The Impact of HIV/AIDS on Rural Aboriginal Communities

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Background
Research on HIV/AIDS is extensive, yet specific populations and specific issues relating to HIV/AIDS remain undeveloped. One of these populations is aboriginal peoples, specifically aboriginal peoples living with HIV/AIDS in rural Canada. We focused originally on aboriginal peoples living in rural Canada to obtain a greater understanding of their vulnerability to HIV infection. Aboriginal peoples, in this paper, include those who identify themselves as Inuit, Metis, Native American, Navajo, Indian, Aboriginal and/or First Nations. Due to a lack of literature available on HIV/AIDS in rural Canada, this paper has been expanded to incorporate literature on rural aboriginal peoples in the United States. Investigations into the number of reported HIV/AIDS cases in Canada were also undertaken in an attempt to gain comparative perspective on HIV/AIDS among Canadian aboriginal peoples. Our central questions are: What are the risk factors faced by rural aboriginal peoples? Are rural aboriginal people more vulnerable to HIV? and What can be done (or is already being done) in terms of prevention?

We found that the literature on HIV/AIDS and aboriginal peoples living in rural communities is limited; nonetheless it suggests that aboriginal peoples living in rural areas are vulnerable to HIV. To support our argument we look at the statistics of HIV/AIDS cases in Canadian populations and their reliability. Then we introduce our literature review and the results of this review. In this section we identify four factors that contribute to the vulnerability of aboriginal peoples contracting HIV/AIDS, accenting how rural residency can increase susceptibility. In our discussion we emphasize the

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2 See Appendix A for summaries of the articles included in this literature review
urgency for further research with rural aboriginal peoples. We also suggest alternative, culturally sensitive methods of HIV prevention and treatment designed with the extensive participation of aboriginal communities.

Statistics

Statistics from Health Canada’s HIV/AIDS surveillance reports\(^3\), First Nations and Inuit Health Branch (FNIHB), National Aboriginal Council on HIV/AIDS (NACHA), National Indian and Inuit Community Health Representative Organization (NIICHRO), and from Indian and Northern Affairs Canada (INAC) reveal that aboriginal peoples are over-represented in the number of positive HIV cases\(^4\) when ethnicity is reported. While the AIDS epidemic in the general Canadian population has stabilized, positive HIV cases among aboriginal peoples have steadily increased over the past decade (First Nations and Inuit Health Branch, 2000).

The total number of aboriginal AIDS cases reported in Health Canada’s surveillance report ending in December 2003 was 520. This number may seem small and insignificant when compared to 14,035 caucasian\(^5\) individuals reported to have AIDS in the same document. However, when taking a closer look at the numbers, 520 AIDS cases should alarm every reader. Aboriginal peoples make up 1.4% of the reported AIDS cases in Canada in 1984-1990, 2.4% in 1990-1992, and 4.4% in 1993-1995 (Indian and Northern

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\(^3\) The statistics in Health Canada’s Surveillance Report are based on the number of HIV and AIDS cases reported to the Centre for Infectious Disease Prevention and Control (CIDPC), which is a part of Health Canada. The report is based on “non-nominal, confidential information regarding positive HIV test reports and diagnosed AIDS cases reported by all provinces and territories of Canada” (65).

\(^4\) Positive HIV cases are used in this paper as an indicator of the success or failure to control the AIDS epidemic.

\(^5\) Statistics Canada uses the term “white”. The ethnic status categories used by Statistics Canada are “Aboriginal”, “South Asian/West Asian/Arab”, “Asian”, “Black”, “Latin American”, “White”, and “Other”. All of the categories have definitions, except for the ethnic status category of “white”, therefore we have decided to use the term “caucasian”.
Affairs Canada, 2004a). Health Canada reports aboriginal people comprising 8.3% of AIDS cases in 1998, 10.1% in 1999, 7.2% in 2000, 5.9% in 2001, 12.8% in 2002, and 13.4% in 2003 (Surveillance Report, 2004). The percentage of aboriginal AIDS cases continues to increase compared to a decrease in the percentage of caucasian cases. To compare, in 2003 aboriginal AIDS cases made up 13.4% of the total number of AIDS cases in Canada while caucasian cases comprised 54.3%. While in 1998 the ratio of percentage of AIDS cases was 2.1 percent of aboriginal cases to 84.9 percent of caucasian cases (Health Canada, 2004).

