

Understanding HIV/AIDS Epidemiology:

HIV/AIDS Surveillance Among Canada's Aboriginal Peoples

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UNDERSTANDING HIV/AIDS EPIDEMIOLOGY: TABLE OF CONTENTS

[0.0] Frequently Used Terms

[1.0] Introduction

- [1.1] Aboriginal People and Disease Control: A Brief History
- [1.2] What Is Epidemiology?
- [1.3] How Can I Use This Manual?

[2.0] Glossary: The ABC's of Epidemiology

[3.0] Frequently Asked Questions

[4.0] Putting The Information To Work

- [4.1] Aboriginal Peoples Epi-Update

- [4.2] Information Overheads
 - [A] Summary Of Epidemic Among Aboriginal People
 - [B] Summary Of Epidemic Among First Nations People
 - [C] Summary of Epidemic Among The Inuit
 - [D] Summary Of Epidemic Among Métis People
 - [E] Why We Collect Surveillance Data

- [4.3] Information Fact Sheets
 - [A] AIDS And Aboriginal People
 - [B] AIDS and Addictions
 - [C] AIDS and Children
 - [D] AIDS and Inuit
 - [E] AIDS and Métis People
 - [F] AIDS and Two-Spirited People
 - [G] AIDS and Youth

[5.0] Appendix

- [A] Introduction To HIV/AIDS
- [B] Information Resources
- [C] Bibliography
- [D] List Of Illnesses and Diseases Associated With AIDS
- [E] CAAN Board Of Directors

UNDERSTANDING HIV/AIDS EPIDEMIOLOGY: FREQUENTLY USED TERMS

ABORIGINAL:

First Nation (Status and Non-Status), Métis and Inuit.

APHA:

An Aboriginal Person Living With HIV/AIDS

AIDS:

(Acquired Immune Deficiency Syndrome)

A group of diseases (a syndrome) resulting from a break-down in the body's ability to fight disease. AIDS results when the immune system is attacked and destroyed by a virus called Human Immunodeficiency Virus (HIV).

EPIDEMIOLOGY:

The study of the occurrence, distribution and frequency of health event and/or disease such as HIV.

HIV:

The virus known to cause AIDS. Having HIV is not the same as having AIDS. Most people who have HIV are healthy and have none or few symptoms. A person may have HIV for many years before AIDS results. Even when not showing signs of illness, HIV infected persons may still transmit the virus through unprotected sexual contact or exchanging blood, or from mother to baby at birth and through breast feeding.

IDU:

Injection Drug User

LCDC:

Laboratory Center For Disease Control. A directorate in Health Canada responsible for monitoring and reporting disease among the Canadian population.

MSM:

Men Who Have Sex With Men.

PREVENTION:

Programs and services aimed at individuals or communities to slow or stop the spread of diseases such as HIV.

STD:

(Sexually Transmitted Disease)

An infection caused by a bacteria or virus that may be passed from one person to another through unprotected sex. Also referred to as VD (Venereal Disease). Examples include herpes, syphilis, gonorrhoea, chlamydia, venereal (genital) warts, HIV or Hepatitis A, B and C.

TREATMENT:

Spiritual, emotional, physical and mental services and programs aimed at an individual to help them achieve better health.

TWO-SPIRITED:

Aboriginal gay, lesbian, bi-sexual, or trans-gendered persons.

WSW:

Women Who Have Sex With Women.

UNDERSTANDING HIV/AIDS EPIDEMIOLOGY:

INTRODUCTION

1.0 INTRODUCTION

In recent years, HIV/AIDS infection among Aboriginal peoples in Canada has steadily increased, but we are missing some vital information that may tell us why. It is clear that some of our communities are at higher risk for HIV infection. We know from past experience that years of colonization and inequality with other populations in Canada have affected our economic situation, our health, and our communal well-being. This may be one of the reasons that we are at such a risk for HIV/AIDS. It has been shown that the more a community suffers economic and social difficulties, the greater risk that community is at for diseases such as HIV. Since the beginning of the HIV/AIDS epidemic, the Canadian government through departments in Health Canada has been monitoring the progression of HIV among our peoples and making this information available in the form of statistics and reports. However, because many of those who do this work are not part of our communities, they are unable to interpret what this information may mean, what role culture plays in rates of infection, and in what ways issues of AIDS and HIV infection should best be addressed in our communities.

In the past ten years, Aboriginal communities in Canada have mobilized against this disease. Aboriginal run and directed AIDS Service Agencies have sprung up all over the country, as well as national networks such as the Canadian Aboriginal AIDS Network (CAAN). Our unique cultural values, our traditional way of doing things combined with modern approaches, have led us to believe that we can effectively address HIV/AIDS within our own communities. Once a year Health Canada publishes an HIV/AIDS epidemiological report called an Epi-Update that highlights the progression of the disease among Aboriginal people. Those in the public health and disease surveillance system have given the matter special attention, yet those of us working in the community know that the problem is a long way from being satisfactorily addressed.

Widespread and effective community response, adequate funding, increased education, culturally appropriate prevention and programming on-reserve, in remote northern Inuit communities, among Métis peoples and in rural and urban centres are just some of the issues that we must continue to address. Another thing that can be

done, and the purpose of this manual, is to make important information such as the Health Canada HIV/AIDS statistics more accessible to those of us doing the work HIV/AIDS and health policy makers, care-givers and program directors.

1.1 WHAT IS EPIDEMIOLOGY?

Epidemiology is the study of the occurrence, distribution and frequency of a health event or disease such as HIV. Public health officials and governments use this information to monitor the way a disease spreads through a community in order to slow it down or stop it.

1.2 ABORIGINAL EPIDEMIOLOGY AND SURVEILLANCE: A BRIEF HISTORY

Since Europeans first came to North and South America in the late fifteenth century, Aboriginal people have been affected by many new diseases. These new diseases smallpox, measles, influenza, bubonic plague, yellow fever, cholera and malaria nearly eliminated Aboriginal people from the Western Hemisphere. By 1600, after twenty years of European occupation, less than one tenth of the original Aboriginal population remained in the Americas. As many as ninety million died the equivalent, in today's terms, of one billion people or one sixth of the world's population. Native North and South Americans had no exposure history to these new diseases, had little or no immunity, and were infected quickly. In some cases, diseases were intentionally introduced to Aboriginal communities by Europeans as a kind of opportunistic biological warfare. As a result, along with the decimation of unprecedented loss of life, Aboriginal leaders, statesmen, holy men and elders were eliminated just when they were needed most, making the Americas unique in the history of world colonization. (1) In the mid-1800's, once the Americas had been effectively colonized and European controlled, Catholic nuns and priests began a program of vaccination among Aboriginal people to control diseases such as small pox. Although this disease and a few others have been brought under control in the Aboriginal communities, others have continued to affect us. In modern times, many governments have changed their policies of indifference to (and assimilation of) Aboriginal people to finding acceptable means of dealing with issues of disease control,



culture and language preservation, and self-determination. While many barriers have yet to be overcome, and many past actions faced, there has been some progress. Today, Aboriginal people are more autonomous than ever before, especially in the area of disease control and prevention. No longer do religious institutions and governments decide how disease is to be dealt with in Aboriginal communities. We have developed our own programs and methods of dealing with disease, though many problems, especially in the area of disease monitoring, still exist.

For many years before colonization, we as Aboriginal people had our own ways of monitoring disease through traditional methods. However, with non-indigenous introduced diseases brought by Europeans and others to the Americas, these methods did not always work. For example, one of the ways the Stò:lo peoples of British Columbia would deal with disease was to gather elders of the community around the sick bed of the ill person to give him or her spiritual strength and guidance. However, because small pox is a crowd based parasitic disease, something practically unknown to Aboriginal people before European contact, coming in contact with the sick person placed other people at risk. In the case of the Stò:lo peoples, this traditional method of dealing with disease, which had been proven effective over and over again in the past, served to infect the elders of the community and the tribe suffered devastating losses, not only human life, but of the keepers of their cultures and traditions. (2)

HIV/AIDS is yet another example of the rapid and destructive progression of disease among our peoples, with one exception. Because HIV has so often been associated as a gay disease, and homophobia exists on many of our reserves and in our urban communities, it has been a struggle to convince some Aboriginal leaders that AIDS is simply another deadly disease. The struggle to control and prevent the disease has for a long while been left in the hands of a few Aboriginal people affected and infected by the disease in urban centres. Slowly, as national organizations such as the Canadian Aboriginal AIDS Network develop prevention and education programs for First Nations, Inuit, and Métis communities, this view is changing. Aboriginal leaders, community health workers and policy/planners are beginning to understand that HIV/AIDS affects all of us, not just those of a particular

sexual orientation.

Surveillance and epidemiological information has gone a long way to convince us of this. Regular updates published by the Bureau of HIV/AIDS, Sexually Transmitted Disease (STD) and Tuberculosis (TB) at LCDC show us that a high proportion of Aboriginal heterosexual women are infected by the disease, the Aboriginal people are infected at a younger age than non-Aboriginal people, and that Injection Drug Use is an important mode of transmission. (3) It is armed with this knowledge that urban and rural leaders and health policy planners begin to develop more programs to deal with the Aboriginal HIV/AIDS epidemic. However, while prevention and education programs among Aboriginal people are largely run by Aboriginal controlled and directed organizations, disease surveillance and monitoring is still directed by government and largely non-aboriginal peoples. This may be because disease surveillance and the science of epidemiology is technical in nature, and only a few Aboriginal people are involved in this field of study. An Aboriginal Working Group at LCDC has been created to remedy this situation. Aboriginal people sitting on this advisory body are consulted on issues of ethics, culture, and the barriers to government controlled disease surveillance in Canadian Aboriginal communities. Still, until current surveillance programs and HIV/AIDS research is put in the hands of the communities being affected, in the form of participatory research and community owned surveillance programs, statistical information about disease will always be lacking context and cultural explanation. One of the ways to begin this process is to make the current standard of language of epidemiology and surveillance clearer to those of use who have not studied epidemiology directly, but may still use the information provided in government HIV/AIDS updates to plan preventions for our community. This is the purpose of this manual.

The manual, *Understanding HIV/AIDS Epidemiology*, is simply an important step towards Aboriginal owned and directed disease surveillance programs in Canada. Much more needs to be done. Ethnic information needs to be gathered for all AIDS and HIV cases, and breakdowns among the three groups, Métis, Inuit, and First Nations, must occur so that each group can respond to the epidemic in a manner appropriate to that specific culture.



More Aboriginal people need to become involved in the public health disease surveillance system. More communities must be directly involved in disease surveillance, so that the word loses its connotation of outsiders looking in; of police raids and government conspiracy. If we can achieve, through a participatory approach, a new understanding of disease surveillance and data gathering, and record by this means who among us is getting the disease and why, we may be able to begin to slow the progression of HIV among Aboriginal people in Canada.

1.3 HOW CAN I USE THIS MANUAL?

This manual is designed to create a new understanding of the science of epidemiology as it relates to HIV/AIDS and Aboriginal people. It is in part reference manual and part education kit. It begins with a glossary — some basic definitions of some of the words that epidemiologists use to describe the progression of HIV disease. It also includes a number of frequently asked questions about HIV/AIDS epidemiology and how this information is gathered and used. Finally, it includes an application section, to give ideas how this information can be used to affect a new understanding of HIV/AIDS epidemiology in the communities we work with. The manual is intended for those Aboriginal people already familiar with HIV/AIDS issues in Aboriginal communities, and who may have had some contact with HIV epidemiological information. For more information on this manual and the process of its creation, contact the Canadian Aboriginal AIDS Network at 1-888-285-CAAN.

