# Residential Schools, Prisons, and HIV/AIDS among Aboriginal People in Canada: Exploring the Connections

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75 Albert Street, Suite 801, Ottawa, Ontario K1P 5E7
Phone: (613) 237-4441
Toll-free: (888) 725-8886
Fax: (613) 237-4442
Email: research@ahf.ca
Website: www.ahf.ca

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Prepared for

The Aboriginal Healing Foundation

By

J. Kevin Barlow
Canadian Aboriginal AIDS Network

2009

# Residential Schools and HIV/AIDS among Aboriginal People in Canada

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## Definitions

**Aboriginal people or Aboriginal** – includes Métis, Inuit, and First Nations regardless of where they live in Canada or whether they are "registered" under the *Indian Act* of Canada.

**AIDS** – acquired immune deficiency syndrome is an illness occurring after HIV infection that sufficiently compromises a person's immune system.

**Dental dam** – a thin square of latex that can be used to prevent the spread of sexually transmitted infections during oral sex; originally designed as a protective barrier for dentists while working on a patient's teeth.

**Elder** – generally means someone who is considered exceptionally wise in the ways of their culture and the teachings of the Great Spirit; recognized for their wisdom, stability, humour, and ability to know what is appropriate in a particular situation and the community looks to them for guidance and sound judgment; and caring and known to share the fruits of their labours and experience with others in the community. The spelling of "elder" with a small "e" means a person who has attained a certain age.

**FAS/E** – fetal alcohol syndrome/effects is a birth defect syndrome caused from prenatal alcohol damage. Fetal alcohol syndrome always involves brain damage, impaired growth, and head and face anomalies. Fetal alcohol effects refer to the presence of some of the criteria for fetal alcohol syndrome, but where the patient does not meet all of the necessary criteria for the full-blown syndrome.

**FASD** – fetal alcohol spectrum disorder is a term used to describe the range of birth defects caused by prenatal alcohol damage.

**Harm reduction** – changes to behaviour that reduces the chance of hurting oneself or another person; making changes to improve health and well-being.

**HBV** – hepatitis B virus that causes liver disease and can lead to serious liver damage, lifelong infection, liver cancer, liver failure, and even death and is spread by contact with infected blood or body fluids that may occur from body piercing, tattoos, acupuncture performed under unhygienic circumstances, by sexual transmission, or among injection drug users sharing needles and drug paraphernalia. It is preventable through a vaccine.

**HCV** – hepatitis C virus is a highly contagious acute or chronic disease of the liver that causes inflammation and scarring of the liver and may lead to permanent damage, liver failure, liver cancer, and death and is spread by contact with infected blood or body fluids that may occur from body piercing, tattoos, acupuncture performed under unhygienic circumstances, by sexual transmission, or among injection drug users sharing needles and drug paraphernalia.

**Historic trauma** – a cluster of traumatic events that operate as a causal factor in a variety of maladaptive social and behavioural patterns. Hidden collective memories of trauma, or a collective non-remembering, are passed from generation to generation, just as maladaptive social and behavioural patterns are

symptoms of many social disorders; or, it is a cumulative emotional and psychological wounding across generations resulting from massive tragedies.

**HIV** – human immunodeficiency virus is a retrovirus that infects humans when it comes in contact with tissues such as those that line the vagina, anal area, mouth, eyes, or break in the skin.

**HIV/AIDS** – HIV leads to AIDS, hence the virus and the syndrome are often referred to in conjunction.

**IDU** – injection drug use or intravenous drug use and may also refer to a user who injects drugs (typically illicit) directly into his or her bloodstream using a needle and syringe.

**Legacy of physical and sexual abuse in residential schools** – (often referred to as "Legacy") is the ongoing direct and indirect effects of physical and sexual abuse at residential schools. It includes the effects of Survivors, their families, descendants, and communities (including communities of interest). These effects may include, and are not limited to, family violence, drug, alcohol and substance abuse, physical and sexual abuse, loss of parenting skills, and self-destructive behaviour.

**Post traumatic stress disorder (PTSD)** – a psychological disorder that develops in some individuals who had major traumatic experiences, such as those who experienced serious accidents or who survived or witnessed violent crimes or acts of war. Symptoms can include emotional numbness at first, depression, excessive irritability, guilt for having survived others who were injured or died, recurrent nightmares, flashback to the traumatic scene, or overreactions to sudden noises.

**Residential schools** – the residential school system in Canada attended by Aboriginal students and may include industrial schools, boarding schools, homes for students, hostels, billets, residential schools, residential schools with a majority of day students, or a combination of any of the above.

**Seroconversion** – the development of detectable antibodies in the blood that are directed against an infectious agent.

**Seroprevalence** – the overall occurrence of a disease within a defined population at one time, as measured by blood tests.

**Survivor** – an Aboriginal person who attended and survived the residential school system in Canada.

## Introduction

A reality for many Aboriginal people is that their lives have been influenced by residential schools, even for those who did not attend them. This flawed educational system—if it can be called such—fell short of its primary purpose, which was to educate. Instead, its secondary purpose of assimilation has resulted in a whole new reality for generations that followed the first school opening.

The question of whether or not assimilation was inevitable is beside the point. The fact remains that the federal government enlisted church organizations to carry out one of the most known systematic attempts of assimilation that changed Aboriginal people forever. So what does this have to do with HIV/AIDS? Are Aboriginal people living in the past? Why must we constantly raise these issues rather than simply move on? One would have to know the lives and stories of every Survivor to understand the answers to these questions.

It is true that not all Survivors experienced the same situations. It is also true that Survivors are not to blame for all the issues and concerns in Aboriginal communities. What is true is that residential schools contributed in hugely significant ways and, when combined with other pressures and shifting economies, helped create some very bleak conditions for Aboriginal people. For example, the introduction of alcohol, accompanied with family violence and sexual abuse, was a difficult issue to address. This was often because Aboriginal communities did not have the resources at the time to face these challenges. Poverty had crept into environments that, while not perfect, they worked for the most part prior to European contact.

As to whether Aboriginal people are living in the past does not preclude the fact that, in the last two generations, government and non-Aboriginal society were still determining what was best for Aboriginal people. Examples such as only being allowed to vote in 1960 without relinquishing treaty or Indian status rights, forced relocation, and the child welfare system removing Aboriginal children into non-Aboriginal homes well into the 1970s (and still some today) took place in the not so distant years.

The systems we speak of, and the subsequent impacts, are believed to impede forward movement. This is also known or referred to as the "healing needs" of the Aboriginal population. Multiple losses, poor socio-economic status when compared to mainstream Canadian society, and insufficient time to grieve a previous loss before the next loss occurs are all factors that have slowed the healing process for many Aboriginal people.

Few non-Aboriginal homes can claim the same level of premature and often violent deaths that occur in many Aboriginal communities. When substance abuse enters the equation, then it becomes easier to see how despair and loss of hope take firm hold. While many Aboriginal communities are climbing out of dark pasts, what remains are significant challenges to retain culture, language, and traditional strengths while seeking to be adaptive to a new era.

This report describes some of these challenges. They will help to understand that Survivors have needs, unique and above others in the Aboriginal population, yet they are still part of the people as a whole who have been impacted by a failed system. These needs become compromised when new health issues such as HIV/AIDS or injection drug use come into play. HIV/AIDS stigma and discrimination, including homophobia, make it all the more difficult to face and respond appropriately. And, when dealing with

Aboriginal people who are or have been in prison, this brings yet another level of healing needs that often goes unanswered. HIV/AIDS and hepatitis C are two of the newer health threats facing Aboriginal people today, especially those in prison. In exploring the connection between the residential school legacy and HIV/AIDS, this report focuses on incarcerated Aboriginal people because it is in the Canadian prison system that some of the most disturbing infection rates are found. Any person whose life path leads to prison has undoubtedly experienced a breakdown in the personal support systems and social networks that keep most people afloat. Prisons, like residential schools, are complete institutions. Far too many Aboriginal people are still spending portions of their lives in institutions where they have little control and are forbidden to leave.

Rather than closing one's eyes to these realities, one needs to understand that the solution to truly overcoming the impact of residential schools is the same one in overcoming HIV/AIDS or hepatitis C, child sexual abuse, or addiction—the solution is simply to be informed and not to be afraid. Through knowledge and reason, Aboriginal people can rely on their traditional strengths to face any challenge that comes their way.

## Background

Over the past few years, the Canadian Aboriginal AIDS Network (CAAN) has played an increasing role in community-based research. In so doing, CAAN has looked into linkages between the influence of residential schools and HIV/AIDS. In 2003, the Aboriginal Healing Foundation (AHF) could only identify relevance between these two issues. The AHF article, entitled *Examining HIV/AIDS Among the Aboriginal Population in Canada in the post-residential school era*, had a three-fold purpose:

> to examine current literature to determine whether there is a link between the legacy of residential schools and HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome); to outline how HIV/AIDS is affecting the Aboriginal population; and to identify what interventions are being made to combat this health issue, including best practices and challenges (Barlow, 2003:1).[1]

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

Since then, CAAN has published several reports that have documented more direct and indirect links between residential schools and HIV/AIDS. The first report was a study released in 2005 (see Jackson and Reimer, 2005/2008a). In this study (herein referred to as the CTS study) 195 Aboriginal people living with HIV/AIDS were interviewed and, of those, 16 per cent had attended a residential school. This was the first evidence that showed both a direct and indirect link, as most of the 195 people interviewed had a parent or grandparent who also attended.

The CTS study confirmed what many front-line workers and Aboriginal AIDS service organizations have been saying for quite awhile: *HIV/AIDS is both a direct and indirect outcome of residential schooling*. From the CTS study group, there were a total of 32 residential school Survivors. The largest number (18) fell within the 40–49 age group. This was followed with nine Survivors between the ages of 30–39, four over the age of 50, and one under the age of 30.

[1] The content of this article has been mostly maintained here, but with new information inserted primarily related to the first objective stated above. The second objective has also been updated with new epidemiological data. The third objective has not been revisited.

**Table 1: Survivor Age Category**

| Age | Per cent (rounded) | Number (Survivors only, n=32) |
|---|---|---|
| under 30 | 3% | 1 |
| 30–39 years | 41% | 9 |
| 40–49 | 45% | 18 |
| 50> | 5% | 4 |

Source: Jackson and Reimer (2005/2008b)

Not surprisingly, the vast majority were First Nations individuals (status, non-status, and Bill C-31) who made up 26 of the 32 Survivors in this data set. The remaining six Survivors identified as Innu, Inuit, or Métis (two per group) (Jackson and Reimer, 2005/2008b). The CTS study also revealed that:

- of those who responded to the residential school attendance question, 17 per cent had attended;
- of the 17 per cent, most (94%) had attended a residential school for two years or more with 20 per cent attending nine years or more;
- 29 per cent or almost one-third of the overall study population had one or both parents attend;
- 46 per cent of those who had responded to the residential school attendance by a parent/guardian/grandparent question had between one and four relatives or guardians who had attended residential school (Jackson and Reimer, 2005/2008a).

The CTS study used a participatory action research methodology through a self-administered survey conducted between 24 March and 15 September 2004. The CTS data provide a purposive data set that yields meaningful insights into the experiences of Aboriginal people living with HIV/AIDS, some of whom are Survivors as well. Although only a small majority of respondents in the CTS study are Survivors, almost half had one or more parent, grandparent, or guardian attend a residential school. Of those respondents who had attended residential school or who had one or more relative attend, 65 per cent felt that their health had been affected by the legacy of residential schools in one form or another; these include poor mental health (psychological/physical abuse), high-risk choices, addictions, lack of parenting skills, and low self-esteem as being the most common (Jackson and Reimer, 2005/2008a).

Thus, the argument is given that there is both a direct and indirect correlation between residential schools and HIV/AIDS. Clearly, considerable numbers of respondents felt that residential schools had serious impacts on their health. While it may have been useful to extrapolate data specifically from Survivors and contrast it here, the study was unable to do so. However, given the presence of intergenerational impacts that saw a high number of parents or grandparents who had attended, there is value in presenting the data as above. As one respondent put it:

> *I came out of Residential school pretty screwed up, and it has caused way more problems that just don't 'go away'. It caused mis-guidance and poor judgment that led to me getting HIV and Hep C. I can live with the disease, but the 'mental' damage from Residential school is a very serious disease* (Jackson and Reimer, 2005/2008a:38).

The AHF article described earlier provides an overview of the literature that resulted in some reasoned linkages between HIV/AIDS and the Legacy. A wide range of existing literature was reviewed, particularly for references or linkages to the residential school legacy, but there is little direct evidence that can be found in the literature in terms of whether a link does exist as most references addressed indirect linkages with other issues such as physical and sexual abuse, addiction, and so on. However, the review offered a broader knowledge base with respect to how and why the HIV/AIDS epidemic is unfolding in the Aboriginal community and identified the gaps that exist in addressing this epidemic. Interventions regarding HIV/AIDS were also noted, especially in terms of identifying best practices. CAAN and its affiliates were instrumental in identifying intervention-related resources, potential research of interest, as well as providing details on the history of the Aboriginal HIV/AIDS movement in Canada.

Shortly after, a second study was also conducted, which was an environmental scan that reached 24 organizations serving Aboriginal two-spirited people and 86 Aboriginal people of whom most but not all were living with HIV/AIDS. This study showed almost one-fifth (17%) had attended a residential school (Canadian Aboriginal AIDS Network [CAAN], 2005). A vast majority of those interviewed for this second report had parents or grandparents who also attended.

Based on these two studies, CAAN issued the statement that residential schools is an Aboriginal determinant of health (CAAN, n.d.); if you attended a residential school or had a relative attend, you were likely to have your health suffer as a result.

## The Residential School Legacy

The literature pertaining to the effects of residential schools on the health of Aboriginal peoples in Canada is, at best, limited. Admittedly, there are no data on the number of residential school Survivors infected with HIV/AIDS. Kirmayer and colleagues note the implications of the residential school legacy with respect to impacts on the overall social conditions of Canada's Aboriginal peoples: "The origins of the high rates of mental health and social problems in Aboriginal communities are not hard to discern. Aboriginal peoples in Canada have faced cultural oppression through policies of forced assimilation on the part of Euro-Canadian institutions since the earliest periods of contact" (2003:S16).