Table 1: Number of reported AIDS Cases

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<tbody>
<tr>
<td>aboriginal</td>
<td>308 2.1</td>
<td>50 8.3</td>
<td>48 10.1</td>
<td>31 7.2</td>
<td>20 5.9</td>
<td>38 12.8</td>
<td>25 13.4</td>
</tr>
<tr>
<td>caucasian</td>
<td>12,441 84.9</td>
<td>432 71.8</td>
<td>321 67.4</td>
<td>325 75.6</td>
<td>232 68.8</td>
<td>183 61.6</td>
<td>101 54.3</td>
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Likewise, the number of HIV positive aboriginal people has been increasing since 1998, while the percentage of HIV positive caucasian people is decreasing. For example, in 1998 the percentage of aboriginal people who tested HIV positive was 18.8%, while caucasians comprised 67.6% of cases. Compared to 2003 when aboriginal people comprised 25.3% and caucasian cases comprised 46.2% of HIV positive cases in Canada (Health Canada, 2004). Aboriginal people are over-represented in both HIV and AIDS cases in Canada. For example, in 1999, aboriginal peoples represented 16% of the

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6 Adapted from Health Canada (2004), page 45.
7 Current methods used to estimate the annual number of positive HIV cases among aboriginal peoples in Canada involve a combination of surveillance data, vital statistics, and epidemiologic studies.
new positive HIV cases yet make up only 5% of the total Canadian population (First Nations and Inuit Health Branch, 2000).

Table: Number of reported HIV Cases

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<tr>
<td>aboriginal</td>
<td>121</td>
<td>18.8</td>
<td>168</td>
<td>24.3</td>
<td>155</td>
<td>22.2</td>
</tr>
<tr>
<td>caucasian</td>
<td>434</td>
<td>67.6</td>
<td>420</td>
<td>60.7</td>
<td>429</td>
<td>61.4</td>
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Despite these increasing numbers, the effects of HIV/AIDS on aboriginal peoples remains largely unacknowledged because it is not concentrated in one area or in populations perceived as high-risk (Mill, 2000). As Dr. Lorna Medd, Northern Health Authority medical health officer states, “Reported [aboriginal] HIV rates remain low and show only slight growth in the past several years. The question remains as to whether there is an undiagnosed iceberg or unidentified iceberg of disease” (Harrison, 2003).

The question of whether there is an ‘undiagnosed iceberg’ of HIV/AIDS among aboriginal peoples arises in part due to the unreliability of data collection. There is difficulty in attaining data on the number of positive HIV cases among aboriginal peoples living in rural settings due to several factors. First, from 1975-1989, statistics were estimated through a method called “back-calculating” which entails counting retroactively, for each year reported, the number of cases that were identified as known AIDS cases (The Centre for Health Promotion, 2000). These estimates were not reliable as new methods of treatments in the 1980s lengthened the onset of AIDS once HIV infection

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8 Adapted from Health Canada (2004), page 45.
occurred. Second, the occurrence of migration of aboriginal peoples makes tracking
difficult. Aboriginal peoples on reserves often travel to other reservations or to urban
centers (Sullivan, 1991), therefore we assume that accurate surveillance of the residents
of a given community is difficult. Third, HIV testing might only be available in larger
towns or cities and often these statistics do not take into account the person’s residency
(direct correspondence with Department of Health and Social Services, 2004). Fourth,
aboriginal people with HIV/AIDS have been misreported as “Asian”, “Hispanic”,
“White”, or “other” ethnic status (Weaver, 1999; Metler et al., 1991). Finally, Canadian
studies on the prevalence of HIV in aboriginal peoples usually concentrate on individuals
in prison and individuals who use drugs intravenously (Mill, 2000).

However limited and underestimated, these statistics are important because they give
us some indication of the pattern of HIV infection. We ask ourselves how such an over-
representation of aboriginal peoples in the number of new HIV-positive cases is possible
when there are no known ethnic differences in biological susceptibility to HIV? What can
be done to slow down the AIDS epidemic in aboriginal communities?

**Literature Review**

A literature review was done to find reasons that might account for such an imbalance in
the epidemiology of the AIDS epidemic on aboriginal peoples in North America.

Although the initial focus of this review was on rural Canadian communities, due to the
limited literature, some studies that looked at aboriginal populations throughout North
America in rural and urban contexts were also included. Canadian aboriginal
organizations’ websites (i.e., Canadian Aboriginal AIDS Network, Healing Our Spirit),
Canadian Government websites (i.e., INAC) and Computer databases (Medline, CINHAL, AIDSline) were searched. Since definitions of rural vary, in this paper rural is defined as a “population living in towns and municipalities (CSDs) outside of the commuting zone of larger urban centres” (du Plessis et al., 2001:12).