NOTES:

1. Ronald Wright 1993 *Stolen Continents* New York: Penguin Books. Pages 13-14
2. Carlson, Keith Thor 1996 "First Contact: Small Pox" Essay, University of British Columbia: Sto:ló Curriculum Consortium
3. Health Canada, HIV/AIDS Among Aboriginal People In Canada. HIV/AIDS & STD Epi Updates Bureau Of HIV/AIDS,



GLOSSARY:

THE ABC'S OF EPIDEMIOLOGY



The following glossary defines some of the more commonly used words in HIV/AIDS Epidemiology. It is in no way meant to be comprehensive. It simply acts as an introduction to the language of this science. For more comprehensive sources in the language of epidemiology refer to this manual's bibliography and resources section.

[Note: Words in the following that appear in italics are defined elsewhere in the glossary. All words are listed in alphabetical order.]

—A—

AIDS

Acquired Immune Deficiency Syndrome (See Frequently Asked Question # 1)

Airborne Communicable Diseases

Diseases that are passed from person to person through dust or other particles in the air or on the skin (e.g. the flu and the common cold). The particles, or bacteria or viruses, are so small they can't be seen with the naked eye.

Anecdotal Evidence

Verbal or written evidence that comes from descriptions of cases or events rather than collected data and is gathered to enhance statistical (numerical) research.

ARC

(AIDS Related Complex)

A group of symptoms or signs that appear in some cases of *HIV* infection, including two or more of the following: fever above 38 degrees Celsius, weight loss, persistent diarrhea, fatigue, night sweats, thin, or poor quality blood with less red blood corpuscles than normal, reduced numbers of disease-fighting white blood cells and blood that won't clot so there is bruising or bleeding under the skin, and swollen glands under the arms and in the groin. (Note: This term was commonly used in the early to mid nineteen eighties but is rarely used today. See also: *Specified Disease Indicators*).

Asymptomatic

Persons who appear to be healthy but actually have a disease, such as those who have *HIV* infection but have not yet shown any symptoms or signs of *AIDS*.

—B—

Baseline Data

A set of *data* collected at the beginning of a study.

Behavioral Risk Factor

A behavior or characteristic that makes it likely for someone to have an outcome such as *HIV* infection (e.g. unprotected anal sex).

Bias

Any trend in the collection or use of *data* and information that can lead to conclusions that do not reflect reality.

Blind HIV Seroprevalance Test

A form of testing where a person whose blood is taken for any reason, such as blood-grouping or to test for one type of disease, is tested for *HIV* without the person's knowledge. It is unethical and may even be illegal to do this without informing the person, unless all personal identifying information is removed from the blood sample before the test is done. Another term for this kind of test is "anonymous unlinked testing", and it is used to estimate how widespread *HIV* infection is in the population, and done in such a way that no one can ever know which persons are *HIV* positive.

Blood Borne Communicable Diseases

Diseases (e.g. Hepatitis C, *HIV*) that are passed on through the exchange of blood or blood products (or sometimes other body fluids).

Blood/Clotting Factors

Ingredients in blood that cause it to clot when there is a cut or bruise. Persons with some diseases, such as hemophilia, have defects or deficiencies of blood clotting factors, which are replaced by blood transfusions or injection of the missing factors. Unfortunately, *HIV* (and the viruses that cause some kinds of hepatitis) contaminated the national blood supply, so for a few years the contaminated blood was the source of many cases of *HIV* infection and *AIDS*. This was one of the worst medical catastrophes that has ever happened.



Case

In *epidemiology*, a person identified as having a particular disease, health disorder, or condition such as *HIV*.

Cluster

A group of cases or infections that occurs in a limited time or geographical area that is considered to be greater than normal.

Cohort Group

A group defined for the purposes of disease control study as having a shared social or historical background. In other words, people who are connected as a group by social or historical circumstances. A cohort group can be any group of people who share similar circumstances and history, such as people of a certain age group who grew up at the same time and in the same country, those connected by race or ethnicity, or those who share a set of behaviors or interests over time. (*MSM: Men Who Have Sex With Men [MSM]* and/or *IDU's [Injection Drug Users]*.)

Confidentiality

The duty to withhold personal and private information from others. May include medical records and other personal information. Health scientists must have permission before using someone's personal health information, and can only use the *data* obtained as long as the person is not identified by name. (See also: *Privacy*)

Control Strategies

A policy or action plan that outlines ways to control the spread of a condition such as *HIV* infection among individuals in a community or *cohort group* (e.g. condom distribution, harm reduction counseling, pre-natal testing).

Cumulative Totals (AIDS)

The total number of *AIDS cases* reported from the beginning of the *epidemic* including those who have died and those who are living with *AIDS*.

Cumulative Totals (HIV)

The total number of *HIV cases* identified from the beginning of the *epidemic*, including those who have died and those who are still alive and living with the virus.

D

Data

A collection of items of information.

(Note: The singular of data is datum, though data is often accepted for both singular and plural.)

Denominator

The bottom number in a fraction used to calculate a rate. Usually represented in the calculation by the total number of the population at risk. (See also: *Incidence Rate, Numerator*)

Determinant of HIV

Factors that cause a person to become *HIV* positive.

Diagnosis

The process for determining the presence, nature and extent of an illness such as *HIV* infection or *AIDS* and the *factors* responsible for producing it.





Endemic

The constant presence of a disease or an infectious agent within a given geographic area or population group.

Epidemic

The occurrence of numbers of *cases* of a disease that is recognizably more than normally expected.

Epidemiology (HIV)

The study of the occurrence, distribution and frequency of a health event or disease such as *HIV*.

Epi-Update

An epidemiological report published once a year by the Bureau of HIV/AIDS, STD & TB, Health Canada that statistically reports cases of these diseases in Canada, how they are being transmitted, and what populations are being infected.

Ethnic Identifiers

Information collected that reports the ethnic background or race of an individual. When reporting *AIDS* cases all provinces currently collect ethnicity information, although ethnicity for all cases on file from the beginning of the *epidemic* at LCDC remains incomplete because in the past the information was not collected. At this stage, however, not all provinces ask for ethnic information when collecting *HIV* data.

Provinces that currently collect ethnic information on *HIV* positive cases are: Manitoba, British Columbia, Saskatchewan, Newfoundland, Nova Scotia, Alberta, P.E.I. and the Yukon.

Provinces that do not collect (and/or do not report) ethnic data on *HIV* positive cases are: Quebec, Nunavut, New Brunswick, Newfoundland, P.E.I. and Ontario.

Exposure Category

The way in which someone became *HIV* positive. For example, if someone became *HIV* positive from a blood transfusion, they fall into the transmission exposure category of Blood/Clotting Factor.

The list of HIV exposure categories currently recognized in Canada are as follows:

- *Men Who Have Sex With Men and are Intravenous Drug Users (MSM/IDU)*
- *Men Who Have Sex With Men (MSM)*
- *Intravenous Drug Users (IDU)*
- *Heterosexual Transmission*
- *Perinatal Transmission*
- *Blood/Clotting Factors*
- *No Indication of Risk (NIR)*

For surveillance purposes, *HIV* infection cases are counted only once in the list of exposure categories, organized by order of major risk factors. Persons with more than one reported mode of exposure to *HIV* are placed in the exposure category considered to contain the highest risk of infection. The only exception are those infected men who have a history of having sex

with other men and have injection drug use history. These make up a separate combined category called *MSM/IDU*.

— F —

Factor

An influence, cause, event, or characteristic that brings about a change in health condition. (Note: Not to be confused with blood/clotting factor.)

Fetus

An unborn child.

Follow-up

Observations over a period of time of an individual or group in order to observe changes in health status (e.g phone calls, interviews, etc.).

— H —

Heterosexual Transmission

The exposure category for those infected with *HIV* through heterosexual sex.

High Risk Group

A group of persons that due to certain behaviors/*factors* put them at higher risk for *HIV* infection (e.g. *Injection Drug Users [IDU]*).

HIV

Human Immunodeficiency Virus. (See Frequently Asked Question #1)





IDU (Injection Drug User/Intravenous Drug User)

Someone who injects drugs into their body through injection equipment and drug paraphernalia (syringe/needle, etc.) IDU's who do not use a clean needle each time they inject may be at higher risk of *HIV* infection because blood from a shared needle can contain the virus and be passed from one person to another. Also, other injection practices, such as rinsing individuals needles in the same glass of water, can put IDU's at risk for *HIV* infection.

Incidence

The number of new *cases* of a disease such as *HIV* diagnosed over a certain time period. (In epidemiological studies, usually over a period of one year.)

Incidence Rate

The number of people infected by a disease such as *HIV* in a given period of time, divided by, or as a proportion of, the number of people at risk during this period. (See also: *Numerator* and *Denominator*)



Major Risk Factor

Behaviors or activities that are classified as containing a high risk of *HIV* infection. Examples of major risk factors are sharing needles for the purpose of injection and unprotected anal or vaginal sex with an infected person.

Mis-classification

In *HIV epidemiology*, the improper placement of an *HIV/AIDS case* into an *exposure category* in which the *case* does not belong.

Mobility

Movement of persons from one place of permanent residence to another.

Morbidity

Sickness. Illness.

Mortality

Death.

Multiple Risks

Where more than one risk factor for the development of a disease is present, and their combined presence results in increased risk for that disease (e.g. a person who is both a *man who has sex with men (MSM)* and an *injection drug user*

(*IDU*) is at multiple risk for *HIV* infection).



National Average

The average number of persons infected within the national population (or total infected in Canada). **Infection rates among Aboriginal people are two to three times that of the national average.**

Needle Exchange Centre

Programs and locations that supply *Injection Drug Users (IDU's)* with clean needles and safe drug paraphernalia to reduce the risk of *HIV* infection.

NIR (No Indication of Risk)

HIV positive persons with no reported history of exposure to *HIV* through any of the routes outlined in any of the other *exposure categories*. NIR cases include persons who are currently under investigation by local health department officials; persons whose exposure history/information is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available but no other *exposure category* could be identified.

Non-Communicable Disease

Diseases that cannot be transferred from a human being, animal or plant to another (e.g. diabetes, cancer).

Non-nominal (HIV tests/AIDS cases)

HIV tests and *AIDS cases* without names. All test *cases* where names are removed or not known are called non-nominal *HIV/AIDS cases*. (See also: *Confidentiality* and *Privacy*)

Notifiable Disease

A disease that by law must be reported to a public health authority in the area where the diagnosis is made (e.g. *AIDS*, TB, Hepatitis C). [Note: Due to issues of *confidentiality* and possible discrimination, *HIV* is not a notifiable disease.]



Numerator

The top number in a fraction used to calculate a rate. When calculating an *incidence rate*, the numerator would be represented by the number of people infected with HIV during a defined period, while the *denominator* (the bottom half of the fraction) would be represented by the number of those at risk. (See also: *Denominator* and *Incidence Rate*)



Outbreak

A localized *epidemic*, as happens when a disease such as *HIV* spreads rapidly among a community or group within a short period of time and such infection rates have risen dramatically and quickly above the national average (higher than normal) within a given population.

Over-reported

Newly diagnosed cases of a disease such as *HIV* that are reported more than once are called over-reported. This can lead to duplicate cases (one *case* counted as two separate *cases* of *HIV* infection within a given population).



Pandemic

The rapid spread of a disease occurring over a whole country or the whole world. Because *HIV* infections are present in every country on the planet, the disease is often correctly referred to as a pandemic. (See Frequently Asked Question #27)

Perceived Risk

A person's own assessment or feelings about the possibility that he or she will become infected.