Particularly notable was the establishment of the residential school system, a result of federal government policy and culmination of a formal partnership between the government and Roman Catholic, United, Anglican, and other churches to educate Aboriginal children. Both church and state had significant roles in the lives of Aboriginal people. Through education, it was thought that Aboriginal children could be integrated into the emerging British Canadian society and imbued with the principles and knowledge required to progress toward civilization (Kirmayer, Simpson, and Cargo, 2003). The consequences of the government's policy of assimilation through residential schools would, in later times, become known as the legacy of residential schools or, more succinctly, the "Legacy."

Assimilation was a central goal of federal policy. In 1920, the intentions of government was expressed in a statement made by Duncan Campbell Scott, then deputy superintendent-general of the Department of Indian Affairs: "Our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic, and there is no Indian question" (1920:63). Aboriginal people did not possess the power or means to resist government policy and Indian agents who held wide-reaching powers, at times enforced by the RCMP.

For several generations, Aboriginal communities were struggling with two key issues that contributed to disruptive changes: adverse social and economic conditions at the community level as well as adverse impacts resulting from the residential school system. Church-operated residential schools in Canada closed in the late 1960s: "Residential schools officially operated in Canada between 1892 and 1969" (AHF, 2001:7), but government-run schools continued until 1996 with the last band-run school closing in 1998.

Aboriginal communities were changing, and not always for the better, through the introduction of new diseases, displaced roles (i.e., parenting), encroachment on traditional lands by European settlers, and the introduction of alcohol and other drugs. Cultural strengths, such as the extended family-based system, decreased in their effectiveness to address the imminent threats, such as physical and sexual abuse, commonly found within residential schools. Thus, not only did Survivors experience trauma during their educational training, but these traumas have been multi-generational, extending to family members and friends. The cumulative effects can be devastating to an individual and wreak havoc on a community. The effects will not only be realized at the time, but they will also resonate long after.

With respect to the Legacy, at least two key areas have been impacted. Firstly, there was damage to cultural identities, such as loss of language, traditions, and connection to family and community. Secondly, there was damage to the individual, which resulted in shame, rage, lack of trust, and engagement in negative

coping patterns such as substance abuse, among others. Marginalization and isolation are further by-products of the Legacy. Isolation, coupled with negative coping patterns, may pose risks for HIV infection for some Survivors. The majority of residential schools ceased operations approximately a decade before the HIV/AIDS epidemic began in North America. The first Canadian death from AIDS occurred in 1983 (Health Canada, 2001) at a time when people succumbed much sooner after becoming HIV positive.

With an acute awareness of the aftermath of assimilation and the establishment of residential schools, assessing the extent and characteristics of the damage is essential in the recovery and resurgence of Aboriginal culture in Canada. Kirmayer and colleagues delve deeper into the two areas the AHF article (Barlow, 2003) had listed by interpolating on the areas impacted by the Legacy:

> Transgenerational effects of the residential schools include: the structural effects of disrupting families and communities; the transmission of explicit models and ideologies of parenting based on experiences in punitive institutional settings; patterns of emotional responding that reflect the lack of warmth and intimacy in childhood; repetition of physical and sexual abuse; loss of knowledge, language and tradition; systematic devaluing of Aboriginal identity; and, paradoxically, essentialising Aboriginal identity by treating it as something intrinsic to the person, static and incapable of change (2003:S18).

The profound and lasting effects of British and French colonialism, closely followed by a continued Canadian policy of assimilation of Indigenous peoples, are still apparent. Indeed, studies suggest that the effects have transcended generations and have produced negative consequences by hindering the development of Aboriginal people in Canada and, in some instances, having a regressive effect on the conditions of various aspects of health. Kirmayer and colleagues note in their review of existing literature that "qualitative studies implicate the collective exposures of Aboriginal peoples to forced assimilation policies as prime causes of poor health and social outcomes" (2003:S18). This can be seen from data collected by Statistics Canada and detailed in a report by Health Canada. In comparison with non-Aboriginal people, Aboriginal "communities are disproportionately affected by many social, economic and behavioural factors such as high rates of poverty, substance abuse, sexually transmitted infections and limited access to or use of health care services" (Health Canada, 2004:46). Through limited access to and use of health care service, individuals "increase their vulnerability to HIV infection" (2004:46).

As Kirmayer and colleagues affirm: "For Canadian Aboriginal peoples, the revelations of the evils of the residential schools have made the notion of individual and collective trauma salient" (2003:S20). Much of the trauma suffered by both individuals and communities has yet to be resolved.

In describing cross-cultural relations, the term ethnostress can provide insight into the Aboriginal experience in residential schools. " '**Ethnostress**' occurs when the cultural beliefs or joyful identity of a people are disrupted. It is the negative experience they feel when interacting with members of different cultural groups and themselves" (Antone, Miller, and Myers, 1986:7). This cultural clash can include normal human responses to abnormal situations. For example, if an Aboriginal child is repeatedly beaten and told that their culture is savage, a normal response could be to start believing this.

Ironically, forced assimilation succeeded only in creating conflict and confusion because both residential schools and reserves segregated Aboriginal people from mainstream society. It is difficult to say what would have happened if residential schools had not been formally entrenched in the lives of Aboriginal people. The fact that these schools operated for many generations and the fact that institutionalized abuses occurred within are factors for many, but not all, of the social ills felt today in Aboriginal communities.

## Understanding Physical and Sexual Abuse

Rigid church doctrine combined with many forms of punishment led to conflicts and trauma for Survivors, many of which often remained unresolved. The inability to resolve these conflicts and trauma is partly due to the impoverished living conditions in many Aboriginal communities that prevent adequate support of their psychological and emotional needs. Christian teachings toward sex and sexuality, in general, were strict and unbending. Aboriginal students were pressured to maintain abstinence until marriage. How confusing it must have been for many of the students to have been taught that sex is for procreation upon marriage by the same people who committed violent sexual acts against them.

Damage to one's sexuality can often predispose a person to high-risk behaviours that could lead to HIV. One outcome for survivors of sexual abuse is confusion around their sexuality. This can be more confusing for same-sex abuse. For example, Saxe outlines the impact of incest on the lives of women as follows: "Feelings such as intense shame and low self-esteem frequently interfere with the completion of important life tasks such as obtaining an education, establishing a nurturing relationship, and/or starting and raising a family" (1993:2–3). Crowder and Hawkings also go on to state that "Many male survivors have been abused by a male offender and this inevitably raises questions for the survivor about his sexual orientation and masculinity" (1993:28).

These types of wounds could contribute to why some people cannot set healthy boundaries, like saying no to unwanted sexual advances or feeling empowered to leave an abusive relationship. These could also translate into why some women are unable to ask a male sexual partner to use a condom. Certainly, the wide-reaching impacts of sexual abuse contribute to a number of mental, emotional, physical, and psychological wounds that affect the formation of healthy relationships. Adding the use of substances as a negative coping mechanism (for some, adding injecting drug use and more volatile substances) can increase the risks for HIV and/or hepatitis C.

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

It is quite common for survivors of childhood sexual abuse to not disclose their experiences until well into adulthood. As a result, the challenges faced are often complex and varied. How well an Aboriginal community responds to these sensitive issues can often determine whether a victim eventually moves from unresolved trauma towards a solid healing journey.

A treatment model developed by Crowder and Hawkings (1993) describes the impacts of sexual abuse on male survivors, many of which are likely similar for female survivors. Some of these impacts can increase the risk for HIV infection and include:

- Posttraumatic Stress Disorder (PTSD) and dissociation;
- difficulties with male gender identity;
- sexual orientation confusion and homophobia;

- abuse-reactive perpetration and aggression;
- sexual compulsions and addictions; and
- interpersonal difficulties (Crowder and Hawkings, 1993:ch. 2).

Clearly, emotional challenges result when an individual experiences childhood sexual abuse. When these emotional difficulties are not dealt with, negative coping patterns may surface. For example, sexual compulsions and addictions can be issues that increase risk for HIV infections.

Both sexual abuse and physical abuse often occur within dysfunctional environments. The effects of physical abuse in some ways mirror those of sexual abuse. Alcoholism (or drug addictions) is a common factor associated with both physical and sexual abuse. Alcoholism or drug addictions may create difficulties due to the erratic and unpredictable behaviours of the abuser. Also, as a result of a traumatic childhood, some individuals may turn to alcohol and/or drugs as a means of coping and/or increasing the tendency to perpetuate the cycle of physical and sexual abuse.

It is safe to say that residential schools have been a contributing factor in why some Survivors have contracted HIV/AIDS. This observation also applies to later generations. It is more likely that those individuals with severe unresolved trauma may be at greater risk for HIV/AIDS based on whether certain high-risk behaviours are present. Simply put, wounded children grow up to be wounded adults.

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

## HIV/AIDS and Aboriginal People

HIV is an acronym for human immunodeficiency virus, which is widely accepted as the cause of AIDS (acquired immune deficiency syndrome). AIDS is classified as a syndrome because the immune system breaks down and infected individuals become susceptible to numerous opportunistic infections and cancers, which are the eventual causes of death. Thus, the term syndrome applies because it is not just one illness or infection that leads to death, but rather more than one disease that could eventually consume the body's defense.

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

AIDS develops after many years of HIV infection. Only a medical doctor can diagnose AIDS by determining whether the CD4 count is less than 200 and whether there is more than one of the AIDS-defining illnesses present. The CD4 or T-helper cells are the body's defense mechanism for any imminent threats and usually attack a viral or bacterial infection. In individuals with HIV, the CD4 count begins to drop and the cells become unable to do their job of defending the body from infection. New antiretroviral medications in various combinations now allow individuals to live much longer. Often, once people develop HIV, they could live up to 15 to 20 years before the more serious threats become evident. The World Health Organization (2004) uses the following Modified Staging model to measure the progression of the AIDS virus, as described by Schneider and colleagues:

> Stage I and II are early disease stages and are largely characterised by being asymptomatic [no symptoms]. Stage III is associated with a very low CD4 count without a major opportunistic infection and Stage IV is usually associated with an AIDS diagnosis (1998:20).

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

According to the Public Health Agency of Canada (PHAC), "Before 1993, 1.2% of reported AIDS cases were among Aboriginal peoples" (2004:2). This increased to "50.3% during 2001-2006" (PHAC, 2007:50). In 1998, there were 19 per cent of positive HIV test reports among Aboriginal people. "However, in 2006 the proportion of positive HIV test reports attributed to Aboriginal persons was 27.3% among the provinces and territories reporting ethnicity information with their HIV reports" (2007:49). PHAC also reports that "Of 605 Aboriginal AIDS cases reported up to December 31, 2006, 73.1% or 442 were First Nations, 7.3% or 44 were Métis, 3.6% or 22 were Inuit, and 16.0% or 97 were in

the category Aboriginal Unspecified" (2007:55) and that HIV infections among Aboriginal people have been on a steady rise over the last decade or so:

> A steady rise has been seen in the proportion of reported AIDS cases and positive HIV test reports among Aboriginal persons in Canada in recent years ... Aboriginal persons accounted for approximately 200 to 400 of the new HIV infections in 2002 and 2005, which is about 9% of the total for 2005 and 10% for 2002. Therefore, the overall infection rate among Aboriginal persons is about 2.8 times higher than among non-Aboriginal persons (2007:48, 56).

According to Statistics Canada (2008), it has been reported from the 2006 Census that the Aboriginal population has grown to represent almost 4 per cent of Canada's total population, an increase of 45 per cent since 1996. Based on the fact that Aboriginal people represent only a small percentage to that of the national population as a whole, despite its growth, this does show an overrepresentation in the higher percentage rates of HIV and AIDS infections among Aboriginal people. Clearly, these figures are disturbing.

The following shows trends over time where the increases are more noticeable:

> [S]ince 1998, the proportion of positive HIV test reports attributed to Aboriginal persons has remained steady, at just over 20%. Of the 647 positive HIV tests reported for 1998 from provinces and territories with ethnicity reporting, 123 were among Aboriginal persons, representing 19.0% of such tests reported in that period. This proportion was 24.5% (178/728) in 2002, after which a slight decrease was noted. However, in 2006 the proportion of positive HIV test reports attributed to Aboriginal persons was 27.3% among the provinces and territories reporting ethnicity information with their HIV reports (PHAC, 2007:49).

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

**Table 2: Comparison of age at time of diagnosis for reported AIDS cases and at time of test for positive HIV* test reports among Aboriginal and non-Aboriginal peoples**

| | Aboriginal | Non-Aboriginal |
|---|---|---|
| | n = number of cases with available information on age | |
| **AIDS (1979-December 31, 2006)** | **n = 605** | **n = 15,744** |
| < 20 years | 1.5% | 1.5% |
| 20–29 years | 19.5% | 14.6% |
| 30–39 years | 46.6% | 43.6% |
| 40–49 years | 24.1% | 28.4% |
| 50 + years | 8.3% | 11.9% |
| **HIV (1998-December 31, 2006)** | **n = 1,457** | **n = 4,793** |
| < 20 years | 4.7% | 1.5% |
| 20–29 years | 27.7% | 19.5% |
| 30–39 years | 37.7% | 36.9% |
| 40–49 years | 23.1% | 27.6% |
| 50 + years | 6.8% | 14.4% |

* For positive HIV test reports, that data are from provinces/territories with reported ethnicity (BC, YT, AB, NT, NU, SK, MB, NB, NS, PEI, NL).

Source: PHAC (2007:54)

To better explain the figures contained in the table above, the majority of Aboriginal HIV infections (37.7%) continue to fall within the 30–39 age range, which would be the lower end of the age group that Survivors could fit. This is followed by 27.7 per cent in the 20–29 age range and 23.1 per cent in the 40–49 age range. In most of these age categories, with the exception of over 40 years, Aboriginal people have a higher percentage of HIV-positive than non-Aboriginal people. This is also true for AIDS data.

During the period 1998–2006, Aboriginal people were being exposed to HIV:

- the majority through injection drug use (58.8%);
- females represented 48.1% of positive HIV test reports;
- youth made up 32.4% of positive HIV test reports (PHAC, 2007).