The literature is in agreement that rural communities, regardless of their ethnic makeup, are at a disadvantage when it comes to containing the spread of HIV. It has been documented in the literature that factors such as geographic isolation, limited access to resources, lack of tolerance for diversity, and lack of privacy, are barriers to dealing with the growing problem of AIDS (Weaver, 1999; Conway et al., 1992; Sullivan, 1991; Kruger et al., 1990). For aboriginal peoples living in rural communities, such barriers are compounded by the lack of culturally specific counseling and outreach services. Furthermore, aboriginal peoples are marginalized, culturally, economically, socially, and politically, which negatively affects health: “Many of the behaviours that put one at risk for HIV infection are associated with poverty and disempowerment” (Marsden et al.) For example, HIV infection is prevalent where poverty, violence, drug abuse, and alcoholism are present, regardless of geography (Canadian Aboriginal AIDS Network, 2003).

Several of the articles included in this literature review listed contributing factors that increase the vulnerability of aboriginal peoples to HIV infection (Marsden et al., Mill, 2000; Weaver, 1999; Mill, 1997; Edmonton Journal, 1993; Conway, 1992; DePoy & Bolduc, 1992; Metler et al., 1991; Sullivan, 1991; Claymore & Taylor 1989). The contributing factors are divided into four categories in this review:

1. A prevalence of sexually transmitted diseases.
3. A prevalence of social problems.

4. Specific cultural factors.

Prevalence of sexually transmitted diseases.

High rates of sexually transmitted disease among aboriginal populations have been documented in the literature (Weaver, 1999; Edmonton Journal, 1993; DePoy & Bolduc, 1992; Metler et al., 1991; Sullivan, 1991; Claymore & Taylor, 1989). This is important to note since unprotected sex is one of the primary ways that HIV is transmitted among aboriginal peoples (Weaver 1999). According to Weaver (1999), high rates of STDs serve as an indirect measure of the frequency of high-risk sexual contact. Sullivan (1991) also used STD rates as an indirect measure of the frequency of high-risk sexual contact because information and data on multiple sex partners, anal sex, and sex for money were not available for the Navajo community she examined. This research is compatible with literature that states that aboriginal teenagers are less likely to use condoms than their non-aboriginal peers (Weaver, 1999; DePoy & Bolduc, 1992). In one study, 61% of the 154 aboriginal peoples residing in rural Maine who answered a questionnaire said they never use condoms (DePoy & Bolduc, 1992). This result is limiting because the author does not address context. For example, individuals in long-term monogamous relationships are in a different situation than individuals with multiple partners. If the respondents were primarily in long-term relationships, it would make sense that condom use was low. Also, the authors do not state how this percentage compares with the use of condoms among non-aboriginals.

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9 The author does not offer a complete definition of the term “high-risk sexual contact”. We assume she defines it as unprotected sexual contact, both heterosexual and homosexual, and a high frequency of partners.
There are different hypotheses as to why ‘safe sex’ practices are not more diligently practiced in aboriginal communities. DePoy and Bolduc (1992) claim that sporadic condom use is attributed to misconceptions of the function of condoms in preventing HIV infection. The authors also claim that traditional gender roles in some aboriginal cultures affect the rates of condom use. This is supported by Brassard et al. (1996) who also argue that gender roles have an effect on condom use in Native communities. For example, in some aboriginal cultures, women may not be perceived as responsible for contraception and therefore it may be difficult for some women to emphasize the use of a condom during sexual intercourse. Further, because rural aboriginal communities are small and intimate, people within the community may feel they know one another well and therefore they do not find it necessary to have protected sexual contact.

Weaver (1999) found that aboriginal teenagers are more likely to be sexually active than their non-aboriginal peers. Some authors use stereotypes of aboriginal people to explain sexual activity in aboriginal populations. For example, Claymore and Taylor (1989) suggest that sexual activity may be due to certain social behaviors common in some aboriginal communities such as lack of individual goals and low self-esteem. We found Claymore and Taylor’s suggestion problematic as it generalizes about aboriginal peoples and defines low self-esteem and lack of individual goals as behaviors.

Prevalence of substance abuse.

Patterns of substance abuse such as alcohol, tobacco, and drugs among aboriginal populations have been extensively examined in the literature (Reading & Nowgesic, 2002; Mill, 2000; Weaver, 1999; Baldwin et al., 1996; Edmonton Journal, 1993; Conway et al., 1992; DePoy & Bolduc, 1992; Metler et al., 1991; Sullivan, 1991; Claymore &
Taylor, 1989). INAC reports that in 1991, 62% of First Nations people perceive alcohol abuse as a problem in their community (Indian and Northern Affairs Canada, 2004a). DePoy and Bolduc (1992) reported that alcohol is the most commonly abused substance among aboriginal peoples in Maine.