Perinatal HIV Screening

Process of identifying women infected with *HIV* through the testing of their blood taken during a pregnancy.

Perinatal Transmission (See Also: Vertical Transmission)

Transmission of a disease from infected mother to *fetus* and/or baby. Perinatal transmission of a blood borne disease such as *HIV* can take place in several ways: (1) the virus can be transmitted to the *fetus* while it is still in the uterus; (2) the infection can take place in the birth process during which the baby comes in direct contact with large quantities of the infected blood of the mother; or (3) the virus may be passed on through breast milk.

Prevalence

The total number of people infected with a disease such as *HIV* in a given population at a specific time.

Prevention Strategies (HIV)

Plans and policies that aim to stop *HIV* infection before it has a chance to start in any given population. (As opposed to *control strategies*, which aim to limit the spread of disease once an *outbreak* has been reported.)

Privacy

The right that all persons have to keep personal information and property to themselves and not to disclose or share things unless they choose to do so.

— Q —

Qualitative Data

Information that is spoken or written in words instead of numbers.

Quantitative Data

Information that is made up of numbers, such as statistics and epidemiological *data*.

— R —

Research

The organized and systematic attempt to discover new knowledge and better understanding of a problem, such as why some people are more likely than others to get *HIV/AIDS*.

— S —

Seroprevalance

A test of blood carried out among members of a population with the aim of finding *HIV* and calculating the *prevalence* (total number of HIV infections) from this.

Specified Disease Indicators

A specific set of indicators, conditions or symptoms that epidemiologists and doctors use to diagnose whether someone has *AIDS*. For *surveillance* purposes, someone has moved from simply having *HIV* to having *AIDS* when he or she is diagnosed with two or more of about

26 specific conditions, including drastic weight loss, night sweats, and cervical cancer.

(See also: *AIDS Related Complex* [See Frequently Asked Question # 23])

Studied Population



A population on which information, such as rates of *HIV* infection, are being measured.

Sub-populations

Groups of people with similar characteristics, historical backgrounds, social environments, behaviours or ethnicity within a larger population (for example, Aboriginal people are a sub-population of the Canadian population. [See also: *Cohort Group*]).

Surveillance

The on-going and organized collection, analysis, interpretation, and dissemination of *HIV/AIDS* infection information in order to control and prevent the spread of the disease. (Note: The word surveillance for many Aboriginal people has negative associations, such as the surveillance of a community or individual by the police or the government. Here it is used only as a way to indicate monitoring and thereby controlling disease *outbreak* among populations.)

Survey (Questionnaire)

A set of questions used to collect *data* and information.

Symptomatic

Those who have developed one or more of the symptoms that mean a breakdown of the immune system and the onset of *AIDS*.



Target Population

Specific population from which *data* is taken or a group of people for whom intervention (positive interference) is planned.

Tactile Communicable

Diseases that are transferable only by touching or physical contact (e.g. scabies, lice, ringworm, venereal warts).

T-Cell (CD4)

Small microscopic cells in the human blood stream, also known as CD4 or fighter cells, that attack and destroy disease. These cells are attacked by *HIV* and cause the immune system to be weakened.

T-Cell Count

To determine the remaining number of T-cells in the human body, doctors perform a T-cell count, using a test. When a person has a T-cell count of 300, this does not mean he or she has only 300 T-cells left in their entire body. Instead it means they have approximately 300 T-cells per cubic millilitres of blood. A normal T-Cell count for someone without *HIV* ranges from 800-1700 T-cells per cubic millilitres of blood.

Tracking

Following the spread of a disease in a particular population.

Transmission

The term for how disease is spread (e.g. *HIV* is transmitted through the exchange of bodily fluids such as blood, semen and urine).

Trend

A pattern that appears over a long period of time. In *HIV epidemiology* it is used to describe positive test results that appear to have a pattern but the reason for that pattern has not yet been determined.



Under-reported

Inability to identify and/or account for all cases of *HIV* infection or *AIDS cases* in a population.



Vertical Transmission

The transmission of *HIV* from mother to *fetus* and/or baby. (See Also *Perinatal Transmission*)

Thirty Frequently Asked Questions

About Aboriginal AIDS Surveillance In Canada



Prepared By The Canadian Aboriginal AIDS Network

THIRTY FREQUENTLY ASKED QUESTIONS

TABLE OF CONTENTS

1. What is the difference between HIV and AIDS?	3
2. What is the Laboratory Centre for Disease Control?	3
3. Does the Laboratory Centre for Disease Control deal only with HIV/AIDS?.....	3
4. What is a Laboratory Centre for Disease Control epi-update?	3
5. What is the mandate of the Bureau’s of HIV/AIDS, Sexually Transmitted Disease (STD) and Tuberculosis (TB)?.....	3
6. Why are the Aboriginal statistics in epi-updates broken down into those who have AIDS and not those who have HIV?	3
7. How many people in Canada have HIV?	4
8. Why does the Laboratory Centre for Disease Control gather epi information?	4
9. Why does the Laboratory Centre for Disease Control use percentages instead of numbers?.....	4
10. How does HIV infection and AIDS information get to the national level and Laboratory Centre for Disease Control?	4
11. How many Aboriginal people are involved in gathering epi information?.....	4
12. What are the problems in gathering this information as far as Aboriginal people are concerned?	5
13. Why don’t all provinces and testing centers ask for ethnic information so we can tell how many of our people are actually affected?	5
14. How often is the information on Aboriginal people and HIV/AIDS updated?.....	5
15. If a person is tested HIV positive at my local clinic, when do they show up in the national statistics and the next epi-update?	5



16. Can someone test HIV positive in Canada and not be included in the national HIV/AIDS database at Laboratory Centre for Disease Control?5
17. Can anyone get one of the diseases that counts as AIDS and not be reported to the Laboratory Centre for Disease Control?.....5
18. If you don't have anonymous testing what does the government do with your name and other information?6
19. What is the difference between those reported as having AIDS and those as having HIV? Are they reported the same, are they reported as different groups in these surveillance reports and epi-updates?6
20. Why do we say Men Who Have Sex with Men (MSM) and not gay or homosexual?6
21. How can you be sure, with tests with no names (confidential tests) that Laboratory Centre for Disease Control is not counting the same person twice and double-reporting?.....6
22. How Do Epidemiologists determine Exposure Categories?.....6
23. What is the Canadian Surveillance Definition of AIDS?.....7
24. What is a surveillance definition?7
25. What is vertical transmission?7
26. What are body fluids? Why can they be dangerous?.....7
27. What's the difference between an outbreak, an epidemic and a pandemic?8
28. Why is it important to understand how culture relates to AIDS?8
- 29 (a) What is a notifiable disease?
 (b) Is AIDS notifiable?
 (c) What about HIV Infection?.....8
30. What is the relationship of HIV/AIDS to TB and STD (VD)?.....9



THIRTY FREQUENTLY ASKED QUESTIONS

1. What is the difference between HIV and AIDS?

HIV is the human immunodeficiency virus, the virus that is believed to cause AIDS. Having HIV is not the same as having AIDS. Some people who have the virus experience no or few effects from it. Others may be quite sick or have AIDS itself. (Two or more of the conditions listed in the glossary that identify a person as having the syndrome.) A person can be affected with HIV for many years before AIDS related diseases appear.

AIDS is defined by the Laboratory Centre for Disease Control as a set of diseases, known as a syndrome, that result from a decrease in the effectiveness of the body's immune system from the prolonged presence of HIV. Current AIDS data provides information on how common HIV infections were approximately ten (10) years in the past (because it takes on average about 10 years for HIV infection to develop into AIDS). Therefore, HIV data provides a picture of more recent infections.

2. What is Laboratory Centre for Disease Control?

Laboratory Centre for Disease Control is a directorate within Health Canada that monitors and tracks the spread of disease among Canadians.

3. Does Laboratory Centre for Disease Control deal only with HIV/AIDS?

No. Laboratory Centre for Disease Control deals with all kinds of diseases. Within Laboratory Centre for Disease Control there is a bureau called the Bureau for HIV/AIDS, Sexually Transmitted Disease (STD) and Tuberculosis (TB). This Bureau is responsible for monitoring these diseases among the Canadian population.

4. What is a Laboratory Centre for Disease Control Epi-Update?

An epi-update is an epidemiological report published periodically by Laboratory Centre for Disease Control at Health Canada that tells how many Canadians are infected with HIV or have AIDS, how they are being infected, and when they were infected. The epi-update covers a variety of topics related to HIV epidemiology in Canada, including Aboriginal issues.

5. What is the mandate of the Bureaus of HIV/AIDS, Sexually Transmitted Disease (STD) and Tuberculosis (TB)?

The official mandate of the Bureau HIV/AIDS, Sexually Transmitted Disease (STD) and Tuberculosis (TB) is to conduct national surveillance and research on the epidemiology and laboratory science related to HIV/AIDS, STD's and TB.

6. Why are the Aboriginal statistics in epi-updates broken down into those who have AIDS and not those who have HIV?

At present only 25% of HIV positive data at the national level has ethnic information. (This rate is higher for some provinces.) Therefore it is difficult to tell how many Aboriginal people in Canada have tested positive for HIV.



All AIDS cases, by contrast, have to be reported to Laboratory Centre for Disease Control for inclusion in the national statistics. Since 85% of AIDS cases reported have known ethnic status it gives us a better picture of how many Aboriginal people have AIDS in the country. It must be pointed out, however, until 100% of reported AIDS cases have ethnic information, and all diagnosed AIDS cases are reported to Laboratory Centre for Disease Control, we will never know for certain how many Aboriginal people suffer from the syndrome.

7. How many people in Canada have HIV?

Although an accurate number does not exist because of under-reporting and delayed reporting, and those who have not taken an HIV test but still may be infected, it was estimated at the end of 1996 that 40,100 people were living with HIV in Canada. This includes those who have AIDS.

8. Why does Laboratory Centre for Disease Control gather epidemiology information?

The Bureau gathers this information and conducts HIV/AIDS surveillance and research to make communities aware of how the disease is affecting individuals in their areas, so that communities can respond to the disease accordingly. For example, due to on-going surveillance of the disease, Laboratory Centre for Disease Control has shown over the past years that infections among Aboriginal people are on the rise. This in turn has resulted in increased community awareness of the problem, an increase in government funding, and an increase in Aboriginal specific programming all over the country.

9. Why does Laboratory Centre for Disease Control use percentages instead of numbers?

Laboratory Centre for Disease Control uses both percentages and numbers when reporting HIV and AIDS data. Because of population numbers, however, a reported number of AIDS cases may seem small but be a high proportion of the total. In 1999, for example, 14 reported AIDS cases were Aboriginal. However, because only 97 cases were reported that year, those 14 people made up 15% of the total number of AIDS cases in Canada that year. Seeing as Aboriginal people on the whole make up only 3% of the entire Canadian population, the percentage of Aboriginal people suffering from AIDS seems to be unusually high. (Note: Due to reporting delays and under-reporting, the 1999 data is not yet complete.)

10. How does HIV infection and AIDS information get to the national level and Laboratory Centre for Disease Control?

An effective AIDS surveillance program is a system involving the patients, their doctors, and the local, provincial and federal health departments. In general, once an HIV or AIDS case has been diagnosed, information about that case moves, beginning with the patient's doctor, through a series of health departments, local and provincial, to make its way to the national database managed by Laboratory Centre for Disease Control and finally to the epi-update publication.