## The Role of Injection Drug Use

The greatest risk factor for HIV infection involves injection drug use (IDU), when needles are shared by more than one person. This practice also increases the risk of HIV infection for sexual partners. There is a pressing need for more prevention efforts in this area. In fact, the role of injection drug use raises a grim reality. Among Aboriginal people in Canada, "the proportion of new HIV infections in 2005 attributed to IDU (53%) was much higher than among all Canadians (14%)" (PHAC, 2007:47).

As many of the drugs used are highly addictive (e.g., heroin and cocaine) and create intense, elevated feelings of euphoria, followed by a steady decline, addicts must continually increase the frequency of their injections to maintain this altered state. When needles are shared, there is a direct entry for HIV into the bloodstream because blood enters the syringe each time it is used. This is one of the most efficient ways to spread HIV as well as other diseases such as hepatitis C.

Sharing needles to inject these highly addictive drugs becomes a more pronounced factor when HIV infections reach a benchmark among the injection drug-using population. "Mathematical modelling demonstrates that once more than 10% of the drug-injecting population is infected with HIV, prevalence almost invariably rises to 40% or 50% within a few years. In many cities, much faster rises have been recorded" (World Health Organization, 1998:37). Because IDU is a key exposure category for Aboriginal people, a critical reason why it continues to increase is because IDU populations reach or exceed that ten per cent benchmark.

A needs assessment conducted by a needle exchange program operated through a Native friendship centre in Nova Scotia found that the majority of drug users were abused in childhood or grew up in alcoholic homes. Although this study represents a small sampling for people of Aboriginal descent, "67% ... of those asked said yes their parents were alcoholics ... [s]ixty-nine per cent ... of those interviewed told us they had been abused physically, 64% described the abuse as mental and 28% said it was sexual abuse" (Grandy, 1995:15, 20). It clearly shows that a large number of people may be predisposed to addiction simply because of the environment they were raised in, which seems to have similar implications for Survivors of residential schools.

## Aboriginal Men Who Have Sex with Men

Men who have sex with men (MSM) represent a significant percentage of the HIV-infected population among Aboriginal people. The phrase *men who have sex with men* is preferred because the term *gay* is not always applicable to those who would fall into this category. For example, a fair number of young male sex-trade workers who sell their bodies to other men do not classify themselves as gay because they rely on the sex-trade as a matter of survival. Some may be gay, but not all. The same holds true for married men who have extra-marital sex with men. Injection drug use among Aboriginal MSM is also a contributing factor to the number of HIV infections in this group.

For the period between 1979 and the end of December 2006, MSM accounted for slightly more than 30 per cent for Aboriginal AIDS cases versus approximately 39 per cent for non-Aboriginal cases. When IDU is also a factor, Aboriginal AIDS cases accounted for almost 7 per cent versus slightly more than 4 per cent for non-Aboriginal cases. For positive HIV test reports, Aboriginal MSM accounted for

slightly less than 7 per cent compared to around 39 per cent for non-Aboriginal MSM. The ratio changes when IDU is also a factor, from over 3 per cent for Aboriginal cases compared to less than 3 per cent for non-Aboriginal cases. This indicates that when Aboriginal men who have sex with men and who are also injection drug users, the risks for AIDS or HIV infections increase exponentially compared to non-Aboriginal men who have sex with men and who are also injection drug users (PHAC, 2007).

Aboriginal gay males in large urban settings were among those first affected by HIV/AIDS. Homophobia, felt to be a key barrier, continues to be a factor in prevention efforts. An Ontario survey to gather information on issues related to general health and HIV/AIDS in First Nations communities found that "The majority of respondents felt that homosexuality was wrong, and perceived their family and community to support this view" (Myers et al., 1993:42). Approximately 80 per cent of respondents held negative views toward homosexuality.

## Aboriginal Women

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

Table 3 shows the number of reported AIDS cases up to the end of 2006 and compares between Aboriginal and non-Aboriginal women. These percentages indicate that Aboriginal women account for almost three times more AIDS cases than non-Aboriginal women. For positive HIV test reports (from 1998 to 2006), the figures show that Aboriginal women are more than twice likely to become HIV positive than non-Aboriginal women.

**Table 3: Comparison of gender of reported AIDS cases and positive HIV* test reports among Aboriginal and non-Aboriginal persons**

| | Aboriginal | Non-Aboriginal |
|---|---|---|
| | *n* = number of cases with available information on gender | |
| **AIDS (1979-2006)** | ***n* = 604** | ***n* = 15,741** |
| Female | 26.5% | 9.1% |
| **HIV (1998-2006)** | ***n* = 1,454** | ***n* = 4,784** |
| Female | 48.1% | 20.7% |

* For positive HIV test reports, the data are from provinces/territories with reported ethnicity (BC, YT, AB, NT, NU, SK, MB, NB, NS, PEI, NL).

Source: PHAC (2007:53)

Available data suggest that an increasing number of Aboriginal women are becoming infected with HIV largely through heterosexual contact. Also, more Aboriginal women are becoming involved with injection drug use compared to non-Aboriginal women. However, there are gaps that still remain in the HIV/AIDS data, especially with respect to Aboriginal women living with HIV/AIDS (PHAC, 2007).

A study done by Ship and Norton revealed some direct evidence of a link between women who are HIV positive and residential schools on an intergenerational level where personal histories of physical and/or sexual abuse were present:

> Our interviews with First Nations women living with HIV/AIDS revealed the painfully clear links between cultural disruption, residential schooling, family and cultural breakdown, multi-generational abuse, and HIV. Almost all of them told us that they came from families where one or both parents had attended residential schools and alcoholism was a problem. Eight HIV-positive women admitted that they had been victims of sexual abuse as children (2001:26).

Sexual violence can result in risks for HIV infection when the attacker has HIV. It is a reasonable assumption that during any act of sexual violence, the perpetrator would not take the time or concern himself to wear a condom. This assumption is apparent because the attacker would likely be rushed so as not to get interrupted by someone who could then identify him. Sexual violence is defined as "*any unwanted or non-consensual sexual touching, act or exploitation achieved through physical force, threat, intimidation and/or coercion* [footnote removed]" (Health Canada, 2002:5). However, not all acts of sexual violence carry the same risks for HIV; for example, forced oral sex is believed to carry less risk unless there is broken skin in or around the mouth. This is not meant to downplay the trauma and violation as some risk may be present if the attacker has HIV. Sexual violence that could increase women's risk of HIV includes acts of:

- sexual assault;
- childhood sexual abuse;
- woman abuse (sexual coercion, sexual assault and other acts of sexual violence against women in their relationships) (Health Canada, 2002:5).

## Aboriginal Offenders

Another contributing factor that could lead to HIV and or hepatitis C infection is institutional homosexuality. This occurs when the offender (usually a heterosexual prior to incarceration) engages in same-sex behaviours while incarcerated. The percentage of occurrence is low and varied in the prison population:

> The findings of studies on sexual conduct in prison are quite consistent. The Montreal medium security prison study found that 6.1% of men and 6.8% of women report having sex in prison. Similarly, the CSC [Correctional Service of Canada] survey found that 6% of inmates report sex in prison. The New Brunswick study found a rate of 9%. Condom use was reported by only 33% of inmates in the CSC survey (Watershed Writing and Research, 1998:28).

Although this indicates that the rates are low, "Many prisoners decline to participate in studies because they claim not to have engaged in any high-risk behaviour" (Jürgens, 2007:8). This suggests that the numbers could be significant. Because sex between inmates is prohibited within a correctional setting, this could lead to unsafe sexual practices. There is also the influence of homophobia that could discourage someone from being more open about engaging in homosexual behaviour, especially when inmates may not be gay yet engage in institutional homosexuality due to the exposure of same-sex activity among the incarcerated population.

## Background on HIV/AIDS in the Canadian Prison System

Within the past ten years, while there have been numerous articles written regarding HIV/AIDS and hepatitis C virus in the Canadian prison system, there is little in-depth analysis regarding their effect and prevalence among the Aboriginal inmate population. Also, it is difficult to ascertain with any certainty the prevalence rate within the total prison population.

There are three major shortcomings in the literature that hinder research to obtain an accurate picture of these infectious diseases within the correctional system: one, many of the reports were written at different times using different statistics; two, some reports have included both provincial prisons and federal penitentiaries in their calculations, and others have concentrated either on those numbers provided by Correctional Service of Canada (CSC) or on a particular provincial system; and three, there are concerns regarding the definition of the incarcerated population. Some reports use incarceration statistics that include those in remand, holding cells, and so on and others use inmates, that is, those who are actually in the prison system. For example, one study says there were approximately 33,000 people in Canadian prisons on any given day (Lines, 2002a), while the 2001 Census states there were 31,500 (Statistics Canada, 2001).

The literature review for this section was completed by the midpoint of 2005, but statistical data has been updated to the most current trends when available. Many of the available reports were written in the early 2000s, relying heavily on statistics from the 1996 Census. Infection rates of HIV/AIDS and hepatitis C are continually on the rise and *true* infection rates are likely to be much higher than is represented by the statistics. When attempting to gain a clearer understanding of the epidemics of HIV/AIDS and

hepatitis C in the Canadian prison system, a number of other factors have to be taken into consideration: rates of disclosure within the prison system, non-testing, non-screening, and under-reporting. Also, some provinces do not report ethnicity, which makes assessing the impact of HIV/AIDS on differing ethnic groups incomplete. It is therefore difficult to obtain an accurate assessment of the number of Aboriginal people infected with HIV/AIDS and/or hepatitis C within the correctional system. All the numbers that have been presented in various reports from the literature are only estimates.

In June 2006, CAAN conducted 17 interviews at four healing lodges that house incarcerated Aboriginal men: Wahpeton Healing Lodge in Prince Albert, Saskatchewan; Stan Daniels Healing Centre in Edmonton, Alberta; Ochichakkosipi Healing Lodge in Crane River, Manitoba; and Waseskun Healing Centre in Quebec's Laurentian district (see Appendix 1). The purpose of the interviews was to gather information about how HIV/AIDS, hepatitis C, and residential schools are addressed within lodges (see Appendix 2). CAAN also asked about their views on the need for further information and resources. Information from the interviews is woven throughout this section. The interviews were conducted with directors, Elders, parole officers, program facilitators, case managers, counsellors, and residential coordinators. Consent forms were signed. Given the small number of participants, this report does not identify interviewees by their position or by the lodge where they are employed.

## Contributing Factors to the Prevalence of HIV/AIDS and Hepatitis C within Canadian Prisons

Several studies have provided possible explanations for the high prevalence of HIV/AIDS and hepatitis C in the Canadian prison system. In particular, three major high-risk behaviours contributing to the high rates of HIV/AIDS and hepatitis C were identified: injection drug use, unsafe sex practices, and tattooing with contaminated or makeshift tools. Outright government acknowledgement of the activities that occur within the correctional system and the prison environment has been limited. Jürgens notes that the lack of government acknowledgement has been detrimental to the prevention and reduction in the spread of HIV in prisons. He states:

> The prevention of HIV transmission in prisons is mostly hampered by the denial of governments of the existence of injection drug use and sexual intercourse in prisons, rather than by a lack of evidence that key interventions work. There is ample evidence that drug use in general, injecting drug use in particular, and sexual intercourse among inmates are widespread in such institutions. Furthermore, there are data indicating that the risk of HIV infection in prisons is usually higher than in the general community. Once this has been accepted, governments have a wide range of program options for preventing HIV transmission in prisons (2004:4).

The failure of government to address the issue of contributing factors to the transmission of HIV and other diseases such as hepatitis C is at the heart of the continuing epidemic among incarcerated individuals.

*Injection Drug Use (IDU)*

As noted above, one significant factor in the spread of HIV/AIDS and hepatitis C in the prison system is injection drug use (IDU). HIV and hepatitis C are transmitted most efficiently through the sharing of unclean needles or other injecting equipment among inmates. Needles are often used so many times that they become dull, causing more damage to the skin upon injection. Inmates may not clean the needle with bleach and water before the next inmate uses it because both possession of drugs and the injection equipment are illegal. Homemade injection equipment is often used, such as those made from pens. These can be so crude and cause significant skin damage upon injection. Because a number of inmates may pass around one needle, HIV and hepatitis can easily be spread. Also, the use of unsterilized equipment for tattooing among inmates is another high-risk factor for HIV infection. As this indicates, clean or unshared needles are viewed as a major factor in harm reduction against HIV. "Drug use within the penal system is a fact of life, but there is no program for providing clean needles in prison. Thus while in prison, Aboriginal IDUs are unable to protect themselves against HIV infection" (Watershed Writing and Research, 1998:3).

As Pállas and colleagues point out, "Injecting drug users (IDUs) show a higher prevalence of bloodborne viruses, mainly human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV)" (1999:699). For injection drug users, the most effective way of preventing HIV and hepatitis C is through the use of sterilized needles. Currently, there are no needle exchange programs within the Canadian correctional system, which prompts inmates to reuse and recycle needles or make their own injection equipment due to the scarcity or to the illegality of contraband.

When needles are not available, inmates will improvise and fabricate their own injection equipment; oftentimes, such equipment is quite crude and typically comprised of any readily available material. In their study, Lines and colleagues note the consequences in the absence of needle exchange programs in prison:

> As a result, prisoners who inject drugs share and reuse syringes out of necessity. A needle may circulate among (often large) numbers of people who inject drugs, or be hidden in a commonly accessible location where prisoners can use it … Sometimes the equipment used to inject drugs is homemade, with needle substitutes fashioned out of available everyday materials, often resulting in vein damage, scarring, and injection-site and other infections (2006:10).

In the absence of needle exchange programs, efforts to curb the inherent risks associated with the rudimentary methods of injection drug use have been implemented. In 1996, CSC implemented a bleach distribution program in all federal penitentiaries, as have some provincial jurisdictions (Canadian HIV/AIDS Legal Network [CHALN], 2008). It is widely believed that bleach with water does not kill the hepatitis C virus. "Hepatitis C is a stronger virus than HIV and can not be killed by cleaning needles with bleach. In Vancouver, 90% of the IDU community is infected with Hepatitis C" (Watershed Writing and Research, 1998:30). While using bleach kits (provided within federal institutions) is better than not using anything to clean needles, it may do little to control the risks of infection for hepatitis. The notion of bleaching remains a contentious issue in terms of arguments for the promotion and accommodation of drug use; nevertheless, bleaching is an important aspect of harm reduction. However, bleaching cannot

entirely assure the prevention of HIV/AIDS or hepatitis C transmission. Indeed, there is no conclusive medical or scientific evidence that bleaching eliminates any or all risk associated with sharing needles or other injection equipment: bleach may kill HIV, but it is not an effective agent in destroying hepatitis C.

