives and project activities. Clearly stated and easily read. Then move on to next aspect of program to be presented. Simple, straight-forward method.
- Expand structure as you talk about different parts of program.
- Program structure — describe the structure of the group, where they get their time.
- Program content — different roles that people perform in an agency. Interrelationships of participants.
- Short summary, discuss the value and importance of the approach, activities.

### *Framework for a community based article*

1. What is the philosophy of your program?
2. What is the history of your program?
3. How is the program organized?
4. What are the unique characteristics of those activities?
5. How is it helping people?
6. Why is what you do important enough to share and communicate to others?

These areas make up a kind of basic story-telling framework. If you are interested in writing an article about your work in HIV/AIDS these six questions form the basis for telling your story.

## Referenced (Academic) Articles

This is another form of telling a story, but now pulls in references and support for some of the statements. Similar organization to Community Based Article.

- Introduction is similar to Community Based Article.
- Historical Background — may include references to documents.
- References — using American Psychological Association (APA) Style.
- Some changing of the type of information you're putting in. Citation of current information and associated research adds credibility to your statements.
- Referencing cultural things (e.g. Circles, Smudging Sweat Lodges) may not include large elaborate descriptions of ceremonies when the article is written for those who are familiar with the ceremonies.
- Conclusion may be longer, generally a page or two pages.
- Acknowledgments — recognize all of the people who helped you out or made contributions to the paper.
- Intellectual property — Governing body of your organization has right to decide what goes into the article you submit about your organization for publishing.

Don't be intimidated if you have a story to tell. Rules about writing and making articles are not meant to limit. There are people who can help you get past these hurdles. What is important is that you tell your story. It doesn't have to be scientific based article. Journals are not meant to intimidate. They are simply a forum for sharing your stories.

There is help out there. Find a person who you see as a good writer and ask them to help write your story. Skills are meant to be shared.

Invitation to contact the journal with themes and story proposals, writers who may be willing to act as a resource helper for people not as comfortable with writing.

Contact Schuyler Webster at Laurentian University in the Social Work Faculty if you are interested in submitting writing to the Native Social Work Journal.

## ***HIV/AIDS Program Delivery: Community Building Within a Community***

Presenters: Tom Howe, Gabe Salinier

The “*Community Building Within A Community*” project at the Atlantic First Nations AIDS Task Force (AFNATF) in Halifax, Nova Scotia is a local project funded by AIDS Community Action Program (ACAP) for the Atlantic Region. It has been funded for the last two years, and is referred to by AFNATF as a “community development” project. The objective of the program is to bring and share information about Aboriginal people and HIV/AIDS with a community focus.

AFNATF, with this project, targeted specific agencies with the Atlantic region to build partnerships and deliver HIV/AIDS information. The main agencies being focused on are Drug and Alcohol Treatment Centers and Family Violence Centers. The idea is to create a link between the Aboriginal AIDS agency and these agencies, with a commitment to train staff to deliver HIV/AIDS information services to their own clients. AFNATF wanted to reach groups that were traditionally hard-to-reach. The best way to do it was to approach a “community within a community” and form partnerships to disseminate the information and skills to deal with the disease.

The first thing AFNATF did was to approach a particular Atlantic treatment center with the idea. There had been an existing partnership between the two agencies, and together they designed a treatment agenda that fit in between treatment cycles for clients. They needed first of all to assess the level of knowledge already in existence in the center, among staff and clients, and then assess particular needs. This was an important part of the process — a time of “feeling each other out” with dialogue, and to gauge the dynamic of the treatment center and what approach would best work. It is important to remember that education programs and needs assessments must be varied for each agency and community. We all have different dynamics and different needs.

AFNATF did three training sessions at the treatment center, spread out over a period of four months. It was decided that a three day intensive session, although valuable, would not spark the kind of long term dialogue within the center that they were looking for. A longer period of contact, as four months provided, would help ease the center staff and clients into the intensive world of HIV/AIDS information exchange and skills training.