11. How many Aboriginal people are involved in gathering epi information?

As of today, only a few Aboriginal people are involved in HIV/AIDS surveillance and research among the Aboriginal community in Canada. Laboratory Centre for Disease Control has pointed this out as one of the problem areas in conducting research in Aboriginal communities, especially on-reserve, and one of the reasons the information they do have is difficult to get back to the communities who need it most.

However, Laboratory Centre for Disease Control has an advisory body, made up of Aboriginal people across the country, called the Aboriginal Working Group on HIV Epidemiology and Surveillance. This working group advises the Bureau on issues of Aboriginal people and data gathering. Also, Laboratory Centre for Disease Control holds regular information sharing meetings with Aboriginal people across the country to gain insight and direction on Aboriginal HIV/AIDS surveillance programs.

12. What are the problems in gathering this information as far as Aboriginal people are concerned?



There are several problems with HIV/AIDS surveillance and tracking the epidemic in the Aboriginal community. These are:

- 1) *Not enough Aboriginal people are doing the work, thereby making it difficult to get full participation of Aboriginal communities who could benefit from this information.*
- 2) *The sensitivity of the collected data.*

(Note: often, we must be careful of statistics, for they can contribute to a biased view of our communities by those receiving the information. We must be careful to present any statistics with a context that explains, for example, why STD rates are so high in many Aboriginal communities.)

13. Why don't all provinces and testing centers ask for ethnic information so we can tell how many of our people are actually affected?

Provinces don't ask for ethnic information when reporting AIDS and HIV cases for two reasons. These are:

- 1) *To protect the confidentiality of the patient who has been diagnosed with HIV/AIDS.*
- 2) *Some provinces have human rights laws that prevent asking questions about ethnic status unless a person volunteers it.*

14. How often is the information on Aboriginal people and HIV/AIDS updated?

Epi-updates are published approximately once a year. Surveillance reports, detailing the process and issues present in gathering epi information, are published twice a year.

15. If a person is tested HIV positive at my local clinic, when would they show up in the national statistics and the next epi-update?

Because of the need to double check information and the process of reporting, a person who tests positive or is diagnosed with AIDS may not appear in the national statistics for some time. It is estimated that 23% of newly diagnosed AIDS cases are reported to LDCD within three (3) months, 45% within 6 months, 65% within a year, 82% within two (2) years, and 95% within five years.

16. Can someone test HIV positive in Canada and not be included in the national HIV/AIDS database at Laboratory Centre for Disease Control?

Yes. If the positive test is not reported to the provincial health department, then that information will not be forwarded to Laboratory Centre for Disease Control and included in the national statistics. Also it may take some time for that positive test to make it to the national level of statistics reporting before it is included in the epi-update. (due to Reporting Delays)

17. Can anyone get one of the diseases that counts as AIDS and not be reported to the Laboratory Centre for Disease Control?

Yes. Sometimes, doctors and health officials do not report AIDS cases in their community for a variety of reasons. Also, some doctors may be unaware they need to report AIDS cases. This results in under-reporting.



18. If you don't have anonymous testing what does the government do with your name and other information?

All information of those who are reported as having AIDS, and all those who test positive have their names removed from the file at a local level. Only a small amount of information is kept in the national database to report exposure category, gender, and, in some cases, ethnic status.

19. What is the difference between those reported as having AIDS and those as having HIV? Are they reported the same, or are they reported as different groups in these surveillance reports and epi-updates?

Those reported with having AIDS are counted as a separate group in the updates, although they are also assumed to have HIV and are counted in those statistics as well.

20. Why do we say Men Who Have Sex with Men (MSM) and not gay or homosexual?

Men Who Have Sex With Men (MSM) is a Laboratory Centre for Disease Control Exposure Category which includes heterosexual, bisexual, and 2-spirited (gay) men. It is not meant to identify groups of people, such as those named above, but only to identify for surveillance purposes those who contracted HIV from a particular behavior.

21. How can you be sure, with tests with no names (confidential tests) that Laboratory Centre for Disease Control is not counting the same person twice and double-reporting?

Simply put, you can't. The provinces, when reporting the total number of HIV positive tests in their region to Laboratory Centre for Disease Control to be compiled, do their best to look at the non-nominal test (tests without names) and eliminate the duplicates by initials, birth dates, region, etc. But it is impossible to eliminate all the duplicates with so little information and it is likely that a small number of HIV/AIDS cases are over-reported (reported twice or more).

22. How do epidemiologists determine exposure categories?

These categories were developed to make reporting easier. The categories are made up based on the known ways the disease is transmitted. The Laboratory Centre for Disease Control keeps track, where possible, how people get HIV disease — through heterosexual contact, blood transfusion, passed on from mother to fetus and/or baby (Perinatal/Vertical Transmission), intravenous drug use (IDU) or male sexual contact with other men (MSM) and then place them into these exposure categories.

For surveillance purposes, HIV infection cases and AIDS cases are counted only once in the list of exposure categories, organized in order by the number of major risk factors in that category. Persons with more than one reported mode of exposure to HIV are classified in the exposure category listed with the highest risk factors. The only exception is men with a history of sexual contact with other men (MSM) and those with injection drug use history (IDU). They make up a separate exposure category called MSM/IDU.

(Note: There are, in some cases, people who don't know how they got infected, and these people fall into an unknown exposure category called No Identified Risk [NIR.]

23. What is the Canadian surveillance definition of AIDS?

For surveillance purposes, a person is said to have AIDS in Canada when they are reported as having one of a number of specific diseases as a result of a weakened immune system, known as specific disease indicators. Some of these diseases are:



- 1) HIV encephalopathy (brain infection/fever)
- 2) HIV wasting (rapid weight loss)
- 3) Pulmonary tuberculosis (TB in the lungs)
- 4) Recurrent bacterial pneumonia (A pneumonia that keeps coming back or does not go away)
- 5) Low CD4 count (few of the fighter or T-cells needed to ward off infection in the body)

These diseases and others are known as specified disease indicators. (See Glossary) All of these diseases, either together or alone, can be life threatening. A patient with HIV who has two or more of these diseases is diagnosed for surveillance purposes as having AIDS.

An HIV positive patient who has one of these diseases and then recovers to a state where he or she no longer officially has AIDS is still counted among the AIDS statistics of the year of the AIDS diagnosis.

Besides a specified disease indicator such as one of those named above, Laboratory Centre for Disease Control requires a positive HIV test in the patient believed to have AIDS. If a patient has a specified disease indicator, and has not tested positive for HIV, and no other reason for the immune system failure can be found, a patient is also then diagnosed as having AIDS. The only cases in humans where a specified disease indicator existed and no HIV positive test was confirmed were in cases where the patient died before an HIV test could be made, or at the beginning of the epidemic, when no methods for detecting HIV in humans existed.

24. What is a surveillance definition?

Surveillance is a way to gather facts about disease as rapidly as possible so the information can be made available before it goes out of date and while it is still useful to all health workers (nurses, doctors, etc) who need to know. This often means that incomplete and rather inaccurate and unreliable facts must be used to decide whether someone has or has not got the disease. So a surveillance definition is sometimes a rough guess, rather than an accurate and reliable diagnosis. It often requires further tests to confirm the diagnosis. (Note: However, in the case of HIV and AIDS, the surveillance definition is relatively clear and precise compared to surveillance definitions of some other diseases.)

25. What is vertical transmission?

This means transmission or passage of infection from one generation to the next, generally from mother to fetus and/or baby. It can occur in one of three ways:

- 1) *While the unborn baby is still in the womb, when infection is passed via the umbilical cord from mother to unborn infant.*
- 2) *During the birth of the baby when both the baby's and the mother's sensitive tissues can be torn or lacerated by the birth process, and are therefore more likely to get infected.*
- 3) *By infected breast milk when the baby suckles its mother's milk.*

26. What are body fluids? Why can they be dangerous?

Body fluids are several varieties of liquids found in the human body.

The most important of these body fluids is the liquid that circulates in the body's arteries and veins — blood, which is made up of liquid serum and tiny solid red and white blood cells and the platelets that are suspended in the liquid serum. Blood and blood products can transmit infection if bacterial germs or viruses like HIV get into the blood from any source.



Other body fluids are saliva (spit), mucus (snot) from a runny nose, sputum (phlegm) which is coughed up from infected lungs or throat, juices secreted by the vagina, semen (jism), urine (piss) and pus, which can come from any open sore, boil, pimple, etc. All of these body fluids can carry infections, but HIV seems to be most often carried in semen, only rarely in saliva, with the other body fluids varying in their ability to carry and pass on the virus. Blood, and blood products used to treat bleeding disorders like hemophilia can be contaminated with infectious agents like HIV, and many cases of AIDS occurred after the virus got into the blood supply in Canada and other countries. For several years in the early 1980s, almost everyone who had a blood transfusion, and all the hemophiliacs treated with blood products, got infected with HIV (and many also got infected with hepatitis viruses).

27. What's the difference between an outbreak, an epidemic and a pandemic?

This is just a difference of scale or degree of severity. An outbreak is usually small and localized; an epidemic is more widespread, affecting people throughout an entire city, region, or province; and a pandemic extends over a very wide region, crosses borders, and can perhaps affect the entire world. AIDS seems to have begun as localized outbreaks in several parts of the world (Los Angeles, New York, Central Africa). It rapidly became a widespread epidemic in Africa, Europe, North and South America and then spread to Thailand, India and other Asian countries. It is the most deadly and dangerous pandemic disease to hit the human race since the black death of the Middle Ages.

28. Why is it important to understand how culture relates to AIDS?

Culture is what makes one particular group of people unique and different from every other group. It is the combination of spiritual beliefs, language, historical traditions, values, ties to family and others, dietary and other customs, that taken all together leads us to behave the way we do. And the way we behave can have a powerful effect on our risks of being exposed to many kinds of disease, infectious and otherwise. For instance, HIV spread very rapidly in the early stages of the AIDS epidemic among members of the gay community in large American cities because of the highly risky behaviour of many members of that community; but once they understood how the disease was transmitted, the risks were greatly reduced by effective health education programs. In many straight communities including Aboriginal communities, promiscuous unprotected sexual intercourse is a high risk behaviour that can be changed in the same way.

29. (a) What is a notifiable disease?

(b) Is AIDS notifiable?

(c) What about HIV infection?

- (a) A disease is "Notifiable" if doctors have to report confirmed cases to the public health department. These diseases can be dangerous not only to those who have them but to other people who come into contact with anyone who has the disease. When a Notifiable Disease is notified to the public health department, public health nurses and doctors take action to prevent the disease from spreading to other people; the kind of action depends on the disease — it varies from quarantine or isolation in cases of dangerous infection like diphtheria, to precautions against letting others come into contact with infected sputum, as with bad cases of TB, to tracing and advising contacts that they may have been exposed to an infection. This is the procedure commonly followed for notified cases of sexually transmitted diseases if their contacts (sexual partners) are identified.*
- (b) AIDS is a notifiable disease. It is notifiable so the person with AIDS and those who have contact with this person can take precautions against getting infected. People with AIDS may not necessarily be very infectious except through intimate contact like having sex. It is certainly not necessary to avoid touching, shaking hands, or even embracing and kissing someone with AIDS, but open-mouth kisses and tongue kisses can transmit HIV. Sexual intercourse is the main way HIV is transmitted, so persons with AIDS should always use condoms when they have sexual intercourse.*
- (c) HIV infection in all provinces is not notifiable. Some people have suggested that it should be, but there would be many problems if it were. Most people who are HIV positive are outwardly in good health and continue to lead a normal life. If it becomes known that they are HIV positive, they can be harmed in several ways. They can lose their job, they might be victimized and others in their community might be cruel to them in various ways. However, it is very important for a person who is HIV positive to know this, and to act responsibly, especially to avoid having unprotected sex or acting in other ways, like sharing injection needles, that can spread HIV to other people.*



30. What is the relationship of HIV/AIDS to Tuberculosis (TB) and sexually transmitted diseases, or venereal diseases (STD or VD)?