Leaving aside the implementation of bleach availability in prisons, the stigma felt when obtaining the bleach may, in fact, undermine the effectiveness of the program. Since IDU is illegal in all prisons, the stigma that accompanies acquiring bleach from prison officials may induce unabridged evasion by the inmate out of fear; fear of being put under surveillance by guards for suspicious activity and fear of possible repercussions. In the face of possible detection by prison guards, inmates increase the risk associated with their behaviour through disregard of due prudence; for instance, "fixing" as fast as one can then sharing the used injection equipment without bleaching. The risk of transmitting or contracting blood-borne diseases, such as HIV/AIDS and hepatitis C, dramatically increases without the sterilization of shared injection equipment.

Although efforts to prevent and reduce the spread of HIV/AIDS and hepatitis C in prisons are encouraging, the innate factors that contribute to the epidemic have received insufficient attention. Medical professionals have brought to light the shortcomings of addressing the conditions that compel inmates to engage in injection drug use; namely, addiction. Ford and Wobeser consider drug use and its linkage to HIV and hepatitis C and offer the disheartening and alarming statement that "There is little evidence that Correctional Service Canada is making any serious effort to provide treatment to any drug users, whether they take drugs by injection or other means" (2000:665). Not only does failure to treat drug addiction perpetuate the use of drugs, it also "makes treatment of HIV or hepatitis C difficult, given that compliance with therapy is linked to treatment of the addiction" (Ford and Wobeser, 2000:665). In consideration of injection drug use in Canadian prisons, substandard care and treatment provided to those inmates who suffer from addictions to drugs prompts the continued use of needles and other injection equipment. The adverse results of this are reflected in the high rates of HIV and hepatitis C prevalence among incarcerated individuals, which are much higher than the general public. Until the system changes to allow needle exchange programs within correctional facilities, more infections will occur.

IDU is not viewed as a serious or prevalent problem in correctional healing lodges for a couple of reasons. First, residents[2] are screened for their commitment to a healing process and agree to participate in programs offered at the lodges. Addiction issues have often been addressed prior to entering the lodge and are then revisited, as required, as part of each individual's healing plan. Also, healing lodges have smaller, more closely knit populations and therefore detection is much easier. Staff at two of the lodges mentioned that the premises are routinely searched, so there is a good chance that drugs and paraphernalia would be quickly discovered and seized. For the most part, neither drugs nor tattooing are problems within the lodges involved in this study.

[2] The term "residents" is used to refer to individuals who reside at healing lodges. Some of the lodges use the word "members" or "relatives" and, in conversation, residents are often referred to as "the guys." Residents live at the lodges anywhere between two months and five years (or longer) depending primarily on the length of their sentence and where they are within it when they enter the lodge.

*Unsafe Sex Practices*

Issues surrounding the harm reduction program of bleach availability run parallel to those observed in prison condom programs. Condoms, dental dams, and water-based lubricants are important in the prevention of HIV/AIDS and hepatitis C through sexual contact. CSC makes condoms available, as do some provincial systems; however, prisoners cannot access condoms discreetly or anonymously in most institutions. The options available for inmates to obtain condoms do not encourage success of the program's goals; inmates must either request them from staff or pick them up in areas of high visibility.

As in the wider society, homosexuality is not accepted in the prison system. Thus, the terms "institutional homosexuality" or "situational homosexuality" are used when inmates engage in same-sex activities with fellow inmates. It is argued that when individuals do not have access to members of the opposite sex, they will engage in homosexual activity. This argument reduces some of the social stigma attached to homosexuality within the prison system. Results of a study found that 6.1 per cent of men and 6.8 per cent of women reported having sex in a Montreal medium security prison (Hankins et al., 1995). Prisoners who want to engage in safer sex practices may not do so for fear of repercussions from the prison staff, and many will not risk calling attention to themselves by asking for condoms. Similar to their concerns about bleaching, inmates fear that they will be put under increased surveillance. Therefore, with these types of restrictions in the Canadian prison system, "unsafe sex is pervasive" (Lines, 2002a:64). Condoms are available to residents in correctional healing lodges, although there are variations within each lodge with respect to ease of access.

*Tattooing*

Another source of concern regarding the spread of HIV/AIDS and hepatitis C within the prison system is the activity of tattooing. It is prohibited in prisons as well as all other correctional facilities, including the four healing lodges mentioned earlier. Tattooing, like injection drug use and sexual engagements, continues to take place in a clandestine manner. Pallás and colleagues state that besides injection drug use being the main risk factor for HIV and hepatitis C, activities such as tattooing are also known "parenteral risk factors" (1999:699); that is, risk of HIV or hepatitis C transmission can also be attributed to other intravenous or intramuscular administration injections.

As with drug use and sexual activities, the pace and time taken to complete the work at hand is of concern to the inmate. In order to avoid detection, prison tattooists often work in haste without taking the time to sterilize their tools. As Collins and colleagues note, "Because tattooing is illegal in prisons, there is also an increased likelihood of prisoners rushing through the process to minimize the risk of detection" (2003:4). Without access to effective sterilization solutions and supplies, the tattooing paraphernalia remains unhygienic and inadequate. The constant reuse of inks and needles leads to very high levels of risk for the transmission of HIV and hepatitis C.

Not to be dismissed or taken lightly, the incidence of tattooing in prison is commonplace. A great deal of research has explored and examined the extent of tattooing. Included in the plethora of international research into the subject, Collins and colleagues cite a Canadian study that made the number of incarcerated individuals partaking in the risky behaviour of prison tattooing unambiguous:

> Several studies have indicated that tattooing activity is common within Canadian prisons. In 1995, the *National Inmate Survey* of the Correctional Service of Canada found that 45% of federal prisoners had received a tattoo in prison [endnote removed]. Research conducted in 1998 at Joyceville Penitentiary in Kingston, Ontario by Dr. Peter Ford found that 57% of prisoners had received tattoos both inside and outside prison, and that 11.1% had been tattooed in prison only (2003:1).

Tattooing in prison presents a considerable risk with regard to the contraction and spread of blood-borne diseases such as hepatitis C and HIV/AIDS. In March 2004, CSC announced a pilot project on safer tattooing practices in an effort to enhance its infectious disease management activities in prisons. The program had provided education on safer tattooing practices and disease prevention. Over the course of 19 months following the announcement, tattoo shops opened in six institutions (Cowansville, Bath, Matsqui, Atlantic, Rockwood, and Fraser Valley) (Gaskell, 2006). A draft evaluation of the pilot project in 2006 indicated the potential reduction of HIV and HCV transmission; however, Public Safety Canada discontinued the program before the final evaluation was completed and released (Elliot, 2007).

*Testing and Screening*

The unavailability of anonymous HIV testing hinders HIV/AIDS and hepatitis C prevention. Anonymous testing allows for a person to not disclose his or her name as a number is given instead. When the results are given back, only the person with the corresponding number will have access to the test results. Currently, prisoners in both federal and provincial systems generally have access to HIV testing by request, and the results of the test are made available to both the prison health unit and to the public health department (Lines, 2002a). With the discrimination and stigmatization of those infected with HIV/AIDS or hepatitis C being just as rampant in the prisons as they are in mainstream society, prisoners are reluctant to go for testing due to confidentiality issues.

Testing and screening for HIV and hepatitis C are generally not available within healing lodges. One centre did attempt in-house testing through a visiting nurse, but other residents assumed that if someone took the test, they must be infected. Now, individuals who desire tests are discreetly escorted to a health centre. One person noted that if all residents participated in periodic testing, there would be less room for speculation. Full confidentiality depends on where the testing is done. Only those residents on day parole in Edmonton, Alberta, have access to an outside anonymous testing site. In more isolated areas, confidentiality may be respected, but the results themselves are not provided anonymously. If the testing is done through CSC, then the parole officer is informed of the results. In one case, testing is done in the correctional institution before coming to the lodge, and the records are then sent directly to the local health centre prior to transfer. No information is shared with the lodge staff and no health records are kept on site.

Prospective residents are often asked if they have any health issues that would prohibit their participation in any of the programs offered. Also, residents undergo full medicals prior to being transferred to a healing lodge, and there was a feeling among many interviewees that HIV positive inmates would probably not be transferred. One interviewee suggested that residents are not especially interested in learning about their HIV status. There are concerns about the confidentiality of the tests, fear of stigma, and fear of getting a positive result: "Carrying on blindly is better than the stigma."

When asked if they had experience with residents who are HIV positive or living with AIDS, answers from interviewees varied, even among staff at one of the lodges. This suggests that confidentiality is being respected. Most of the staff involved in interviews said that they would know if someone had tested positive for HIV or hepatitis C only if the individual himself disclosed it. One person had advised residents against informing other residents to avoid stigma. In one case, someone living with AIDS began experiencing health problems and requested a private room. The other residents had guessed the reason: "rumors immediately circulated and this was damaging because he lost trust in the organization and people." He was subsequently moved to a halfway house in another community. Some healing lodge staff expressed an interest in being informed if anyone is HIV positive, but this information is not shared. Their concerns were primarily around occupational health and safety, but one staff member focused on the desire to be more sensitive to residents' needs: "To be totally honest, it would be nice if we knew. We could be more sensitive about task assignment. The medications can burn them out and it would be nice to cut them slack." Another person said that individuals living with AIDS may be screened out if there is no easy access to medical care in the area of the lodge.

An interviewee raised an issue relevant to the support and counselling that should follow the receipt of a positive test: "Lots of times when a guy has hep C or HIV, he is mostly trying to learn and deal with the impact rather than understand it, how it is spread … most are ill-informed … What I'd like to see is mandatory training on HIV, STDs, and FAS. To tell you the truth, I don't think these guys give a shit whether or not they get infected."

## Statistics

Two federal departments collect and publish data on the number of inmates in correctional facilities in Canada: Statistics Canada and Correctional Service of Canada. From Statistics Canada, one can get an accurate count of inmates in Canada. For the purpose of the 2006 Census, no distinction was made between provincial and federal penitentiaries, and only those actually housed in prisons on Census day were enumerated. According to Statistics Canada, on an average day in 2004/2005 there were 32,100 offenders housed in provincial and federal penal institutions, and "Nearly one-third (30%) of all females and one-in-five males (21%) admitted to sentenced custody were Aboriginal" (Beattie, 2006:1).

Other literature surveyed used statistics that included all prisoners within the correctional system. On 5 October 1996, in collaboration between federal, provincial, and territorial corrections authorities and the Canadian Centre for Justice Statistics, a census was conducted of all adult inmates in Canadian correctional facilities. Statistics from the one-day census of Canadian inmates are listed below in Table 4.

**Table 4: One-day Census of Inmates in Canadian Correctional Facilities, 5 October 1996**

| | Prisoners | Men | Women | Non-Aboriginal | Aboriginal | Aboriginal % |
|---|---|---|---|---|---|---|
| **Canada Total** | 35,847 | 34,156 | 1,694 | 29,586 | 6,108 | 17.04 |
| **Federal** | 13,829 | 13,619 | 210 | 11,865 | 1,964 | 14.2 |
| **Provincial / Territorial** | 22,018 | 20,537 | 1,484 | 17,721 | 4,144 | 18.82 |

Source: Trevethan et al. (1999)

*Federal Prison System*

Correctional Service of Canada (CSC) deals directly with those imprisoned within the federal penitentiary system. Those inmates who are in the federal corrections system are serving sentences greater than two years in length. CSC reports that Aboriginal people currently represent approximately 18 per cent of the federal offender population, but only 4 per cent of the general population in Canada (Landry and Sinha, 2008). The disproportionate representation of Aboriginal persons within the federal system can also be observed in the regional differences across Canada. CSC notes:

> Aboriginal people represent 20 percent of all adult inmates in Canadian correctional facilities and up to 64 percent of the prison population in the Correctional Service of Canada (CSC)'s Prairie region ... While Aboriginal people make up only 15 percent of the general population in Manitoba and Saskatchewan, they comprised 64 percent of the provincial jail admissions in Manitoba and 76 percent in Saskatchewan (CHALN, 2008:info sheet #10).

CSC (n.d.) reports that in the year of 2001, the breakdown of Aboriginal offenders were as follows:

**Table 5: Aboriginal Offender Population as of 31 December 2001**

| | Gender | National Total | Atlantic | Quebec | Ontario | Prairie | Pacific |
|---|---|---|---|---|---|---|---|
| First Nation | Female | 128 | 9 | 3 | 15 | 91 | 10 |
| | Male | 2,219 | 91 | 99 | 339 | 1,269 | 421 |
| Métis | Female | 50 | 0 | 1 | 2 | 43 | 4 |
| | Male | 885 | 9 | 115 | 35 | 569 | 157 |
| Inuit | Female | 4 | 2 | 0 | 0 | 2 | 0 |
| | Male | 128 | 17 | 18 | 53 | 36 | 4 |

On 11 April 2004, a one-day census was taken in Canadian federal penitentiaries. The levels of incarceration rates for both length of term and percentage of prison population are shown. The CSC, in their latest report, summarized the Aboriginal profile of men, including rates of incarceration for both length of term and percentage of prison population as follows:

**Table 6: Inmate Profile of Aboriginal Men on 11 April 2004**

| | **Men 2,193** | **% of Inmates** |
|---|---|---|
| **Age Group** | | |
| Less than 18 | 2 | 0.09% |
| 18 to 19 | 36 | 2% |
| 20 to 29 | 795 | 36% |
| 30 to 39 | 748 | 34% |
| 40 to 49 | 432 | 20% |
| 50+ | 180 | 8% |
| Serving a first federal sentence | 1,411 | 64% |
| **Length of Service** | | |
| Under three years | 530 | 24% |
| Three to under six years | 662 | 30% |
| Six to under ten years | 319 | 15% |
| Ten years or more | 220 | 10% |
| Life or indeterminate | 462 | 21% |

**Source: CSC (2005)**

*Provincial Prison System*

Inmates within the provincial correctional system are sentenced to less than two years. Through these periodical "snapshot" one-day censuses, one can get a view of the Canadian correctional system at a certain time. Statistics Canada released this summary of 2000–2001 (see Table 7) regarding the provincial breakdown of the Aboriginal population in corrections. The total number of prisoners is inclusive of all that entered the corrections system during the 2000 calendar year. As with the previous table, the rates of incarceration for both length of term and percentage of prison population are shown. Please note, however, that lengths of term for Aboriginal inmates are not provided: the median sentence length provided is inclusive of all those inmates who took the Census that day, not just Aboriginal people (Hendrick and Farmer, 2002).