One main objective of the project was to “Train the Trainer.” Instead of always expending limited AIDS agency resources by making repeated visits and holding repeated information sessions in various communities, it was felt that staff at the Treatment Agency could be taught to

train their clients in the issues of HIV/AIDS. This kind of information training is more sustainable. As the staff at the center gain knowledge and confidence, they can continue to work with their clients on HIV/AIDS issues, with AFNATF available for support and additional information and skills training if needed.

The *Community Building within a Community* is on-going project with AFNATF, as they target various centers in the Atlantic region and attempt to bring their large community together on the issues of HIV/AIDS and Aboriginal people. The project has been a success, but needs to continue, as in a region as large as the Atlantic, there is always more work to do.

## ***National Round Table Discussion of Aboriginal HIV/AIDS: An Update***

Presenter: Jake Linklater

The purpose of these Round Table consultations is to obtain feedback and guidance from community stakeholders, program developers, proposal writers, and health technicians in the field of HIV/AIDS for Health Canada. This is done in hopes of providing a National forum for Aboriginal peoples across Canada to express their needs and concerns regarding Aboriginal HIV/AIDS funding within the Canadian Strategy on HIV/AIDS for Health Canada.

Participants are people who work for Aboriginal HIV/AIDS service organizations, work at provincial level. There is a wide spectrum of insight and experience among these participants. Looking for an exchange of views and thought on HIV/AIDS funding issues.

Five sites for round tables.

- Edmonton
- Quebec City
- Vancouver
- Winnipeg
- Iqaluit

After the five round table discussions there will be a generic report available in French and English. Information packages will be available on CAAN web site ([www.caan.ca](http://www.caan.ca)). There will be a call for proposals in June or July. The information available from the round table discussions should be put together by mid-April 1999 and can be used in preparing the proposals.

Group formed to bring in representation from National organizations — National Aboriginal Reference Group on HIV/AIDS (NARGA). They are working in partnership with CAAN in this process. CAAN is the administrator in this process.

How consistent are the recommendations?

The concerns over how or who is going to determine funding have been consistent. Every site has had different interests, focuses. To some degree there have been some similarities, but a summary has not been completed yet.

*Comment from participant:*

Need someone to work on recommendations only. To make sure that the recommendations are followed up and people keep working on them until they get funded and carried out. Concern that in processes such as these the recommendations come in but they never get out. Need support and commitment from leaders/participants.

The focus of these discussions is to work through the questions and guidelines in the book. Another part of the discussions is to dispel the myths and address the concerns of people living and working with HIV/AIDS.

# ***APHA Caucus Report***

Presenter: Roger Carsen

Recorder: Alex Archie

We would like to say that we appreciate the opportunity to meet with Aboriginal people living with HIV/AIDS from all four directions — North, East, South, and West.

We want an **Elder** to participate in our discussions.

Concerns were raised regarding the meeting space and we felt that there wasn't consideration to the protection of APHA's confidentiality. We felt that a lot of APHA's did not feel comfortable enough to come to the caucus. There was a feeling that there were barriers to attending the caucus that should be addressed.

The following recommendations were discussed and agreed upon:

1. That a separate day be set aside before the Annual General Meeting (AGM) for the Aboriginal People Living with HIV/AIDS (APHA) Caucus and that food and water be provided.
2. We would like more APHA gatherings throughout the year. We need to hear about treatments and therapies, and to share our experiences with each other. We recommend that CAAN find the necessary funding to host an APHA gathering at the national level. (Contacts have already been made with The Prevention and Community Action Program (PCAP) of Health Canada). We want to gather and discuss traditional healing.
3. We would appreciate seeing better communications between CAAN and the Canadian AIDS Society, at all levels, not just the staff level.
4. CAAN needs to hire an APHA Coordinator to focus on issues brought forward from the APHA caucus. (Hire more APHAs).
5. There is a need for better mechanisms to connect APHAs for networking purposes. Perhaps discuss the possibility of providing calling cards for increasing support from other APHAs, especially for those from remote communities.
6. Drum music to unite the spirits of those who attend the caucus and AGM. The drum will call the people together.