HIV infection and AIDS have several kinds of relationship to both Tuberculosis (TB) and sexually transmitted diseases, or venereal diseases (STD or VD). The most important is that HIV infection damages resistance to both TB and some STDs, especially syphilis (the pox) and seems to make the bacteria that cause these diseases more dangerous and more infectious. Neither TB nor STD are caused by HIV, but when someone has HIV infection or AIDS, their resistance to TB and STD is badly damaged, and the bacteria that cause TB and syphilis not only overwhelm the body's resistance, but also spread more easily to other people. Another way that STD and HIV/AIDS are related is that people with most kinds of STDs have inflamed tissues in their genital organs, and these are more likely to pick up infection with HIV. Sexually transmitted diseases (STDs) are a group of about 25 diseases, including syphilis (the pox), gonorrhoea (the clap), genital herpes, etc., spread by unprotected sexual intercourse.



Understanding HIV/AIDS Epidemiology



Putting The Information To Work

The following are some tools to make epidemiology and surveillance information more accessible to your community. It includes a version of the LCDC Epi-updates, over-head presentation to make AIDS and HIV statistics more accessible to your community, fact sheets explaining the epidemic among Aboriginal people and some explanations of how AIDS surveillance is done and why can be useful to you and your community.

Aboriginal Peoples and the AIDS Epidemic In Canada



An Update: December 1999

**Report From Health Canada
Laboratory Centre for Disease Control**



**Health Canada Santé
Canada Canada**

**In Partnership With
The Canadian Aboriginal AIDS Network**



Summary of the Aboriginal HIV/AIDS epidemic in Canada, December 1999

Number of AIDS cases reported to date (Prevalence)	16,628
Total Number of Aboriginal AIDS Cases Reported To Date (Aboriginal Specific Prevalence)	341
Total Number of AIDS cases reported in first half of 1999 (Incidence)	97
Total Number of Aboriginal AIDS cases with known ethnicity reported in first half of 1999 (Aboriginal Specific Incidence)	14

References:

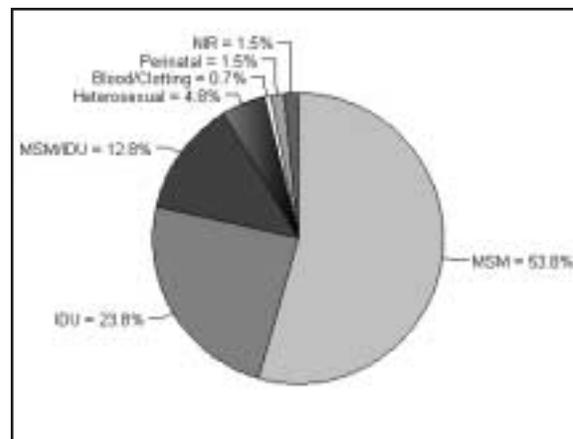
1. _____ May 1999 HIV/AIDS Among Aboriginal People in Canada, HIV/AIDS & STD Epi-Update
2. _____ November 1999 HIV/AIDS In Canada: Surveillance Report to June 30, 1999 Bureau of HIV/AIDS, STD & TB Laboratory Centre for Disease Control, Health Canada

The Aboriginal AIDS epidemic in Canada

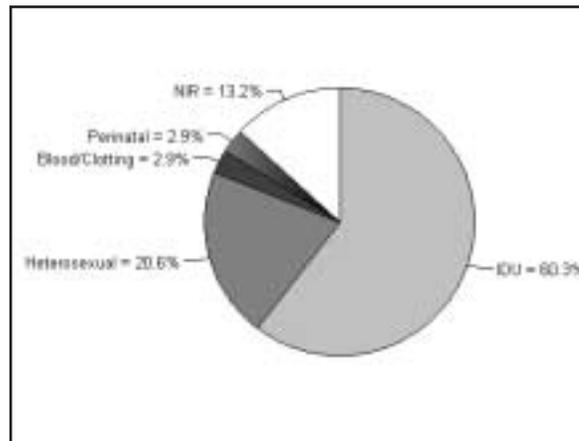
Over the past decade, the HIV/AIDS epidemic has risen steadily among the Aboriginal population in Canada. Many years of colonisation and oppression have resulted in social and economic problems among our communities that place us at higher risk for STD's and other diseases such as HIV. Available evidence suggests that Aboriginal people are infected earlier than non-aboriginal people, that injection drug use is an important mode of transmission, and that the HIV epidemic among our peoples shows no signs of abating.

AIDS and Aboriginal People

- As of June 30th, 1999, a total of 16,628 AIDS cases were reported to the Bureau of HIV/AIDS, STD and TB since the beginning of the epidemic, including those who have died from the disease. Of these cases, 341 were reported as Aboriginal.
- Of the 85% of AIDS cases with known ethnic status, the annual proportion of AIDS cases among Aboriginal people has risen from 1% before 1990 to 15% in the first half of 1999.
- Among the 273 male AIDS cases reported as Aboriginal, exposure categories were follows:



- Among the 68 female AIDS cases reported as Aboriginal, exposure categories were as follows:



- Aboriginal AIDS cases are diagnosed at a younger age than non-aboriginal cases. 29.3% of all Aboriginal AIDS cases are diagnosed at less than 30 years of age, as opposed to 17% of non-aboriginal AIDS cases.
- Aboriginal AIDS cases are under-estimated because of under-reporting of ethnicity, variations in reporting ethnicity within and between provinces, delays in reporting and mis-classifications in ethnic status.
- The proportion of women among adult Aboriginal AIDS cases is higher than among adult non-aboriginal AIDS cases (15.9% vs 7%)
- Recent data (1997) from B.C., Alberta, and Saskatchewan show that Aboriginal people account for 15%, 26% and 43% of newly diagnoses HIV positive cases respectively, and that Injection Drug Use (IDU) and heterosexual behaviours were the most significant risk factors.
- At a B.C. clinic which cares for the majority of HIV infected pregnant women in the province, 41% (21/51) of the women under care were Aboriginal people.
- In some cities, 11-75% of clientele using inner-city services such as needle exchange and counselling referral sites are Aboriginal people.
- 14% of federal inmates in Canada are Aboriginal people, with incarceration rates up to 40% in provincial or federal jails in some provinces.

Understanding HIV/AIDS Epidemiology and Surveillance

Information Overhead Templates



The following overhead templates break down current epidemiological statistics on Aboriginal people for use during presentations. The statistics have been omitted, so that presenters can write in the actual statistics as they change and copy to an overhead for use over and over again.

(Note: Although statistical breakdowns between the three Aboriginal groups in terms of AIDS cases are not yet available from public health and LCDC, these blank overheads have been included in the hopes that this information will be available in the near future. When this information becomes available you may access the national statistics from the Canadian Aboriginal AIDS Network [on-line, by mail, fax or telephone and at conference displays] or directly from your local disease control centre listed in the resources section.)

SUMMARY OF ABORIGINAL HIV/AIDS STATISTICS IN CANADA

Date: _____

Number of AIDS cases (Aboriginal and Non-Aboriginal) reported to date (Prevalence)	
Number of Aboriginal AIDS cases reported to date (Aboriginal Specific Prevalence)	
Total number of AIDS cases (Aboriginal and Non-Aboriginal) reported in 1999 (Incidence)	
Total Number of Aboriginal AIDS cases reported in 1999 (Aboriginal Specific Incidence)	

References:

1. _____
2. _____
3. _____



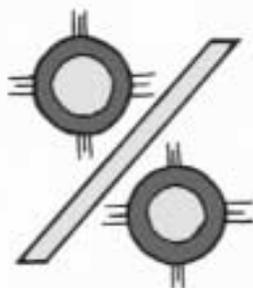
SUMMARY OF FIRST NATIONS HIV/AIDS STATISTICS IN CANADA

Date: _____

Number of AIDS cases (Aboriginal and Non-Aboriginal) reported to date (Prevalence)	
Number of First Nations AIDS cases reported to date (First Nations Specific Prevalence)	
Total number of AIDS cases (Aboriginal and Non-Aboriginal) reported in 1999 (Incidence)	
Total Number of First Nations AIDS cases reported in 1999 (First Nations Specific Incidence)	

References:

1. _____
2. _____
3. _____



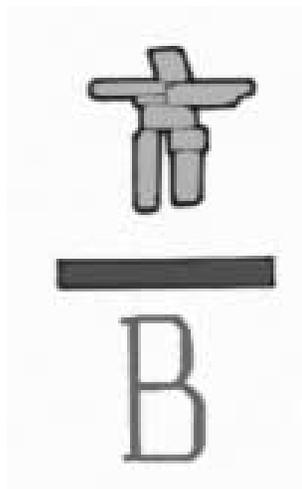
SUMMARY OF INUIT HIV/AIDS STATISTICS IN CANADA

Date: _____

Number of AIDS cases (Aboriginal and Non-Aboriginal) reported to date (Prevalence)	
Number of Inuit AIDS cases reported to date (Inuit Specific Prevalence)	
Total number of AIDS cases (Aboriginal and Non-Aboriginal) reported in 1999 (Incidence)	
Total Number of Inuit AIDS cases reported in 1999 (Inuit Specific Incidence)	

References:

1. _____
2. _____
3. _____



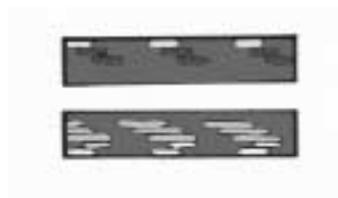
SUMMARY OF MÉTIS HIV/AIDS STATISTICS IN CANADA

Date: _____

Number of AIDS cases (Aboriginal and Non-Aboriginal) reported to date (Prevalence)	
Number of Métis AIDS cases reported to date (Métis Specific Prevalence)	
Total number of AIDS cases (Aboriginal and Non-Aboriginal) reported in 1999 (Incidence)	
Total Number of Métis AIDS cases reported in 1999 (Métis Specific Incidence)	

References:

1. _____
2. _____
3. _____



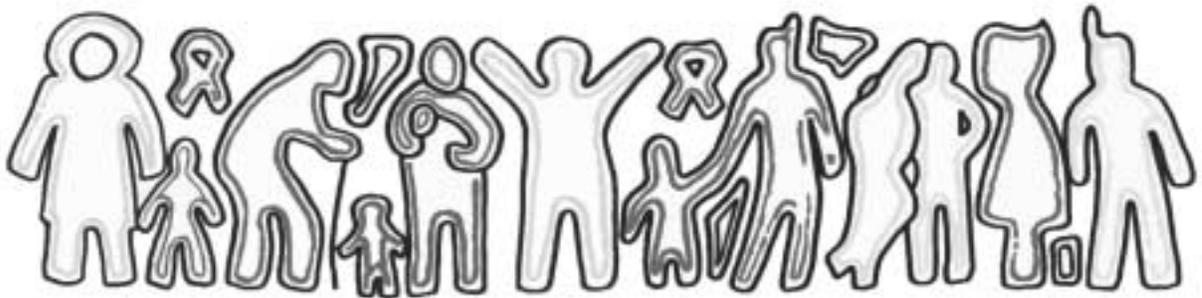
UNDERSTANDING HIV/AIDS EPIDEMIOLOGY

WHY COLLECT HIV/AIDS SURVEILLANCE DATA?