**Table 7: Selected Characteristics of Admissions to Sentenced Custody, 2000/01**

| | Admissions | Aboriginal (%) | Median Age | Median Sentence Length (Days) |
|---|---|---|---|---|
| **Newfoundland and Labrador** | 944 | 6.6 | .. | .. |
| **Prince Edward Island** | 586 | 0.6 | .. | .. |
| **Nova Scotia** | 1,624 | 7.0 | 30 | 60 |
| **New Brunswick** | .. | .. | .. | .. |
| **Quebec** | 14,951 | 1.8 | 35 | 28 |
| **Ontario** | 30,999 | 8.5 | 32 | 40 |
| **Manitoba** | 2,901 | 64.0 | 30 | 90 |
| **Saskatchewan** | 3,219 | 76.0 | 29 | 119 |
| **Alberta** | 14,859 | 39.3 | 31 | 30 |
| **British Columbia** | 9,520 | 20.0 | 31 | 60 |
| **Yukon** | 294 | 72.0 | 31 | 30 |
| **Northwest Territories** | 802 | .. | .. | .. |
| **Nunavut** | 229 | 98.0 | .. | .. |
| **PROVINCIAL / TERRITORIAL TOTAL*** | **80,928** | **19.0** | **…** | **…** |

*Note: Rates may not aggregate to totals due to rounding*
*.. Not available for specific reference period*
*… Not applicable*
** Excludes New Brunswick sentenced admissions*

Source: Hendrick and Farmer (2002:11)

According to Statistics Canada, the provincial/territorial rate of incarceration for Aboriginal inmates is 19 per cent. Provincial prisons house offenders receiving a sentence of less than two years or conditional sentences. Statistics Canada, which counts all prisons in Canada, states:

> In Canada, the administration of corrections is shared between the federal and provincial or territorial governments. Offenders sentenced to custody for two years or longer are the responsibility of federal correctional authorities. Provincial and territorial correctional authorities are responsible for offenders receiving sentences of less than two years or conditional sentences, as well as for individuals remanded to custody while awaiting trial. The proportion of convicted adult cases resulting in a sentence to prison remained stable from 1997/98 (33%) to 2001/02 (34%). The average sentence length was about four months (2003:para. 1–2).

Although current data and information on the composition of Canadian penal institutions are limited, data collected in recent years on the numbers of Aboriginal peoples within the correctional system are suitable to gain further insight. The need for accurate data on Aboriginal peoples was highlighted in the 2005 report by the Canadian Centre for Justice Statistics:

> Without sound data on Aboriginal people's involvement in the justice system, governments cannot be accountable to Aboriginal communities or to the public for justice outcomes for Aboriginal people. These data are essential for responding to issues of transparency, accessibility, fairness and equity in the justice system, and are particularly relevant for Aboriginal people given their high level of over-representation in this system (Kong and Beattie, 2005:7).

## Prevalence of HIV/AIDS, Hepatitis C, and Co-infection in the Correctional System

The information in this section relies primarily on statistics gathered by CSC. The perceptions and experiences of staff in Aboriginal healing lodges, as outlined in personal interviews, are also included.

### *HIV/AIDS*

While there is a distinction between HIV and AIDS, no such distinction was made in any of the reviewed literature with respect to the estimated numbers within the correctional system. Some literature did not mention AIDS but just HIV positive rates.

> In Canada's federal prison system (which houses people sentenced to prison terms of two years or more), the number of reported cases of HIV rose from 24 in 1989 to 170 in 1996 to 204 in 2005. This means that as of 2005, 1.66 percent of all federal prisoners were *known* to be HIV-positive … As in federal prisons, the number of prisoners living with HIV in provincial prisons is on the rise. For example, in British Columbia, a study conducted in all adult provincial prisons in 1993 found an HIV seroprevalence of 1.1 percent. The study has not been repeated, but in 1996 a review of just known cases in B.C. provincial prisons revealed seroprevalence ranging from 2 to 20 percent in various prisons (CHALN, 2008: info sheet 1).

CSC stated at the year-end of 2004 that 1.43 per cent with 188 cases of inmates in federal penitentiaries had reported to be HIV positive (Smith, 2006). The rate still remains low, and CSC's caution in 2003 may still be relevant: "Testing uptake levels for HIV and HCV indicate that up to 70% of inmates may remain unscreened for these infections. As a result, reported infection rates may severely underestimate the true burden of disease within federal correctional facilities" [emphasis removed] (CSC, 2003:3). If 70 per cent of the inmates are going unscreened in federal penitentiaries, it is difficult to obtain an accurate quantitative description of the prevalence of HIV/AIDS and hepatitis C cases among prisoners. In 2004, a pilot project was initiated to test three new surveillance and screening forms of which 888 male new admissions took part from across five regions of the CSC. Of the new admissions, 77 per cent were tested for HIV, yielding five positive cases (Smith, 2007). However, unpublished data of the CSC's

Infectious Disease Surveillance System notes that "the overall prevalence of HIV infection among new admissions is estimated at 2.97% in 2004 and 2.76% in 2005" (Smith, 2007:10).

The literature reviewed did not reveal any documentation that deals specifically with HIV/AIDS prevalence rates among Aboriginal inmates. Current literature regarding this topic has been written in sub-context of the general population; that is, logical inferences are made with respect to the fact that since HIV/AIDS prevalence rates are extremely high in the Aboriginal communities and since most prison communities have high Aboriginal populations, the assumption can be made that HIV/AIDS prevalence rates are likely to be extremely high among Aboriginal inmates.

> The large numbers of Native people in the prison system, high rates of IVDU [intravenous drug use] and needle sharing in prisons, presence of HIV in the prison population, and the increasing proportion of Aboriginal AIDS cases attributed to IVDU all point to an emerging HIV epidemic in Aboriginal communities. The dramatic overrepresentation of Aboriginal people in prison is a serious problem; it has its roots in social inequity [endnote removed]. What has not been recognized is that imprisonment itself is contributing to the increase of HIV in Native communities (Lachmann, 2002:1592).

However, when viewing HIV prevalence statistics, one must be aware that they are not national in scope because two of the largest provinces in Canada, Ontario and Quebec, do not report ethnicity information on HIV surveillance data to the Public Health Agency of Canada (PHAC, 2007).

While it is understood that only about half of the new admissions to the prison population go for testing (PHAC, 2007), the need for an effective response to the issues of HIV in prisons is a significant concern, and the prison system must address this issue.

> Generally, about one in 600 (approximately 50,000 of 30 million) Canadians are living with HIV, but depending on the various studies undertaken, one in 100 to one in nine prisoners are living with HIV. This means that the proportion of prisoners with HIV is six to 70 times higher than the proportion of all Canadians with HIV.
>
> HCV prevalence rates in prisons are even higher than HIV prevalence rates, and have continued to rise since 1996. Overall, 19.2 percent of all federal prisoners and 41.2 percent of women prisoners were known to be HCV-positive in December 2000 (Lines, 2002b:ii).

In the interviews at healing lodges, CAAN did not ask about the number of current or past residents who are HIV positive, as the small numbers could compromise confidentiality. CAAN did ask if they had any experience with residents who are HIV positive or living with AIDS. In general, the healing lodges are not set up to accommodate people with serious health problems. However, there was one case where an inmate living with AIDS suited the criteria for acceptance at a healing lodge. Initially, the staff were hesitant about accepting him, but a nurse was brought in to conduct an AIDS awareness workshop for both residents and staff: "The workshop lasted most of the day, and evidently it worked out fine and we brought a lot of information out and made everyone more at ease." The prospective resident was later accepted at the lodge. Another example was cited (from a different lodge) of a former resident who

shared his HIV positive status with a roommate and "the guys started giving him a hard time and he was severely alienated."

Most of the people interviewed were familiar with universal precautions and mentioned practices such as handwashing, wearing rubber gloves in the kitchen, accessing first aid kits with gloves, disinfecting showers daily, and making condoms available. In one of the lodges, condoms are requested through staff, but these are more readily accessible in the other lodges or can be bought when residents are out on day passes. Residents often arrive from other institutions with knowledge of harm reduction techniques and sometimes with prison-issue bleaching kits. A number of residents who have diabetes have their own needles and insulin kits. Many of the interviewees mentioned having attended HIV awareness sessions, although most reported wanting more information and training.

*Hepatitis C Virus (HCV)*

HIV/AIDS is a grave concern, but the astonishing advent of HCV-infected individuals in prisons presents another source of health care distress. As a general observation, Ford and colleagues declare that "More recently, it has also been recognized that the prevalence of hepatitis C in prisons is also much higher in comparison to the general population" (2000:113). For some diseases, including HCV, "we are looking at levels usually found in developing countries" (Ford and Wobeser, 2000:665).

The literature that examines hepatitis C infection among prisoners indicates that prevalence rates are much higher than the rates of HIV. Interviewees at the healing lodges confirmed that most had experience with residents infected with HCV. The Canadian HIV/AIDS Legal Network (CHALN) info sheet series on HIV and hepatitis C in prisons expresses the extent of HCV frequency: "Studies undertaken in the early- and mid-1990s in Canadian prisons revealed HCV prevalence between 28 and 40 percent" (2008:info sheet 1). Not only are the rates of HCV infection high, but studies examining the behaviour of such rates in recent years suggest that the rates are increasing.

Notwithstanding the rates reported by CHALN from the early- and mid-1990s, there is evidence that suggests there has been no significant impact on the prevalence of HCV in recent years. In fact, CSC has released statistics that support the notion of HCV prevalence having a continued presence. "The prevalence of HCV in CSC penitentiaries is much higher than the Canadian population average, and as shown, higher among women inmates (33.7%) than men (25.2%). Overall, 25.8% of federal inmates were reported to be HCV positive at the end of 2002" (Smith, 2005:7). These rates are derived from the total federal inmate population (3,173) known to be HCV positive in 2002 (CHALN, 2008). The comparable rates observed by the studies surveyed by CHALN and those reported by CSC reiterate the fact that HCV is very much a contemporary health issue among inmates in Canada.

To know the number of infections of HCV is an important advantage in assessing the extent of the epidemic, but Lines and colleagues note that the true number of infected individuals may indeed be much higher than reported. Citing a report by CSC, the authors caution that "HCV may be under-reported because '[p]ersons at highest risk of infection may be less likely to be tested, leading to biased testing patterns and possible continued transmission of infection'" (CSC, 2003:20 cited in Lines et al., 2006:8).

With regard to statistical error and bias, efforts to advance information concerning the extent of HCV infection have been implemented. "The number of new admissions and general population inmates screened for HCV in CSC has risen steadily since 2000 ... While this is encouraging, it is important that we continue to be vigilant about offering HCV testing" (Smith, 2005:7). When considering reported data and statistics on the rates and numbers of infected inmates, it is prudent to bear in mind that, at this point, statistics may be lower than the actual value. Nevertheless, efforts to correct such shortcomings are being deliberated by stakeholders involved in serving this population, such as CAAN.

Although there is minimal data on hepatitis C infection among the Aboriginal population, preliminary evidence indicates that the virus is very much present and is having a significant impact. In its special report to Parliament, the Canadian Human Rights Commission stated:

> All inmates face serious health risks resulting from the transmission of communicable diseases, including HIV and hepatitis C. However, in Canada, women and Aboriginal persons have been identified as vulnerable populations for contracting HIV and hepatitis C … Infection rates among offenders serving federal sentences may be even higher than reported because not all of them have been tested. There are no data available on the rates of HIV and hepatitis C infection among Aboriginal women offenders (2003:36).

Staff at the healing lodges reported having more experience with residents living with hepatitis C than those with HIV/AIDS. They noted that there were lower levels of stigma associated with hepatitis C. Lower levels of stigma engender a more open atmosphere where residents feel relatively safe in disclosing their hepatitis C status. One person said that talking about it helps build a sense of community among residents, and this in turn reduces stigma. Also, holding a firm line against stigma and discrimination builds trust. Treatments for hepatitis C (interferon) are generally available and can be taken at most of the lodges, and residents also have access to traditional medicines, such as milk thistle to cleanse the liver. Traditional treatments, including boosting the immune system through diet and cleansing through sweats, are organized by Elders and medicine men.

Once they are aware that a resident is infected with hepatitis C, one of the issues for staff at the lodges is kitchen duty: "The only issues it raised, we didn't put them in the kitchen. There's a rotation process so the person wouldn't be singled out." Another person cautioned, "Everything here is fast-paced, we wear gloves in the kitchen but we sometimes slip." Many of the interviewees expressed the need for more information about how hepatitis C is spread. A couple of people raised questions about participating in a sweat lodge ceremony. In the sweat lodge, the pipe is shared at the end of the ceremony along with sweat foods and water. "Sweat foods make the rounds. We don't have to eat it, we can take some and put it on the rocks." Still, concerns were raised about the safety of sharing food, water, and the pipe. They would like Elders to gather and discuss these issues with someone who is knowledgeable about the risks of contracting hepatitis C in the sweat lodge to answer questions such as, "Can we get hep C from passing the pipe?" More information could alleviate fears and, if necessary, some of the practices could be altered. This, however, could be controversial as well. For example, one person mentioned that removable plastic tips could be used on the pipe, but this would be considered sacrilegious. Concern over the spread of hepatitis C is increased by reports that harm reduction strategies to prevent the spread of HIV are reportedly less effective with hepatitis C. Leonard and colleagues state:

> High HCV prevalence and incidence rates have been reported in a number of studies despite apparent widespread implementation of risk reduction strategies that appear to have been adequate to maintain a low or lower prevalence of HIV. In particular, HCV seroconversion among attenders of harm reduction programs suggests that prevention directed selectively against HIV transmission is only partly effective in preventing HCV infection among IDUs (2001:54).