7. Create a safe space for relaxation and networking during all gatherings. Also have a place for people to smudge, with water and food provided.

The preceding report was presented during the Annual General Meeting held on the final day of the forum. The following statement was made:

“The APHA Caucus would like to appoint Roger Carsen, from the Pacific region to the Board of Directors as the male APHA representative and Quinn Smith from the Atlantic region as the female designated seat”.

Thank you.

# ***Evaluation***

There is a two-step process to the evaluation of Skills Building Forum '99:

- I. Evaluation forms were distributed at the forum for participants to rate and comment on individual workshops;
- II. The second evaluation is a tracking process, measuring what participants were looking for in the forum, what they finally got out of it, and how they implemented this information. This study is a long term process, using interviews and follow-ups for as many as five months after the forum. Results from this study will be available to conference participants in October 1999.

## **Evaluation Statement**

Overall comments about accommodations and conference spaces were favourable. Delegates seemed generally pleased with the availability of Skills Building Forum staff and volunteers given the hectic nature of the forum.

Per diem cheques seemed to be of some concern to many participants. Perhaps cheques should have been written in advance. However, it was the intention of the Skills Building Forum staff to include both meal allowances and ground travel costs on one cheque. These could not have been granted until receipts for ground travel were received and a total was tabulated. One suggestion was to have regional sponsor organizations front some funds to the scholarship participant to ensure that no one arrives at the conference without resources.

Most of the comments about individual workshops were positive. However, there was some overall concern that the forum itself was not traditionally based. There was little information available about native healing, and not enough elders were present. Also, there was concern that the forum had ignored women's issues to a degree. Several complaints came over AFN's presentation, where statistics in their research projects about women were not yet available.

Other participants thought that this forum, and many others, take an middle approach to education. There is too much information based on a median knowledge. Newcomers need more intensive sessions, and old-timers as well. It has been suggested that at the next forum workshops are broken down into streams of Veterans, Beginners, and Intermediates, so that people know what workshops will be for them.

A common complaint was the use of Acronyms. Too many are used and not explained. We must be respectful of our beginners and their learning curves. There were also complaints that not

enough presenters were Aboriginal.

CAAN is in the process of dealing with these concerns, and publishing them in the longer term, broader evaluation coming out in October. In that report, CAAN will examine exactly how effective these forums are, and whether we are exchanging information in the best way possible.

If you would like a copy of this October evaluation, please contact CAAN to put your name on a mailing list.

## *Participants*

John Abram  
Fred Andersen  
Diane Aubry  
Barbara Bowditch  
Alan Boutilier  
Glen Brown  
Robert Campbell  
Roger Carsen  
Laura Commanda  
Stella Devenney  
Jeff Dodds  
Joanne Fraser  
Richard Elliot  
Virginia Forsythe  
Donna L. Gamble  
Michelle George  
Samuel Green  
Shelley Gladstone  
Tamera Golinsky  
Marten Hill  
Elizabeth Holmes  
Alain Houde  
Tom Howe  
Larry Johnny  
Keitha Kennedy  
Allan Kivari  
Rick Kotowich  
Wendy Lameman  
Marlene Lightening  
Annie Loonskin  
Renée Masching  
Heather McClay  
Marisa Meher  
Dean Moncayo  
Diane Monds  
Melwyn Morning Bull  
Peter Oka

Darcy Albert  
Alex Archie  
Elizabeth Benson  
Roxanne Boekelder  
Edna Brillon  
Ralph Brown  
Gary Carbonnell  
Jendy Clark  
Norval Desjarlais  
Leonard Dick  
Janice Dyck  
Jonathon Ehwalt  
Arlo Yuzicapi Fayant  
Winston Gabriel  
Lyndon George  
Cheryl Gervais  
Terry Greene  
Olive Godwin  
George Henry  
Brenda Marie Hilliar  
Rodney Horne  
Judy Howard  
Randy Jackson  
Steven Keewatin  
Mike Keshane  
Henry Koo  
Simeonie Kunnuk  
Tim Lathlin  
Rod Little Mustache  
Diedre MacLean  
Stephan Matiation  
Hal McIntyre  
Conrad Merasty  
Darrel Monds  
Laverne Monette  
Duane Morrisseau  
Jane Oliver