- 1. Data will assist in the development of short and long term plans.**
- 2. Data can provide descriptive information that helps define the problem and potential solutions.**
- 3. Data is valuable in helping decision makers/planners set priorities.**
- 4. Data can help elicit opinions from the community.**
- 5. Data can stimulate awareness, support, and eventually action on the issues.**

Understanding HIV/AIDS Epidemiology

Community Fact Sheets



The following fact sheets were first prepared by the Canadian Aboriginal AIDS Network (CAAN) for the first annual Aboriginal AIDS Awareness Day in 1997. They have been updated and included here as an example of how epidemiological information and surveillance can be put into cultural context. CAAN will update these fact sheets regularly and they will be available by mail or on the Internet. For more information about how to receive updated fact sheets call CAAN at 1-888-285-CAAN (2226).

Canadian Aboriginal AIDS Network

1-888-285-CAAN (2226)

Ph: 1-613-567-1817 Fax: 1-613-567-4652

AIDS & Aboriginal Peoples

Here Are the Facts!

- The HIV/AIDS pandemic continues to grow and threaten Aboriginal Peoples throughout the world. The last decade has seen a steady rise in Aboriginal AIDS cases in Canada. Experts speculate that as many as twenty percent of 16,000 AIDS cases in this country could be Aboriginal.
- Infection rates in Aboriginal women and 2-spirited (gay) people are rising rapidly. Injection drug users, inmates, and street involved persons are increasingly at risk.
- Aboriginal AIDS cases are younger than non-Aboriginal AIDS cases. 30% of all newly documented cases among First Nations Peoples are under 30 years old, with a female to male ratio of 3 to 1. In some cases, people are being infected at ages 19 and 20.
- Why Are Aboriginal People Susceptible To HIV/AIDS?
- No one is immune from AIDS. The economic and social power imbalance between Aboriginal people and non-Aboriginal people in this country plagues our communities with a host of social problems. HIV is rapidly becoming one of them. Studies in mainstream society also show that instances of HIV infection occur more frequently where poverty, violence, drug abuse and alcoholism are present.
- The high degree of movement of Aboriginal people between inner cities and rural on-reserve areas may bring the risk of HIV infection to even the most remote First Nations reserves. Some reserves may be governed by leadership that are unsympathetic to AIDS and HIV. Cases where HIV infected 2-spirited men have been unable to return to their reserve for holistic treatment have been reported.
- Disproportionate inmate populations with higher at-risk factors can unwittingly contribute to new infections both during incarceration and after release.
- In some rural and northern areas, HIV/AIDS culturally specific counseling and outreach services are practically nonexistent.

What Can Be Done to Help?

- More education and better information among Aboriginal people in Canada is needed to guide prevention and control strategies.
- More on-reserve, northern Inuit, and Métis programming and treatment must occur. The barriers between leadership and rival political groups must be broken down, and issues of homophobia must be addressed on-reserve, northern and remote rural communities.
- More Aboriginal programming and education in prisons and institutions must be provided.
- Communities must take an active role in the education of their children and members about the dangers of unprotected sex and other risk associated behaviours.

All statistics used in this fact sheet are taken from Health Canada's HIV and AIDS Among Aboriginal People in Canada. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada, May 1999.

Canadian Aboriginal AIDS Network

1-888-285-CAAN (2226)

Ph: 1-613-567-1817 Fax: 1-613-567-4652

AIDS & Aboriginal Peoples'

- Governments and other agencies must respond to HIV/AIDS in all Aboriginal communities by ensuring that resources and services are culturally appropriate with access to counseling and HIV testing.
- This fact sheet was prepared by The Canadian Aboriginal AIDS Network located in Ottawa, Canada. CAAN is a National Coalition of Aboriginal people and organizations that provide leadership, support, and advocacy for Aboriginal people living with and affected by HIV/AIDS regardless of where they reside. For more info call CAAN at 1-888-285-2226. Statistics taken from LCDC Epi-Updates.

All statistics used in this fact sheet are taken from Health Canada's HIV and AIDS Among Aboriginal People in Canada. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada, May 1999.

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AIDS & Addictions

Here Are The Facts!

- Intravenous drug users (IDU's) are the fastest growing at-risk group in Canada. In one study in Vancouver (1997) 57% of 151 Aboriginal HIV positive people reported injection drug use as their main exposure category.
- It is not only injection drug users that are at higher risk for HIV infection. Cocaine and alcohol abusers are also at higher risk because of impaired judgement at time of use.

Why Are Drug Users at High Risk for HIV/AIDS?

- Even intravenous drug users aware of the high rates of HIV transmission through needles and drug paraphernalia are sometimes unwilling or unable to clean their works. The compulsion to use is sometimes stronger than the need to protect themselves.
- Men and women who abuse drugs are more likely to turn to sex-trade related work to feed their habit. In these sometimes dangerous environments they are not always possible to protect themselves.
- Drugs may impair the judgement of a person so severely as to make them unable to negotiate safe methods of using or having sex.

What Can Be Done to Help?

- Although it is illegal to use certain drugs, it is not illegal for people to protect themselves while using them.
- Although clean needles exchanges exist in some cities, clean works for addicts should be made more widely available.
- Service providers in the addiction communities can recognize HIV as one of the most important issues that drug users have to confront. On site testing and culturally appropriate counseling in treatment and drop-in centers would go a long way to ensuring that addicted persons do not get overlooked when HIV/AIDS issues are being address and harm reduction techniques practised.
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AIDS & Aboriginal Children

Here Are The Facts!

- A study in all HIV pediatric centres in Canada found that 19% (50/259) of women known to be HIV positive at the time of birth of a child between 1995-97 were Aboriginal.
- Vertical transmission (HIV passed on from mother to child during or shortly after birth) accounts for 5.2% cases of HIV infection among Aboriginal females, and 1.5% cases of infection among Aboriginal males.
- Many of our children, though not infected, are affected by HIV. Some have positive parents or family members, and are dealing with the disease in this form daily.
- Just as residential school abuse affected generations before them, children suffering from abuse today may be at higher risk for HIV infection later in their lives due to emotional and self-esteem problems as a result of the abuse.

Why Are Children Affected by HIV?

- HIV positive mothers run the risk of passing on HIV to their unborn children. Also, there have been documented cases where HIV positive mothers have passed on the virus to their children through breast feeding, unaware that they had HIV. In a few cases in Toronto in 1997, HIV positive mothers on disability assistance with negative children who didn't qualify for a milk supplement allowance breast fed out of necessity, which risked passing on the virus to their infants.
- Children are generally the first victims of abuse and neglect in any society. Because they are small, and undeveloped, children have little ability to defend themselves from the abusive or irrational behaviour of adults.
- Sexual, emotional, physical and spiritual abuse can lead to any number of developmental problems in children. Abused children may be at higher risk for HIV infection when they reach adulthood.

What Can Be Done to Help?

- Education about HIV in schools often does not take into account the cultural and social problems Aboriginal Peoples face. Parents can learn about positive parenting to help protect and teach their children about the dangers of HIV infection.
- Service providers and communities can begin child development teachings as early as age five to better understand healthy sexual development.
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All statistics used in this fact sheet are taken from Health Canada's HIV and AIDS Among Aboriginal People in Canada. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada, May 1999.

Canadian Aboriginal AIDS Network

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AIDS & First Nations Peoples

Here Are the Facts!

- The HIV/AIDS pandemic continues to grow and threaten Aboriginal Peoples throughout the world. The last decade has seen a steady rise in Aboriginal AIDS cases in Canada. Some studies have shown that as many as twenty percent of 16,000 AIDS cases in this country may be Aboriginal.
- Infection rates in First Nations women and 2-spirited (gay) people are rising rapidly. Injection drug users, inmates, and street involved persons are increasingly at risk.
- First Nations AIDS cases are younger than non-Aboriginal AIDS cases. 30% of all newly documented cases among First Nations Peoples are under 30 years old, with a female to male ratio of 3 to 1. In some cases, people are being infected at ages 19 and 20.

Why Are Aboriginal People Susceptible To HIV/AIDS?

- No one is immune from AIDS. The economic and social power imbalance between Aboriginal people and non-Aboriginal people in this country plagues our communities with a host of social problems. HIV is rapidly becoming one of them. Studies in mainstream society also show that instances of HIV infection occur more frequently where poverty, violence, drug abuse and alcoholism are present.
- The high degree of movement of First Nations people between inner cities and rural on-reserve areas may bring the risk of HIV infection to even the most remote First Nations reserves. Some reserves may be governed by leadership that are unsympathetic to AIDS and HIV. Cases where HIV infected 2-spirited men have been unable to return to their reserve for holistic treatment have been reported.
- Disproportionate inmate populations with higher at-risk factors can unwittingly contribute to new infections both during incarceration and after release.

What Can Be Done to Help?

- More education and better information among First Nations people in Canada is needed to guide prevention and control strategies.
- More on reserve programming and treatment must occur. The barriers between reserve and off-reserve leadership must be broken down, and issues of homophobia must be addressed in reserve communities.
- More First Nations programming and education in prisons and institutions must be provided.
- Communities must take an active role in the education of their children and members about the dangers of unprotected sex and other risk associated behaviours.
- Governments and other agencies must respond to HIV/AIDS in First Nations communities by ensuring that resources and

All statistics used in this fact sheet are taken from Health Canada's HIV and AIDS Among Aboriginal People in Canada. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada, May 1999.

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AIDS & First Nations People

services are culturally appropriate with access to counselling and HIV testing.

*This fact sheet was prepared by The **Canadian Aboriginal AIDS Network** located in Ottawa, Canada. **CAAN** is a National Coalition of Aboriginal people and organizations that provide leadership, support, and advocacy for Aboriginal people living with and affected by HIV/AIDS regardless of where they reside. For more info call CAAN at 1-888-285-2226. Statistics taken from LCDC Epi-Updates.*

Canadian Aboriginal AIDS Network

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AIDS & The Inuit

Here Are the Facts!

- The HIV/AIDS pandemic continues to grow and threaten Aboriginal Peoples throughout the world. The last decade has seen a steady rise in Aboriginal AIDS cases in Canada. Some studies have shown that as many as twenty percent of 16,000 AIDS cases in this country may be Aboriginal.
- Inuit in the Northern regions of Canada are often over-looked when it comes to Aboriginal specific HIV/AIDS programming. Limited Inuit specific HIV/AIDS programming in Northern regions and in Inuit populated urban areas puts the Inuit at risk for HIV due to lack of prevention efforts and HIV/AIDS education.
- Although the number of reported Inuit AIDS cases in Canada are small, there is reason to believe, based on percentages of population, that the epidemic is expanding among the Inuit in Canada.

Why Are Inuit People Susceptible To HIV/AIDS?

- No one is immune from AIDS. The economic and social power imbalance between Aboriginal people and non-Aboriginal people in this country plagues Inuit and other Aboriginal communities with a host of social problems. Studies in mainstream society also show that instances of HIV infection occur more frequently where poverty, violence, drug abuse and alcoholism are present.
- The north is a harsh environment. Inuit are plagued with additional issues of isolation, violent death, poverty and a host of specific social problems that also put them at risk for HIV.
- According to long standing practice and culture, the Inuit in the North may be a transient people, which makes it difficult to set up permanent programs and services to deal with health issues such as HIV.
- In many Northern and some rural areas, culturally appropriate counselling and HIV testing is almost non-existent, and outreach services are desperately needed.
- Inuit culture and language differences make it difficult for outsiders to provide safer sex education in a way that will be accepted and understood by Inuk people.
- It is difficult for the Inuit to participate in AIDS initiatives in Southern Canada. Prohibitive flight costs, long distances and lack of communications technology such as computers and fax machines isolate the Inuit from the rest of Canada.
- Issues of poverty, racism, addiction, and culture shock for an Inuk living in a Southern city may make it too difficult for him or her to protect themselves from HIV.