***Co-infection of HIV/AIDS and Hepatitis C***

The emergence of co-infection of HIV/AIDS and hepatitis C among prisoners in the Canadian correctional system is not well explored in the literature. Typically, the literature that focused on HIV/AIDS and hepatitis C in the prison system investigates HIV/AIDS or hepatitis C prevalence rates separately, and research conducted on co-infection of these viruses is limited. There are, however, a couple of studies, both Canadian and international, which offer rudimentary estimates of the prevalence of the condition.

Pallás and colleagues conducted a cross-sectional study to determine the prevalence and risk factors for co-infections among HIV, hepatitis B (HBV), and hepatitis C. Although the research was conducted in northern Spain, the results offer a clear picture of HIV/AIDS and hepatitis C co-infection among prisoners."Prevalence of HBV-HCV coinfection (42.5%) was higher than HIV-HBV-HCV coinfection (37.3%), whereas, monoinfections were very uncommon (overall: 13%)" (1999:699). There is a greater likelihood that inmates infected with one of the viruses will also be infected with another virus such as hepatitis C. It becomes far clearer from their survey of research that co-infection of HIV/AIDS and hepatitis C is a very real concern and demands greater attention.

Estimates of those co-infected with HIV and hepatitis C proves to be a daunting calculation given the availability of data on individuals with HIV and/or hepatitis C infections. As Remis notes of his study on the subject, "Our analysis is subject to uncertainty due mostly to the lack of precise Canadian serologic data on persons with combined infection. Nevertheless, the number of persons in Canada with dual HCV-HIV infection is undoubtedly substantial" (2001:i). Remis conducted his examination of hepatitis C and HIV co-infection across Canada not only in a broad scope, but he attempted to estimate the number of hepatitis C-HIV co-infection among prisoners and also in the Aboriginal population.

An accurate picture of hepatitis C and HIV/AIDS co-infection among Aboriginal inmates in Canada has not been determined. Nevertheless, the levels of hepatitis C and HIV co-infection within the incarcerated population and the Aboriginal community across Canada are ominous. From Remis' research, an estimated 1,477 Aboriginal persons were co-infected with HIV and hepatitis C as of December 1999. Of those, Remis estimates that approximately 611 were incarcerated Aboriginal individuals. From both of these estimates, he found that the majority of co-infected persons were injection drug users. He also found that among Aboriginal co-infected persons, 87 per cent were heterosexual injection drug users and 10 per cent were men who participate in injection drug use and have sex with other men. It can then be estimated that 98 per cent of all co-infected prisoners were also injection drug users.

## Residential School Legacy: Connection to HIV/AIDS and Aboriginal Offenders

In the healing lodge interviews, many respondents recognized residential school effects as a social issue and, thus, see the resolution as lying within the community: a collective rather than an individual response. As such, healing includes things such as relearning the language, reconnecting with the culture, and, as one interviewee said, relearning "the old ways." An interviewee spoke about the need to intervene in communities rather than just with individuals: "we have to keep educating families, stay focused, help people trying to harm themselves ... Every community should have a suicide prevention worker ... and we need healing facilities for youth."

The trauma of the residential school system contributes to a culture of behaviours conducive to participation in activities that increase the risk of HIV/AIDS transmission. Kirmayer, Brass, and Tait note that "The high rates of suicide, alcoholism, and violence, and the pervasive demoralization seen in Aboriginal communities, can be readily understood as the direct consequences of a history of dislocations and the disruption of traditional subsistence patterns and connection to the land" (2000:609). As noted earlier, violence and substance abuse as coping mechanisms for the traumatic experiences in residential schools and the history of dislocation and disruption increase the risk associated with activities that result in incarceration.

In other words, increased risk of contracting HIV or hepatitis C is associated with behaviours and social conditions commonly linked to the residential school legacy, including intergenerational impacts. Moreover, large numbers of incarcerated Aboriginal people are Survivors of residential schools or foster homes. They may even have had parents or grandparents who attended a residential school, or both. When asked to comment on this, most respondents from the healing lodges agreed that residential school impacts were substantial: "Probably ninety-eight per cent of residents had at least one parent or grandparent in residential school." A number of those interviewed identified as Survivors. One person said that "People were not born to go to jail. It's the direct result of residential schools and foster homes." Another said that "This is the basis of where problems began [such as] sexual abuse. There is lots of anger and people don't understand what's happening." Others observed the impacts most notably in the younger generation: "The scary thing now is the intergenerational impacts: it's in the bloodline." "The Aboriginal Healing Foundation created and supported lots of resources, they did a lot of training on working with Survivors. That should continue for intergenerational issues."

Staff at the healing lodges associated many personal and social problems with residential schools and foster homes, such as: high-risk parenting; distorted concepts of family and of women; institutionalization; loss of sexuality; loss of language, culture, and traditions; addictions; suicide; cycle of abuse within families and communities; loss of traditional knowledge (e.g., dream interpretation, how to use medicinal plants); loss of connection, of ways of visiting; inability to trust; and deep-seated anger over the many losses and abuses suffered.

When asked what they do to capture residential school experiences, interviewees at two of the lodges said that they have a practice of asking about experiences in a residential school and/or foster home during the intake process. The Waseskun Healing Center has a particularly clear set of questions and asks about attendance of parents and grandparents. At the other lodges, the information emerges in

various ways; it may be recorded in a resident's file or the resident will mention it during a counselling session or other program.

Residential school impacts and, especially, intergenerational effects were well recognized; however, some interviewees gave more credence to the issue than others. In some cases, residential schooling is viewed as only one of a long list of issues and problems facing Aboriginal people in conflict with the law, such as fetal alcohol syndrome/effects (FAS/E), gangs, gambling, alcohol and drug abuse, relationship issues, and violence. In fact, one of the challenges associated in working with incarcerated people is that they are often afflicted by multiple problems. One person said: "If I had an idea of just how it's impacting more than the gang situation … I feel there are enough issues, it's mute after awhile." This person (and a couple of others) stressed that FAS/E is the greatest challenge, especially since it is undiagnosed in most cases as "there is no indication of any testing being done at CSC. CSC is behind the times on this issue." Others mentioned that FAS/E and low literacy levels among some residents must be considered in the design of public education materials and in the delivery of programs.

Residential school issues are addressed directly in the Waseya Program for sexual offenders at Waseskun Healing Center and indirectly at other lodges in sessions with Elders, in programs dealing with relationships and grief, and in the "In Search of Your Warrior" Program. These programs incorporate an understanding of residential schools and foster homes as root causes of many personal, family, and community problems. Elders, sweats, and ceremonies are considered especially effective in dealing with residential school effects. When asked whether they believe their lodge is equipped to deal with residential school issues, most answered yes:

> We do what we can. We provide the "In Search of Your Warrior" Program and address generational effects. This is big … we are always cognizant of residential school effects. The Relationships Program deals with them as one of a whole lot of issues around parenting, spouses, family relations. The Elder works with these issues.

Still, many of the interviewees felt that they would benefit from additional training and more information and resources. They would attend or send other staff to attend workshops if they were delivered locally. However, one interviewee warned that some residents may be looking for a label on which to blame their problems and residential schools fit the bill: "Residential school is just a label slapped onto another dysfunction. They want to put a name to it, blaming society, blaming someone else."

The issue of the federal government's compensation program and payments to individuals was raised in a couple of interviews, once positively and twice in a negative way. An interviewee said that "It does nothing to improve quality of life ... It's like punching a kid in the face then saying sorry and handing him twenty dollars. Money does not address psychological and social effects." He went on to say that there is a need for community-based psychotherapy and support services.

What should not be startling is that the effects of assimilation of Aboriginal peoples in Canada have transcended generations. A great deal of sociological research has been conducted to study the impact of changes that tear the social fabric and result in social disruption and disenfranchisement. Residential schools provide a core explanation for many of the social problems facing Aboriginal peoples and communities, including high rates of incarceration. For some of those working in healing lodges,

however, the residential school legacy is viewed as just one of a myriad of problems; one that may have less immediacy in their work than gangs, FAS/E, or addictions. Others are more aware of the residential school system and the forced removal of children to foster homes as root causes, foundational issues that underlie social disruption, family dysfunction, violence, and abuse. As in any population, those working at Aboriginal healing lodges had varying levels of personal knowledge and experience: some experienced residential schools first-hand, others had family members who attended, and others had no personal connection to the issue at all. Most, however, said that they would appreciate more resources, networking, referrals, and workshops, in part, to accommodate ongoing staff changes as well as turnover among residents. A couple of people felt that residential school issues were adequately addressed within their lodge, but that they could personally benefit from more information.

Kirmayer, Simpson, and Cargo offer a number of suggestions on addressing key issues related to residential school impacts:

> Understanding the consequences of this history [assimilation and residential schools] for mental health and well-being requires a model of the transgenerational impact of culture change, oppression and structural violence ... the treatment of mental health problems as well as prevention and health promotion among Aboriginal peoples must focus on the family and community as the primary locus of injury and the source of restoration and renewal.
>
> Individual identity and self-esteem, which are central to health and wellbeing, may draw strength and depth from collective identity ... Mental health promotion with Aboriginal peoples must go beyond the focus on individuals to engage and empower communities. Aboriginal identity itself can be a unique resource for mental health promotion and intervention. Knowledge of living on the land, community, connectedness, and historical consciousness all provide sources of resilience ... Only collaborative approaches that focus on the transfer of knowledge, skills, power and authority can hope to transcend [the backdrop of structural violence, racism, and marginalization] (2003: S21–S22).

## Work Done in Prisons by the Aboriginal HIV/AIDS Movement on HIV/AIDS and/or Hepatitis C Virus

The Aboriginal HIV/AIDS movement in Canada, while relatively young compared to some non-Aboriginal HIV/AIDS organizations that have been around 20-plus years, has made inroads in the area of HIV/AIDS and/or hepatitis C in prisons. HIV/AIDS is increasingly becoming a disease related to addiction. With addiction comes the consequence of contracting hepatitis C or co-infection when it involves sharing needles or other equipment used for injecting drugs.

A key player in the movement is the Canadian Aboriginal AIDS Network (CAAN), which functioned for many years as the National Aboriginal Persons living with HIV/AIDS Network (NAPHAN). In 1997, the organization reincorporated as CAAN and established a small office in Ottawa. In recent years, another key player in the movement has been the National Aboriginal Council on HIV/AIDS (NACHA), which provides policy advice to Health Canada and the Public Health Agency of Canada.

In 1997, the *Report of the National Task Force on HIV, AIDS and Injection Drug Use* was released (Hankins, 1997), which includes these Aboriginal-specific recommendations:

1. Data describing the situation must be routinely gathered, and quality must be improved ...
2. Unique cultural factors must be acknowledged and addressed ...
3. Efforts to address the complex issues must be coordinated (1997:Aboriginal Peoples).

Since the formation of CAAN, they have undertaken several projects examining Aboriginal inmate issues for HIV/AIDS and hepatitis C, a consistent area of concern for CAAN. Starting with national initiatives, CAAN undertook a needs assessment project called *Joining the Circle I* in 1997. The project was funded under the Medical Services Branch (MSB) of Health Canada (now First Nations and Inuit Health Branch or FNIHB). The needs assessment reached six urban sites and two federal correctional facilities, resulting in twelve inmates being part of the sample of 126. The results of this work culminated in the development of an Aboriginal harm reduction model. This model offers four components: needle exchange, condom distribution, methadone maintenance, and counselling. These are considered necessary aspects for a comprehensive harm reduction program. The challenge with respect to correctional facilities is that only some of these components have been acted on, and there are various obstacles in the implementation of these on any widespread scale.

CAAN, in partnership with Sir Wilfred Laurier University, also pursued another project called *Joining the Circle II* from 2000–2003. The result was an Aboriginal harm reduction model manual to support the establishment of harm reduction programs. Another initiative that CAAN undertook was called *Circles of Knowledge Keepers* (Barlow, Serkiz, and Fulton, 2001), which is a peer education manual for Aboriginal inmates. This manual offers a comprehensive outline for getting inmates involved at a peer level to address the concerns surrounding HIV/AIDS and hepatitis C inside the prisons.

In 2006, CAAN (2007) developed a proposal to train service providers, including those at correctional healing lodges, using a manual entitled *Walk With Me Pathways to Health: Harm Reduction Service Delivery Model*.

Around 2001, a number of Aboriginal HIV/AIDS organizations were involved in developing an Aboriginal strategy for federal institutions. This community advisory body held solid expertise and experience. However, through government intervention in February 2005, it was replaced with new people who, for some, had far less experience. The result is a current work plan that does not have measurable, comprehensive targets. Even with this work, some key organizations that sought to implement some of the priorities that were identified the previous year, such as the Canadian Aboriginal AIDS Network, were excluded from a December 2005 meeting. This lack of consistency has a direct impact and is a potential setback when designing HIV/AIDS initiatives inside federal institutions.

Many of CAAN's member organizations have all operated outreach programs to inmates and/or needle exchange programs. Some of these organizations include, among others:

- Healing Our Spirit BC Aboriginal HIV/AIDS Society in Vancouver, British Columbia;
- Positive Living North (formerly AIDS Prince George) in Prince George, British Columbia;
- Kimamow Atoskanow Foundation in Onoway, Alberta;
- All Nations Hope HIV/AIDS Network in Regina, Saskatchewan;
- Blood Ties Four Directions Centre in Whitehorse, Yukon;
- Red Prairie AIDS Project in Brandon, Manitoba;
- Ontario Aboriginal HIV/AIDS Strategy in Toronto, Ontario, with workers in Kingston and in partnership with 2-Spirited People of the 1st Nations operate a needle exchange site in Toronto, Ontario;
- Native Friendship Centre of Montreal in Montreal, Quebec;
- First Nations of Quebec and Labrador Health and Social Services Commission in Wendake, Quebec;
- Healing Our Nations Atlantic First Nations AIDS Network in Dartmouth, Nova Scotia;
- Mi'kmaq Native Friendship Centre in Halifax, Nova Scotia; and
- Canadian Inuit HIV/AIDS Network, housed under Pauktuutit Inuit Women's Association in Ottawa, Ontario.