Julie Ozagowawash  
Michael Parsons  
Denis Peter  
Jamie Pitts  
Sandra Richard  
Moses Sanderson  
Adella Saul  
Barbara Ann Skaling  
Jacqueline Smith  
Vernon Smith  
Clarence Spence  
Doreen Sterling  
Trevor Glen Stratton  
Nazareth Therriault  
Jeanette Tough  
Rolande Veilleux  
Cynthia Wahlman  
Judy Weiser  
Art Zoccole

Gord Parker  
Mary-Ann Peltier  
Judy Pike  
R. Keith Prince  
Roger Sabot  
Timothy J. Sanford  
Gabe Saulnier  
Christine Smith  
Quinn Smith  
Jeffery Sparks  
Catherine Spence  
Cindy Stewart  
Earl Peter Sunshine  
Lydia Thompson  
Laurie Touesnard  
Wanda Villanueva  
Schuyler Webster  
Ralph Wushke

## ***Glossary***

<b>AAAS</b>	Alberta Aboriginal HIV/AIDS Strategy
<b>AASO</b>	Aboriginal AIDS Service Organization
<b>ACAP</b>	AIDS Community Action Program
<b>AFNATF</b>	Atlantic First Nations AIDS Task Force
<b>AFN</b>	Assembly Of First Nations
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANHAN</b>	All Nations Hope AIDS Network
<b>APHA</b>	Aboriginal Person Living with HIV/AIDS
<b>AYA</b>	AIDS Yukon Alliance
<b>AY</b>	AIDS Yellowknife
<b>BCAATF</b>	British Columbia Aboriginal AIDS Task Force
<b>CAAN</b>	Canadian Aboriginal AIDS Network
<b>CAS</b>	Canadian AIDS Society
<b>CATIE</b>	Community AIDS Treatment Information Exchange
<b>FOH</b>	Feather Of Hope Prevention Society (Edmonton)
<b>HEP C</b>	Hepatitis C
<b>HIV</b>	Human Immunodeficiency Virus
<b>HOS</b>	Healing Our Spirit (Vancouver)
<b>HPPB</b>	Health Promotions and Programs Branch

<b>HRM</b>	Harm Reduction Model
<b>HRPS</b>	High Risk Project Society (Vancouver)
<b>IDU</b>	Injection Drug User
<b>LCDC</b>	Laboratory Centre For Disease Control
<b>MAATF</b>	Manitoba Aboriginal AIDS Task Force
<b>MSB</b>	Medical Services Branch
<b>MSM</b>	Men having sex with men
<b>NAPHAN</b>	National Aboriginal Persons Living with HIV/AIDS Network (Evolved into CAAN)
<b>NARGHA</b>	National Aboriginal Research Group on HIV/AIDS
<b>NAS III</b>	National AIDS Strategy III
<b>NICHRO</b>	National Indian and Inuit Community Health Representatives Organization
<b>NGO</b>	Non-Governmental Organization
<b>OAAS</b>	Ontario Aboriginal HIV/AIDS Strategy
<b>PASAN</b>	Prisoners with HIV/AIDS Support Action Network
<b>PCAP</b>	Prevention and Community Action Program
<b>PIWA</b>	Pauktuutit Inuit Women's Association
<b>STD</b>	Sexually Transmitted Disease
<b>TB</b>	Tuberculosis
<b>TPFN</b>	Two-Spirited People of the First Nations (Toronto)
<b>WIDE Study</b>	Winnipeg Injection Drug User Epidemiology

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