What Can Be Done to Help?

- More education and better information among the Inuit in Canada is needed to guide prevention and control strategies.

All statistics used in this fact sheet are taken from Health Canada's HIV and AIDS Among Aboriginal People in Canada. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada, May 1999.

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AIDS & The Inuit

- More funding and Inuit specific programming and education must occur in the North. Aboriginal AIDS agencies and networks in the south providing national advocacy and programs must take into account language and culture differences among Inuit people in urban areas and in the north.
- Partnerships between First Nations, Métis and Inuit organizations must be built to address the needs of the Inuit in general Aboriginal HIV/AIDS programming.
- Governments and other agencies must respond to HIV/AIDS in Inuit communities by ensuring that resources and services are culturally appropriate with access to counselling and HIV testing in Northern and urban Inuit populated regions.
- Regional differences in culture and varying dialects in the Inuktitut language make a blanket Northern approach to the issues of HIV/AIDS nearly impossible. Specific programs must be developed for each region, and funding must be made available to facilitate this.

*This fact sheet was prepared by **The Canadian Aboriginal AIDS Network** located in Ottawa, Canada. **CAAN** is a National Coalition of Aboriginal people and organizations that provide leadership, support, and advocacy for Aboriginal people living with and affected by HIV/AIDS regardless of where they reside. For more info call CAAN at 1-888-285-2226. Statistics taken from LCDC Epi-Updates.*

All statistics used in this fact sheet are taken from Health Canada's HIV and AIDS Among Aboriginal People in Canada. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada, May 1999.

Canadian Aboriginal AIDS Network

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AIDS & Métis Peoples

Here Are the Facts!

- The HIV/AIDS pandemic continues to grow and threaten Aboriginal Peoples throughout the world. The last decade has seen a steady rise in Aboriginal AIDS cases in Canada. Experts believe that as many as twenty percent of 16,000 AIDS cases in this country may be Aboriginal.
- The Métis are one of three Aboriginal groups in Canada. In the early eighteenth century the Métis formed a strong nationalist movement, at which time there were two groups of Métis descendants of the Anglo/Indian unions known as Half-Breeds and the descendants of Franco/Indian unions known as Métis. The two were a closely knit group bound by their common Indian origin, the fur trade, and their western homeland.
- On the plains of Western Canada these "mixed-bloods" increased in numbers and married among themselves, developing a new culture neither European nor Indian but a mixing of the two and a new identity, Métis. This new culture developed their own traditions and language: "Michif".

Why Are Métis People Susceptible To HIV/AIDS?

- No one is immune from AIDS. The economic and social power imbalance between Aboriginal people and non-Aboriginal people in this country plagues the Métis and other Aboriginal communities with a host of social problems.
- Over 51% of the Métis population are women who are marginalised and live in poverty.
- Studies in mainstream society show that instances of HIV infection occur more frequently where poverty, violence, drug abuse and alcoholism are present.
- The high degree of movement of Métis people between inner cities and rural areas may bring the risk of HIV infection to even the most remote Métis communities. In Northern and some rural areas, culturally appropriate counselling and HIV testing is almost non-existent, and outreach services are desperately needed.
- Métis culture and language differences make it difficult for outsiders to provide safer sex education in a way that will be accepted and understood by Métis people.

What Can Be Done to Help?

- More education and better information among the Métis in Canada is needed to guide prevention and control strategies.
- More funding and Métis specific programming and education must occur in Métis communities.
- General Aboriginal AIDS agencies and networks providing advocacy and programs must take into account language and culture differences among Métis people in urban and rural areas and in the north.
- Partnerships between First Nations, Métis and Inuit organizations must be built to address the needs of the Métis in general Aboriginal HIV/AIDS programming.
- Governments and other agencies must respond to HIV/AIDS in Métis communities by ensuring that resources and ser-

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AIDS & Métis Peoples

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AIDS & Two-Spirited

Here Are The Facts!

- Two spirited (gay) Aboriginal males show a higher rate of HIV infection than any other Aboriginal group.
- Men who have sex with men constitute 57.4% of infections among Aboriginal males.
- Why Are Two Spirited Men at Higher Risk Than Straight Men?
- Although sex between two-spirited men is normal and healthy to engage in, anal sex without a condom is an extremely high risk behaviour.
- Feelings of guilt and shame may surround the same sex activities of younger gay men. Alcohol and drugs are sometimes used to counteract these feelings. Impaired reasoning and judgement often result, leaving two-spirited men unable or unwilling to negotiate safer sex while under the influence.
- Studies have shown that gay men who have had experiences of sexual abuse when younger are often confused about their sexual orientation. Two-spirited survivors of residential school abuse may be unable to explore their same sex orientation in a safe and healthy way. Unresolved abuse issues often lead to depression, substance abuse, low self-esteem all of which may in turn lead to the kind of risky sexual and drug-use behaviour that puts people at risk for HIV infection.
- Gay men often internalize the negative attitudes they encounter about homosexuality. Messages received from churches, schools, leadership, and other institutions saying homosexuality is wrong can lead a gay man to believe he is worthless or deviant. Such feelings often lead to reckless behaviour that put him or her at risk for HIV infection.

What Can Be Done to Help?

- Two-spirited members of our communities must be encouraged to share and express their sexuality without fear of hatred or violence. Specific programs aimed at Two Spirited men and women must be developed in order to reach this high risk segment of our populations.
- Support groups and workshops must be developed to address healthy sexuality, including homosexuality.
- Homophobia is defined as a fear or hatred of homosexuals. Service providers must learn to address this problem in our communities.
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AIDS & Aboriginal Youth

Here Are The Facts!

- Aboriginal AIDS cases are younger than non-Aboriginal cases. 26% of Aboriginal people who are infected are under the age of 30, compared to 17.6% in the non-aboriginal population.

Why are Aboriginal Youth at Risk?

- Young people are likely to experiment with activities that put them at higher risk alcohol and drug use, and various forms of sex.
- Young people often believe they are invincible, and that it won't happen to them. Coupled with mind altering substances, this combination can be very dangerous.
- Young people are more likely to traffic between high and low risk areas. For example, it is not uncommon for young people to leave their reserve and move to a larger city like Toronto, where the risk of HIV infection is higher, then return and pass the virus on to youth in lower risk areas.
- Education provided in schools is sometimes not culturally appropriate to reach our young people. Also, HIV is often identified as a gay disease, and straight or bi-sexual youth believe they will not be affected by it.

What Can Be Done to Help?

- Targeted HIV/AIDS programs for Aboriginal youth need to be developed with active Aboriginal youth involvement in all stages of the process.
- This fact sheet was prepared by The Canadian Aboriginal AIDS Network located in Ottawa, Canada. CAAN is a National Coalition of Aboriginal people and organizations that provide leadership, support, and advocacy for Aboriginal people living with and affected by HIV/AIDS regardless of where they reside. For more info call CAAN at 1-888-285-2226. Statistics taken from LCDC Epi-Updates.

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AIDS & Aboriginal Women

Here Are the Facts!

- The proportion of Women among Aboriginal AIDS cases are higher than of Non-Aboriginal AIDS cases. Aboriginal women are more likely to be infected at a younger age than both Aboriginal men and non-Aboriginal populations.
- Women are at higher risk than men when having sex with an HIV positive male partner.
- At a BC clinic which cares for the majority of HIV infected pregnant women in the province, 41% (21/51) of the women under care in 1996 were Aboriginal people.

Why Are Aboriginal Women Susceptible To HIV/AIDS?

- Women are biologically more vulnerable than men to HIV/AIDS infection. Male to female transmission can be 2 to 4 times higher than female to male transmission. In part, this is because semen normally contains a higher concentration of the HIV virus than vaginal fluid.
- Young girls are particularly vulnerable to HIV infection. Their immature cervixes and low vaginal mucus production present less of a barrier to HIV. Also, tears in the vaginal wall can occur more easily with adolescent women.
- Women are more likely to be the victims of abusive relationships. This may lead to powerless in sexual relationships and an inability to negotiate safer sex. Trying to do so may lead to serious consequences like violence or abandonment.
- Women are more vulnerable to coerced sex, including rape and other sexual abuse and forced sex work.
- In forced or abusive situations men are not likely to wear condoms and women unable to protect themselves.

What Can Be Done To Help?

- More education and better information among Aboriginal women in Canada is needed to guide prevention and control strategies.
- Targeted HIV/AIDS programs for Aboriginal women need to be developed with active Aboriginal involvement at all stages of the process.
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All statistics used in this fact sheet are taken from Health Canada's HIV and AIDS Among Aboriginal People in Canada. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada, May 1999.

Appendix A

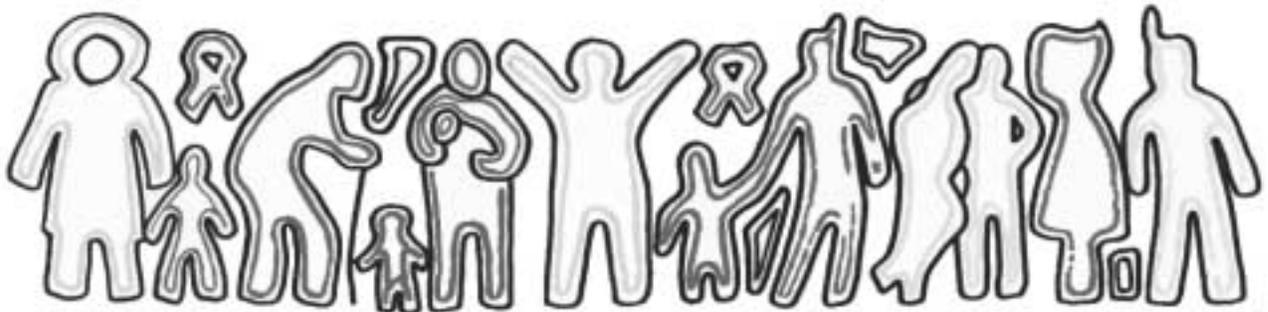
Introduction to HIV/AIDS

Funded and Developed by Manitoba Health

Prepared by Albert Mcleod

Used by Permission

The following is an HIV/AIDS visual presentation from the HIV/AIDS Teaching Kit distributed by



Manitoba Health. It is included here for those who wish to know more about the prevention of HIV and AIDS.

Appendix B

Information Resources



The following is a list of resources to be used in seeking out HIV/AIDS surveillance and AIDS information both nationally and in your region. They include contact information for disease control centres, a list of published documents on HIV/AIDS disease control, and a floppy disk of Internet resources and links.