CAAN also developed the *Aboriginal Strategy on HIV/AIDS in Canada* (ASHAC) in 2003 that supports broad-based harm reduction approaches and mentions legal, ethical, and human rights issues as two of the strategic areas that require attention to combat the HIV/AIDS epidemic. There is also mention of both residential school Survivors and inmates.

Some suggestions for advancing this area of work include having consistent community advisors to maximize the benefit of having the right expertise at the table. Furthermore, more recognition needs to be made of community HIV/AIDS groups that can develop outreach services with greater effectiveness with far less cost. Government employees who deliver these outreach programs have less time to devote to these services as most have other duties attached to their position.

Lastly, long-term contractual arrangements with community HIV/AIDS groups would greatly enhance the effectiveness of program planning and delivery, rather than the current sporadic or tenuous funding arrangements. Funding over a two-year period allows for better planning, delivery, and evaluation; a one-year project, especially if it begins late in the fiscal year, could compress the work into the final three or four months.

## Other Concerns

Many stigmas and fears exist that impede prevention messages. When someone is HIV positive, these negative attitudes can affect how they access proper medical attention, care, and support. The following provides some insight into how fear and isolation can affect someone living with HIV or AIDS: "In the First Nations [First Nations - Communities Health Resources Project] Supplemental the question 'When you are back home, how comfortable do you feel telling people you are HIV+?' was asked. Of those who responded, 63% (40/63) stated that they were either 'Somewhat Uncomfortable' (10/40) or 'Very Uncomfortable' (30/40)" (Schneider et al.,1998:41). Thus, one can see how difficult it may be to gain a more accurate assessment of how prevalent HIV/AIDS is among the Aboriginal population.

Aboriginal youth are also a particular concern. Available data indicate a significant proportion of Aboriginal people are becoming HIV-infected at younger ages than in the mainstream population. The rates of teenage pregnancies and levels of sexually transmitted infections among Aboriginal youth in some areas support this concern, meaning that unprotected sex is occurring among youth. According to the Public Health Agency of Canada, Aboriginal youth are approximately three times at greater risk than non-Aboriginal youth: "Aboriginal persons with a diagnosis of HIV tend to be younger than non-Aboriginal persons. Almost a third (32.4%) of the positive HIV test reports from Aboriginal persons from 1998 to the end of 2006 were younger than 30 years as compared with 21.0% of this age among infected non-Aboriginal persons" (PHAC, 2007:47).

Another concern is that sexually transmitted infections (STIs) increase the risk for HIV infection, in part, because of the open sores, and this can impact on the immune system. The concern centres on the levels of unprotected sex that is demonstrated by the increasing number of teen pregnancies.

> Data from the Atlantic provinces, the Prairies and British Columbia show 1997 teenage pregnancy rates in First Nations that were up to four times higher than the 1995 national rate [endnote removed]. The rate in younger First Nations adolescent girls (under the age of 15) was especially high, particularly on reserves, where it was about 18 times higher than in the general Canadian population (11.0 per 1000 live births, versus 0.6, respectively) (PHAC, 2000:10).

It is critical to get the message across that HIV is a preventable disease. The argument for supporting more prevention efforts is strengthened when the costs of treating this disease are examined, as the economic burden is high."Estimating the direct cost of HIV/AIDS is complex because the distribution of health care costs shifts dramatically as the disease advances" (Dodds et al., 2001:7). Health cost per individual could range anywhere from $9,165 to $23,464 (in 1999 dollars).

> In sum, the direct health costs of HIV/AIDS in Canada in 1999 were $560 million. To this must be added another $40 million, mostly from the Canadian Strategy on HIV/AIDS, for prevention, research, support to national AIDS coalitions, aboriginal communities, correctional services and other supports to HIV/AIDS victims that are not included in the direct cost … [footnote removed] **Total direct costs of HIV/AIDS are therefore about $600 million a year** (Dodds et al., 2001:7–8).

Albert and Williams state that "The present value of the direct costs of the new HIV/AIDS episode is estimated to be $153,000 spread over a 17-year episode [emphasis removed]" (1998:38). They further state: "we estimate the episodic (per case) indirect cost to be $600,000 [italics removed]" (1998:27).

According to Health Canada, "the number of persons newly infected with HIV was about 4 200 per year in both 1996 and 1999" (2001:1). This equates to roughly 11 people per day. If an additional 11 Canadians become infected with HIV per day, multiplied by estimated lifetime care costs of $192,500 in 2008 dollars, one can expect a minimum of $2,117,500 for every 11 cases found. Therefore, it could cost Canada over $63 million each month to care for those who become infected with HIV. There is some evidence to suggest that "First Nations persons living with HIV in Vancouver are accessing combination drug therapies at a rate significantly lower than non-First Nations men who have sex with men" (Vancouver HIV/AIDS Care Co-ordinating Committee, 2000:ch. 3.3). Thus, increased rapid disease progression, including more complications, may likely happen more often to Aboriginal people living with HIV/AIDS.

# Best Practices and Challenges

## Best Practices

Very little research is available on best practices for addressing HIV/AIDS, especially with respect to Aboriginal people. Although the Canadian Strategy on HIV/AIDS undertakes regular evaluations and individually funded initiatives generally implement evaluative measures, it appears that no major evaluation on efforts to combat Aboriginal HIV/AIDS has occurred.

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

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

The other resource on best practices is a report of the Federal/Provincial/Territorial Working Group on Aboriginal Peoples and HIV/AIDS (Lemchuk-Favel, 1999). Contributors to the report self-identified 41 examples of what they felt were best practices. These are categorized into eight key areas as follows:

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

Source: Lemchuk-Favel (1999:74–119)

The term *best practice* is not always applied in the same sense, and there may even be a shift toward using *preferred practices*. A best practice usually has solid evidence that certain approaches achieve desired results. Best practices describe ideal models and provide recommendations on policy and procedures. It is difficult to confirm whether the above-mentioned examples are best practices without the opportunity of doing further research; however, some may in fact be *good practices*.

## Learning Based on Interviews at Healing Lodges

The interviews with staff and directors of the healing lodges added a personal and experiential element to the information gathered in the literature review. The following is a summary of some of the insights gained as a result of these interviews.

An interviewee recalled a discussion of healing herbs that took place at a workshop on AIDS and hepatitis B and C. Following the workshop, he asked an Elder if there is a healing for these blood-borne diseases. The Elder responded, "When all Elders get together in Canada, that's when healing will happen." A meeting of Elders to discuss HIV, AIDS, and hepatitis C would be a worthwhile initiative. It could be used as a venue to provide up-to-date information on the viruses, including prevention, as well as offer an opportunity for the Elders to discuss traditional and herbal treatments and raise issues or questions they may have about HIV and HCV transmission. Moreover, the venue could provide an opportunity for Elders to connect with Aboriginal people living with HIV/AIDS (APHAs), perhaps initiating a support network that links these two groups.

Interviewees expressed an interest in receiving more information on healing from the residential school legacy, HIV/AIDS, and, especially, hepatitis C. With respect to HCV, more information is desired about how the virus is spread and the associated precautions. Other suggestions regarding information and resources include:

- information packages adapted to the specific needs and circumstances of Aboriginal people living in urban areas or in rural settings;
- a listing of all relevant resources, including videos and a list of APHA speakers; and
- easy-to-understand, Aboriginal-specific information sheets, posters, and pamphlets on HIV, AIDS, and hepatitis C that include concrete information on symptoms, treatment options (traditional and Western), modes of transmission, and ways to prevent passing the virus on to others.

Education and prevention materials are most effective if accompanied by workshops and presentations by APHAs and/or knowledgeable health professionals. This is a staff preference as well as the preferred approach for residents (as reported by staff). Respondents preferred locally delivered training programs where staff and residents could both participate. Workshops and open discussions were recognized as routes to greater tolerance; they were found to significantly reduce the stigma associated with being HIV or hepatitis C positive. Further, repetition is considered to be very important. Education and prevention initiatives should be held at regular intervals to accommodate staff turnover and changes in the resident population and to reaffirm the importance of the message.

Print materials should present as much information as possible through visually attractive diagrams. Consideration must also be given to how print materials are made available at the healing lodges. One person mentioned that residents tend to seek out and read materials on HIV or hepatitis C on their own only if they have been diagnosed or if they are concerned. This means that if someone is seen reading the literature, it is assumed they have the virus. Educational materials must be placed where they can be read discreetly; posters work well.

With respect to the high-risk lifestyles and behaviours that can lead to both incarceration and increased risk of contracting HIV and/or hepatitis C, one interviewee suggested targeting educational activities at provincial institutions where inmates serve shorter sentences and would be back in the community more quickly than those in the federal system. Regular or periodic presentations could reach large numbers of people vulnerable to engaging in high-risk behaviours. Moreover, because provincial institutions have fewer regular programs, inmates will often welcome the distraction of a workshop or presentation.

Many of the residents of correctional healing lodges are Survivors of residential schools and foster homes or they were raised in families dealing with the intergenerational impacts of residential schools. While residential school effects are clearly acknowledged by staff at the healing lodges, they sometimes get lost in the myriad of competing issues and problems facing residents, such as gang membership, FAS/E, addictions, and family violence. Yet, the healing potential found in addressing deeply rooted issues such as the residential school legacy must not be underestimated. As one of its healing guideposts, the Aboriginal Healing Foundation states:

> The healing needs of First Nations, Inuit and Métis peoples derive from multiple sources, one of which is abuse in residential schools experienced directly or as a secondary impact. Residential school healing is proving to be an effective entry point for engaging broad-based individual and community effort regardless of the source of trauma (Castellano, 2006:165).

HIV and hepatitis C prevention efforts within correctional healing lodges (and probably in prisons as well) may be hampered by negative self-images and a disregard for personal health and well-being. People beset with the many disparate issues and problems that lead to incarceration often have a "who cares" attitude about their health. As one person said during the interview, "Self-care is not a top priority among the guys. Caring about their bodies and emotional health, many are not there yet."

Confidentiality is almost always a concern in closed systems where word has a way of spreading like smoke from a bonfire on a windy afternoon. However, among staff at the healing lodges, there are strong indications that confidentiality is respected. Problems may arise when a resident requires special considerations, such as a separate room, and other residents might surmise the reason being HIV or AIDS. Stigma related to HIV and AIDS exists; there tends to be much less stigma associated with hepatitis C.

Condoms are freely available to varying degrees. Injection drug use and tattooing appear to be less of a problem in healing lodges than in prisons.

Universal precautions are followed at all the lodges by both staff and residents, although it was acknowledged that practices occasionally slip during particularly busy or frenetic periods. Staff claimed varying degrees of knowledge about universal precautions and some had only a general knowledge. Refresher courses for staff and residents and access to someone who can answer questions that arise would be helpful. For example, should residents with hepatitis C be excused from food preparation duties?

Everyone who was interviewed expressed an interest in attending CAAN's annual general meetings (AGM) and skills-building workshops if funding was available in order to increase their knowledge on this issue.

## Challenges

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

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

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

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

## Conclusions

This report sought three objectives: 1) to determine whether there was a link between the legacy of residential schools and HIV/AIDS; 2) to outline how HIV/AIDS is affecting Aboriginal populations; and 3) to identify and describe interventions, including best practices and challenges. Research indicates that there is a clear and disproportionate overrepresentation of Aboriginal people in both prevalent (cumulative) and incident (new) HIV infections. AIDS figures also reveal a similar overrepresentation. Although gaps in data exist, certain trends are noticeable, such as the exposure categories that contribute to how Aboriginal people are becoming infected with HIV/AIDS. Unprotected sex, whether heterosexual or homosexual, and, more so, injection drug use account for a large number of HIV/AIDS infections.

This report suggests that both direct and indirect links can be drawn when considering the impact of physical and sexual abuse, significant risks associated with injection drug use for HIV, and the high level of injection drug use as it contributes to HIV infections among the Aboriginal population. The health of Aboriginal people has suffered in general over the course of time as a result of lower socio-economic conditions. The poor overall health of Aboriginal people continues to raise questions about the best response to this concern.

In terms of a link, it is both plausible and possible that the Legacy has played a role in the spread of HIV/AIDS among certain segments of the Aboriginal population, perhaps more indirectly than directly. It is a reasonable claim that the Legacy has been a factor in the spread of HIV/AIDS among the Aboriginal population. However, the real question is: to what extent? A study cited earlier on injection drug users revealed troubled homes and childhoods where physical, sexual, mental, and emotional abuse were common factors. This further confirms a relationship between troubled childhoods and homes and subsequent self-destructive patterns in adulthood. When this self-destructive pattern is injection drug use, there are high risks for HIV. Another study referenced earlier that specifically targeted Aboriginal injection drug users also found physical and sexual abuse common to both male and female study participants. HIV/AIDS data clearly show the role of injection drug use as a risk factor among the Aboriginal population, which means that substance abuse is a common, yet negative, coping pattern being used. Finally, data from Health Canada confirm injection drug use as a key exposure category for Aboriginal people in regards to HIV/AIDS.

Residential schools were more than just a place of loneliness for many Aboriginal children who were separated from their parents and community; these schools were part of a formally entrenched system that sought to ensure the goals of assimilation would be achieved. This resulted in negative change as seen by many Survivors and Aboriginal communities. Many individuals have passed through the doors of residential schools, resulting in several generations of negative impacts and cumulative losses. Where institutional abuse occurred, it increased the burden on Survivors because there was little or no opportunity to question those in authority. The most devastating types of abuse known are physical and sexual abuse. With the added impact of cultural and language losses, it is easy to understand how so many individuals were so gravely wounded.

Ethnostress further creates conflict and confusion for Aboriginal communities, and many do not have the full capacity or the resources to effectively respond to the needs of individuals who were physically and/or sexually abused. Social ills, such as addictions and family violence, keep the abuse hidden. This

increases the grief and loss work that is required to overcome the legacy of physical and sexual abuse in residential schools, including intergenerational impacts.

Aboriginal people account for only a small percentage of the total Canadian population, yet they account for about one-fifth of the total prison population, both federally and provincially. A small percentage of all persons in correctional services are known to be HIV positive and one-quarter of the federal inmates are diagnosed hepatitis C positive. While noting that the prison population includes a disproportionate number of Aboriginal people, the prevalence rates of HIV, hepatitis C, and co-infection are much higher in prisons than in the general public, and the rates are believed to be high among the Aboriginal inmates.

The literature reviewed does not provide a comprehensive view of the current and impending effects of HIV/AIDS, hepatitis C, and co-infection in prisons. However, it has been shown that these infections are more pervasive in Canadian prisons as well as in Aboriginal populations, both inside and outside the confines of the Canadian correctional system.

Negative results from government assimilation policies have led to significant changes in Aboriginal communities. These changes include loss of traditional economies, new illnesses, and damaged individuals and communities. Residential schools are among the key influences that have helped shape Aboriginal communities to what they are today. These cumulative traumas and troubled personal histories, combined with low socio-economic conditions, affect the ability of Aboriginal people to overcome adverse situations such as HIV/AIDS. It is this current state of affairs that many believe contributes to a number of the negative situations Aboriginal people face. HIV/AIDS is one of the newer issues being confronted, and efforts must continue so that HIV/AIDS remains a preventable disease.

As the literature suggests, more information is required on the real extent of the problem of HIV/AIDS, hepatitis C, and co-infection among Aboriginal people. This information must be gathered in a way that does not compromise confidentiality, and it must be accompanied by care, treatment, and support services for all those affected. Clearly, there is work to be done, and it should be consistent, practical, and innovative in order to address the care and treatment needs of all Aboriginal people living with HIV/AIDS and/or hepatitis C and to prevent further transmission.

## Background on the Healing Lodges

There are currently eight healing lodges associated with the federal correctional system. Four are run directly by Correctional Service of Canada (CSC) and four are independently run through a contractual relationship with CSC. The interviews took place in the independent facilities.[1] Healing lodges were established to provide services and programs for Aboriginal offenders who meet the criteria for residency set up by each lodge according to its particular mandate and the terms of its contract with CSC. The following table provides an overview of the governance and facilities of the four lodges involved in this study.

**Overview of Healing Lodges**

| LODGE | GOVERNANCE/ ADMIN. | FACILITIES |
|---|---|---|
| Wahpeton Spiritual Healing Lodge<br>Prince Albert, Saskatchewan | A shared Aboriginal/ federal/ provincial healing lodge for male offenders operated by the Prince Albert Cree Grand Council | 30 beds for men: 25 beds designated for provincial offenders; 5 for federal offenders |
| Stan Daniels Healing Centre<br>Edmonton, Alberta | Native Counselling Services of Alberta | 73 beds: residents are either conditionally released offenders (day parole or full parole / statutory release with residency) or residents with federal inmate status |
| Ochichakkosipi Healing Lodge<br>Crane River, Manitoba | O-Chi-Chak-Ko-Sipi First Nation: Board of Directors | 18 beds for residents with a section 81 classification |
| Waseskun Healing Center<br>c/o Kanawake, Quebec | Board of Directors | 34 beds: 15 beds, section 81 (federal); 8 beds; section 84 (federal); 8 beds provincial; 3 beds reserved for Health Canada (private, long-term) |

The term "residents" has been used in this report to refer to individuals who reside at a healing lodge. Some of the lodges use the word "members" or "relatives" and, in conversation, residents are often referred to as "the guys." Residents live at the lodges from anywhere between two months and five years (or longer),

[1] CSC's procedures for allowing research to take place in their institutions are lengthy and cumbersome. As a result, only the independent healing lodges were involved in this study.

depending primarily on the length of their sentence and the length of time served when they enter the lodge.

All of the lodges make an effort to hire Aboriginal staff, and the ratio ranges from 45 to 80 per cent.

Health services are provided in different ways at each lodge and much is dependent upon the location of the lodge and the incarceration status or conditions of residents. For example, the Stan Daniels Healing Centre is located in downtown Edmonton in a courtyard opposite a CSC facility. Residents have access to CSC health services or they can access clinics and doctors within the city. The other three centres are located in rural areas and have a variety of arrangements. At Waseskun Healing Center, a nurse comes once a week and a doctor once a month (or more if needed) for the section 81 residents. For non-emergency hospital care, section 81 residents go back to the prison (escorted). Otherwise, residents use community health services. Ochichakkosipi,Healing Centre has a memorandum of understanding with the First Nation heath clinic. They send residents to the community health nurse there as well as to a nearby town for appointments and prescriptions. They also send residents to Dauphin, a larger centre but more distant, to consult with doctors and dentists. Wahpeton Spiritual Healing Lodge accesses outpatient clinics and family doctors in nearby Prince Albert.

When asked where they would go for more information about HIV/AIDS, interviewees mentioned public health nurses, CSC, the Assembly of First Nations' Health Department, local HIV/AIDS organizations, and local health services.

# Interview Questions for Healing Lodges

## Introduction

In February 2006, the **Canadian Aboriginal AIDS Network (CAAN)** sent a letter describing our plan to conduct a needs assessment on HIV, Hepatitis C and the related needs of Aboriginal residents of Healing Lodges. Thank you for agreeing to an interview.

CAAN also forwarded a draft document entitled, "Incarceration Issues for Aboriginal People with Emphasis on HIV, Hepatitis C, Co-Infection and Residential Schooling." We are in the process of supplementing this draft paper with information on the needs of healing lodges with respect to these issues. The revised paper will include material from interviews such as the one with you. The purpose is to gather information about how HIV/AIDS, Hepatitis C, Co-Infection and Residential Schooling are addressed within healing lodges. We are also interested in your views on the need for further information, resources, programs or services.

**Confidentiality will be respected**. In our paper we may include statements such as, "one healing lodge director said…" or "an Elder/counsellor suggested…" but all identifying information will be removed.

This interview will take approximately 30 minutes.

Date of Interview:

Name of Healing Lodge:

Part 1: Background Information on the Healing Lodge *(Directors ONLY)*

First I would like to ask you about the healing lodge, including facilities, staff and residents:

Number and type of beds:

Current number of Residents and classification: (e.g., federal, section 81, provincial)

What is the average length of time residents stay at the Healing Lodge?

Number of Staff and positions: (full time, part-time, positions…)

Number of Aboriginal Staff:

Governance Structure: (e.g. Board of Directors)

Part 2: HIV/AIDS and Hepatitis C

In general, how are health services provided at your lodge? For example, are services proved internally or do residents use a community clinic or other provider outside the Lodge? *(Directors ONLY)*

(All Interviewees)

1. In 2000, CSC began to offer inmates the opportunity to discover their HIV infection status as well as counselling on the meaning of test results and education on ways to reduce the risks of acquiring and transmitting HIV. Also, beginning in 2001, a number of federal inmates had signed up for a first-time voluntary HIV treatment. (http://www.csc-scc.gc.ca/history/2000/third_e.shtml)

   a) Can you describe any HIV testing, screening and counselling programs operating at your lodge?

   b) What about testing, screening and counselling for Hepatitis C?

      (Probes: Are these arrangements satisfactory? How are issues of confidentiality addressed?)

      (Do residents have access to anonymous testing? For example, are there facilities near the Lodge that offer anonymous testing? If so, are residents informed of this?)

2. Have you had experience with residents who are HIV positive, living with AIDS and/or Hepatitis C (or co-infected with HIV and Hepatitis C)?

   If so, please describe the issues this raised for your Healing Lodge and how you addressed them (e.g., issues related to the needs of infected/affected individuals as well as those of staff and other residents.)

3. What measures do you take to reduce the risks among residents of acquiring and transmitting HIV and Hepatitis C?

4. a) Where do you (or would you) go for information on the care, support and treatment of residents living with HIV/AIDS and/or Hepatitis C?

   b) What about preparing residents for re-integration into the community? What special measures would be taken with respect to someone living with HIV/AIDS or Hepatitis C?

   c) Are there needs associated with HIV/AIDS or Hepatitis C and residents being sent to other corrections institutions rather than released to the community? (Is this a common practice? Is it something that should addressed by, for example, developing special resources or materials?)

5. The Canadian Aboriginal AIDS Network produces a variety of publications, pamphlets, fact sheets, research reports, posters and other educational materials and resources. It would help us to know more about the information needs of your Healing Lodge. For example, the following materials were included in the 2005 Aboriginal AIDS Awareness Week packages sent to Aboriginal communities.

| Would you be interested in receiving any of the following: | Yes | No |
|---|---|---|
| **CAAN Newsletter** | | |
| **Aboriginal AIDS Awareness Week Posters** | | |
| **Developing a Policy of Non-Discrimination** (publication) | | |
| **Aboriginal Peoples & HIV/AIDS** (booklet) | | |
| **Fact Sheet: Aboriginal Youth & HIV/AIDS** | | |
| **Fact Sheet: Residential Schools & HIV/AIDS** | | |
| **Microbicides: New Ways to Protect Against HIV** (pamphlet) | | |
| **LinkUp** information cards and business cards (LinkUp provides access to on-line publications) | | |
| **Aboriginal AIDS Awareness Week Planning Kit** | | |
| **Hand Game Quiz** (two versions). | | |
| **Strengthening Ties - Strengthening Communities:** Aboriginal Strategy on HIV/AIDS in Canada | | |
| **Strengthening Ties – Strengthening Communities:** (*condensed)* | | |

What other information and resources would you like to receive related to HIV/AIDS and Hepatitis C? (Do you have any advice for CAAN on developing educational and prevention materials and/or programs specifically for Aboriginal residents of Healing Lodges and correctional institutions?)

6. Would you be interested in attending CAAN's annual skills-building forum?

7. Do you have any advice for CAAN on developing educational and prevention materials and/or programs specifically for Aboriginal residents of Healing Lodges and correctional institutions?

Part 3. Residential School Experience

8. I am now going to ask some questions about working with residents who attended a residential school or whose parents attended.

   We suspect a relationship between the experience of residential school abuse, the cycle of violence and despair, and HIV/AIDS and Hepatitis C. A determinants of health perspective suggests a link between high-risk behaviours associated with higher rates of HIV transmission and some of the well known consequences of residential school attendance, such as abuse, cultural repression and disconnection from family and community.

   a) In your opinion, to what extent are residential school impacts an issue among residents?

   b) Do you believe your Healing Lodge is equipped to deal with residential school effects or is more information and/or training required?

   Why or why not? Please explain your answer:

(Probe for details about information/training needs and for barriers to providing the needed information/training.)

9. What do you do to capture residential school experience in the intake process?

10. Is there anything you would like to add about addressing residential school impacts within the Healing Lodge?

Part 4: Final comments

11. Do you have any additional comments?

***Thank you very much for participating in this interview.***

*For further information, please contact Linda Archibald at 613-757-3916 (archlind@zon.ca) or Kevin Barlow, Executive Director, Canadian Aboriginal AIDS Network at 1-888-285-2226*

## Recommendations from the Literature

The following are quotes of recommendations, suggestions, and points of concern that stem from other selected sources surveyed for the purposes of this literature review. Determined through their respective analyses, the authors present below suggestions for successful treatment of incarcerated individuals.

**Seal, David Wyatt, Andrew D. Margolis, Jim Sosman, Deborah Kacanek, Diane Binson, and the Project START Study Group (2003). HIV and STD Risk Behavior Among 18- to 25-Year-Old Men Released from U.S. Prisons: Provider Perspectives. AIDS and Behavior 7(2): 131–141.**

> First, making sure that men have a basic understanding of HIV/STD is essential (140).
>
> Second, many men would benefit from an individualized risk-reduction plan shortly before their release from prison (140).
>
> Providers believed that an inability to obtain stable housing and employment after release from prison leads men back to drug dealing and eventually back into the risks associated with this lifestyle (e.g., drug use, risky sex) (138).
>
> Providers generally believed that community-based support groups and in-patient and out-patient treatment programs can help men to reduce their drug-use and sexual risk behaviors (138).
>
> A few providers mentioned that treatment programs do not work for everyone and referred to the need for more culturally specific programs (138).

**Frank, Linda (1999). Prisons and Public Health: Emerging Issues in HIV Treatment Adherence. Journal of the Association of Nurses in AIDS Care 10(6):24–32.**

> The ability of some persons to adhere to treatment is associated with the lack of understanding by health care providers on the ethnocultural influences on health behaviors (26).
>
> Inmates educated in HIV risk reduction and long-term behavior changes have the skills to impart that knowledge and understanding to others within their own families and communities (28).
>
> The correctional health care team should facilitate the needed community resources and linkage for the inmate to make a successful transition from institutional to community HIV care (30).
>
> *Coordination with probation and parole* … This must occur long before the inmate's release to engage the parole officer in the transition process from institution to community setting (30).

> For incarcerated persons with HIV disease and those soon to be released, continuity of care is more important than ever in improving the quality and longevity of life for the individual with HIV disease, and in maintaining the public health of the community through prevention education and risk reduction (31).

**Rich, Josiah D., Leah Holmes, Christopher Salas, Grace Macalino, Deborah Davis, James Ryczek, and Timothy Flanigan (2001). Successful Linkage of Medical Care and Community Services for HIV-Positive Offenders Being Released from Prison. Journal of Urban Health 78(2):279–289.**

> Addiction is the greatest barrier to continuity of care and social stabilization that most ex-offenders face (285).
>
> Incarcerated individuals, both within the prison and on release, may demonstrate difficulty developing even low levels of trust in service providers (286).
>
> To provide transitional services for ex-offenders, it is important to make contact within the first week following release (286).
>
> The psychological health of the individual must be part of the care plan; a history of emotional, physical, or sexual abuse is very common among persons who are HIV positive. In our program, 86% (83) reported histories of trauma. There were 45% (44) who reported a mental health disorder. Depression (41%) was the most common, followed by anxiety disorders (36%) and chronic mental illness (10%). These disorders need to be diagnosed and treated in conjunction with HIV care (287).
>
> In summary, by coordinating discharge planning between the correctional setting and community providers, ex-offenders can be mainstreamed back into the community without interruption in their health care (287).

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Aboriginal Healing Foundation
75 Albert Street, Suite 801, Ottawa, Ontario K1P 5E7
Phone: (613) 237-4441
Toll-free: (888) 725-8886
Fax: (613) 237-4442
Email: research@ahf.ca
Website: www.ahf.ca

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