Provincial and Territorial HIV/AIDS Surveillance Coordinators

Ms. Pat Mandl
Communicable Disease Officer
Yukon Region
Whitehorse General Hospital
No. 2 Hospital Rd.
Whitehorse, Yukon
Y1A 3H8
tel: (867) 667-8369
FAX (867) 667-8349
e-mail-pat.mandl@gov.yk.ca

Dr. Michael Rekart
Director, STD/AIDS Control
BC Centre for Disease Control
655 West, 12th Ave.
Vancouver, B.C. V5Z 4R4
Tel: (604) 660-6170
FAX: (604) 775-0808
E-mail: michael.rekart@bccdc.bnet.bc.ca

Dr. Bryce Larke
Medical Consultant
Disease Control and Prevention
Alberta Health and Wellness
Telus Plaza North Tower
23rd floor
10025 Jasper Ave
Box 1360, Stn Main
Edmonton, Alberta
T5J 2N3
Tel: (780) 445-2804
FAX: (780) 422-6663
e-mail- Bryce.Larke@health.gov.ab.ca

Dr. Eric Young, Director
Communicable Disease Control
Saskatchewan Health
3475 Albert St
Regina, Saskatchewan
S4S 6X6
Tel: (306) 787-8847
FAX: (306) 787-3220
E-mail: dbutlerj@health.gov.sk.ca

Pat Matusko
AIDS Program Coordinator
Public Health Branch
Communicable Disease Control Unit
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R3B 3M9
Tel: (204) 948-2040
FAX: (204) 948-2040
E-mail: pmatusko@health.gov.mb.ca

Dr. Evelyn Wallace
Senior Medical Consultant
Disease Control and Epidemiology Service
Ontario Ministry of Health
Public Health Branch
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North York, Ontario
M2M 4K2
Tel: (416) 327-7429
Fax: (416) 327-7439
E-mail: wallacev@epo.gov.on.ca

Dr. Bruno Turmel
Coordonnateur
Module Prevention et controle MTS/SIDA
DSC Hôpital général de Montréal
1301 Sherbrooke Est
Montréal, Québec
H2L 1M3
Tel (514)528-2400 ex 3618
Fax (514) 932-1502
E-mail- BTURMEL@SANTEPUB-
MTL.QC.CA

Dr. Christofer Balram
Director, Health Promotion and
Disease Prevention
Provincial Epidemiologist
520 King St, Carleton Place
P O Box 5100
Fredericton, New Brunswick
E3B 5G8
Tel: (506) 453-3092
Fax: (506) 453-2726
e-mail-chrisba@gov.nb.ca

Dr. Jeff Scott
Medical Officer of Health
N.S. Department of Health
1690 Hollis Street-11th floor
P O Box 488
Halifax, Nova Scotia
B3J 2R8
Fax: (902) 424-0506
tel: (902) 424-8698
e-mail-hlfjose.heal.scottj@gov.ns.ca

Dr. Lamont Sweet
Chief Health Officer
Dept of Health & Social Services
P O Box 2000
Charlottetown, Prince Edward Island
C1A 7N8
Tel: (902) 368-4978
FAX: (902) 368-4969
no e-mail: lesweet@gov.pe.ca

Dr. Faith Stratton
Director, Disease Control and Epidemiology
Newfoundland Dept. Of Health
West Block, Confederation Bldg
P O Box 8700
St. John's, Newfoundland
A1B 4J6
Tel: (709) 729-3430
Fax: (709) 729-5824
e-mail-fstratton@health.gov.nf.ca

Dr. Andre Corriveau
Health & Social Services
8th floor,
Centre Square Tower
P O Box 1320
Yellowknife, Northwest Territories
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Tel: (403) 920-8946
Fax: (403) 873-0266

Understanding HIV/AIDS Epidemiology Some Publications

(Entries with Asterisks have on-line sources.)

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Understanding HIV/AIDS Epidemiology Internet Information Resources

This resource list was created by the Canadian Aboriginal AIDS Network as a companion piece to Understanding HIV/AIDS Epidemiology: AIDS Surveillance Among Aboriginal People in Canada. For more information on this manual, and to order a copy please contact CAAN at

#409 - 396 Copper Street
Ottawa Ontario K2P 2H7

Toll Free 1-888-285-CAAN (2226)

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Fax: 1-613-567-4652

e-mail: caan@storm.ca

Contents:

1. National HIV/AIDS Organizations pg. 3
2. Canadian HIV/AIDS Epidemiological and Surveillance Resources pg. 4
3. International HIV/AIDS Epidemiological and HIV/AIDS Resources pg. 11
4. Related Topics pg. 11

Last Updated on April 10, 2000 by Canadian Aboriginal AIDS Network

National HIV/AIDS Organizations

The following are some general Internet resources concerning AIDS and HIV in Canada.

AIDS Foundation Of Canada
<http://www.aidsfoundation.ca>

Canadian Aboriginal AIDS Network
<http://www.caan.ca>

Canadian AIDS Society
<http://www.cdn aids.ca/cdn aids/home.nsf>

Canadian Association Of Nurses In AIDS Care
<http://www.canac.org>

The Canadian HIV/AIDS Clearinghouse
http://www.cpha.ca/clearinghouse_e.htm

Community AIDS Treatment Information Exchange(CATIE)
<http://www.catie.ca>

National Aboriginal Political Organizations

Assembly Of First Nations
<http://www.afn.ca>

Inuit Tapirisat Of Canada
<http://www.tapirisat.ca/>

Pauktuutit Inuit Women's Association
<http://www.pauktuutit.on.ca/publications/main.html>

Canadian HIV/AIDS Epidemiology and Surveillance Resources

The following are some national Internet resources for HIV/AIDS Epidemiology and Disease control in Canada.

Aboriginal People and HIV/AIDS (Health Canada)
http://www.hc-sc.gc.ca/hppb/hiv_aids/can_strat/aboriginal/aboriginal_hiv.html

Bureau of HIV/AIDS TB and STD
<http://www.hc-sc.gc.ca/hpb/lcdc/bah/index.html>

Bureau Of HIV/AIDS and STD Update Series
http://www.hc-sc.gc.ca/hpb/lcdc/bah/epi/epi_e.html

HIV/AIDS Among Aboriginal People (Health Canada)
http://www.hc-sc.gc.ca/msb/fnihp/aids_e.htm

HIV/AIDS in Canada (Health Canada)
<http://www.hc-sc.gc.ca/hpb/lcdc/publicat/aids/>

HIV/AIDS LCDC Epi-Update (Aboriginal Specific)
http://www.hc-sc.gc.ca/hpb/lcdc/bah/epi/aborig_e.html

Research On HIV/AIDS Among Aboriginal Peoples (Medical Services Branch)
<http://www.hc-sc.gc.ca/msb/fnihp/hivpaper.htm>

International HIV/AIDS Epidemiology, Surveillance and Prevention Resources

Here are some international Internet resources highlighting HIV/AIDS epidemiology, surveillance and prevention/education.

AIDS Action International
<http://www.hain.org/aidsaction.html>

AIDS Education and Research Trust (Avert)
<http://www.avert.org/>

American Association For World Health
<http://www.aawhworldhealth.org/>

BBC World Service AIDS
<http://www.bbc.co.uk/worldservice/health/sexualhealth/aids/what.shtml>

Global HIV/AIDS Surveillance (World Health Organization)
<http://www.who.int/emc-hiv/>

Harvard AIDS Institute
http://www.hsph.harvard.edu/Organizations/hai/hai_tra.html

Interagency Coalition on AIDS Development (ICAD)
http://www.hsph.harvard.edu/Organizations/hai/hai_tra.html

International AIDS Economics Network
<http://www.iaen.org/>

International AIDS Society
<http://www.aidsonline.com/>

International Association of Physicians on AIDS Care
<http://www.iapac.org/>

International Council Of AIDS Service Organizations (ICASO)
<http://www.icaso.org/>

U.S. Center For Disease Control (CDC)
http://www.cdc.gov/nchstp/hiv_aids/pubs/facts.htm

Related Documents

Some additional on-line resources highlighting Aboriginal peoples and culture, Aboriginal disease epidemiology and related information.

Aboriginal People and HIV/AIDS In Prisons Aboriginal Voices Magazine
<http://www.sfu.ca/continuing-studies/pubpol/aids/>

Diabetes and Aboriginal People (Windspeaker)
<http://plaza.v-wave.com/ammsa/windspeaker/wind-diabetes.html>

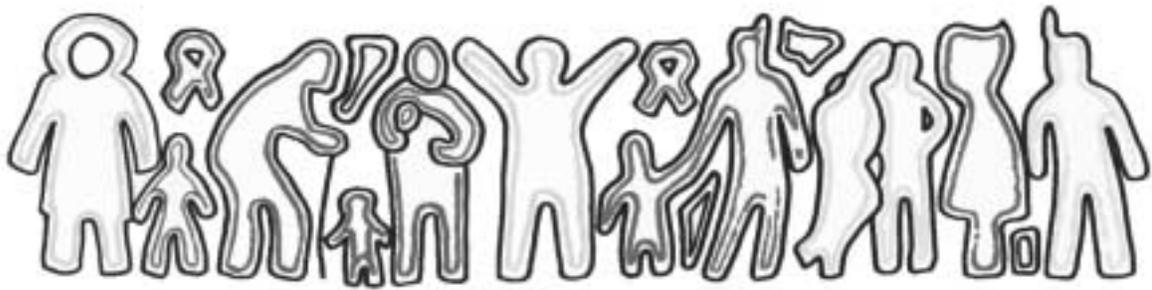
Disease as Genocide In Australia
<http://www.aiatsis.gov.au/research/dp/8/genocide.htm>

First Contact: Small Pox
<http://web20.mindlink.net/stolo/firstcon.htm>

Native Web (U.S)
<http://www.nativeweb.org/>

Appendix C

Bibliography



The following are the resources and publications used to prepare this manual. Other sources were used from the Internet, the web addresses can be found in the information resources section and updated web links can be found on the CAAN web page (www.caan.ca).

Understanding HIV/AIDS Epidemiology

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(Entries with Asterisks have on-line sources.)

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Appendix D

List of Illnesses and Symptoms Associated with AIDS



Possible Illnesses Associated With AIDS

Allergy
Aspergillosis
B19 parvovirus
Bacterial infections
Blastomycosis
Cancers - overview
Candidiasis
Cardiomyopathy
CMV
Coccidioidomycosis
Cryptococcus
Cryptosporidiosis
Depression
Entamoeba histolytica
Giardia lamblia
Gingivitis
Guillain-Barré syndrome
Hairy leukoplakia
Hepatitis B
Hepatitis C
Herpes simplex
Histoplasmosis
HIV-associated dementia
HIV-associated salivary disease
Hodgkin's disease
Human herpes virus 6
Human papilloma virus
Isosporiasis
Kaposi's sarcoma
Lactic acidosis
Leishmaniasis
Lung cancer
Lymphocytic interstitial pneumonitis
MAI
Microsporidiosis
Molluscum contagiosum
Mycobacterium haemophilum
Mycobacterium kansasii
Neuropathy
Neutropenia
Non-Hodgkin lymphoma
Osteoporosis
Pancreatitis
PCP
Pelvic inflammatory disease
Persistent generalised lymphadenopathy
Progressive multifocal leukoencephalopathy (PML)
Psoriasis

Q fever
Salmonellosis
Seborrhoeic dermatitis
Syphilis
Testicular cancer
Thrombocytopenia
Tinea
Toxoplasmosis
Tuberculosis
Ulcers
Vascular myelopathy
Varicella zoster virus
Wasting syndrome

Possible Symptoms Associated With AIDS

Dealing with symptoms
Anaemia
Anorexia
Anxiety
Blackouts & fits
Breathlessness
Bruising
Cough
Dermatitis
Diarrhoea
Dry mouth
Fatigue
Fever
Gingivitis (Gum problems)
Headaches
Hearing loss
Insomnia
Memory problems
Mouth infections
Mouth ulcers
Nausea
Night sweats
Numbness
Pain
Rashes
Sexual problems
Sickness
Swallowing difficulties
Visual problems
Vomiting
Walking difficulties
Weight loss

Appendix E



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