Assessing the vulnerability of tribal nations in an Aberdeen area, Claymore and Taylor (1989) suggest that unemployment in some aboriginal communities may lead to alcoholism, which in turn inhibits judgment and can result in a higher risk of HIV infection. Perhaps the financial and emotional stresses associated with unemployment can explain the authors finding.

The authors concluded that alcohol abuse can inhibit judgment and can increase the risk of unprotected sex, thereby increasing the risk of HIV transmission. Similarly, a survey of 37,681 Native Americans and Alaska Natives conducted by Conway et al. (1992) produced findings that link alcohol abuse among youth to increased risk for HIV infection. Among the Navajo, Sullivan (1991) states that alcohol contributes to the spread of HIV by acting as a “disinhibitor” leading to carelessness about personal safety. Binge drinking periods may be particularly high risk times for HIV transmission (Sullivan, 1991). Also, solvent abuse among youth is identified as a concern by INAC: “22% of First Nations youth who report solvent abuse are chronic users” (Indian and Northern Affairs Canada, 2004a).

There is a contradiction in the literature with regards to the relationship between drug abuse and HIV infection (Baldwin et al., 1996; Conway et al., 1992; Metler et al., 1991; Claymore & Taylor, 1989). Some authors argue that drug use can lead to an increased risk of HIV infection through impaired judgment and the sharing of unsterilized needles
(Weaver, 1999; Edmonton Journal, 1993). Additionally, sharing needles was the most frequently mentioned source of infection among aboriginal women in northern Alberta (Mill, 2000). However, contradicting this, other studies report no or very low occurrences of intravenous drug use among aboriginal peoples (Baldwin et al., 1996; Sullivan, 1991). These papers do not compare the occurrence of intravenous drug use to other populations. Intravenous drug use is a complicated issue and there could be many explanations as to the contradictions in the literature, such as rural and urban differences, access to needle exchange centers and access to urban areas.

There are other views on substance abuse and aboriginal people in the literature. In a qualitative study by Mill (1997) where eight aboriginal women were interviewed, substance abuse is seen as a survival strategy. Each woman interviewed had problems with substance abuse before they became infected with HIV. The author suggests that HIV risk behaviors may become survival techniques for some aboriginal women. Substance abuse becomes an escape from their reality although this lifestyle comes at a high risk for HIV infection.

It is important to keep in mind the consequences of generalizing and stereotyping aboriginal peoples. There are stereotypes of extensive alcohol use among aboriginal peoples, yet it is safe to assume that not all aboriginal peoples consume excessive amounts of alcohol. Alcohol use occurs only within specific parts of communities (Sullivan, 1991). Further more, although alcohol use may be prevalent in some communities, Weaver (1999) argues that these stereotypes impede HIV/AIDS prevention and treatment by ignoring the diversity of aboriginal experiences and life.

*Prevalence of other social problems.*
Aboriginal peoples living in both rural and urban settings face numerous social problems from unemployment to sexual abuse. Most aboriginal people in Canada live at or below the poverty line (Indian and Northern Affairs Canada, 2004a). High rates of unemployment and poverty are other contributing factors to the vulnerability of some rural aboriginal communities to HIV infection. Survey findings of American Indians and Alaska Natives suggest that the effects of long term unemployment and poverty may increase the risk of such populations for HIV infection (Conway et al., 1992). The director of the National Native American AIDS Prevention Centre is cited in the Edmonton Journal (1993) as saying that risk factors such as poverty combined with malnutrition can lead to an increase in the vulnerability of aboriginal people to HIV infection. The author did not provide any further explanation as to how malnutrition and vulnerability to HIV infection are linked. We assume that malnutrition decreases the body’s ability to fight against the viral infection. These risk factors add up and further marginalize some rural aboriginal communities, reducing their access to educational resources and prevention programs.

*Specific cultural factors.*

A variety of culturally specific risk factors also come into play in the vulnerability to HIV/AIDS. For example, isolated aboriginal communities may not acknowledge the existence of homosexual activity (Weaver, 1999), or believe they are not at risk for AIDS because AIDS is a ‘non-aboriginal disease’ or a ‘gay disease’ (Marsden et al.). More specifically, traditional ceremonies involving piercing of the flesh such can be a source of HIV infection if the piercing object is not sterile (Weaver, 1999).
Second, aboriginal approaches to health are not always compatible with the Western medical model (Mill, 2000; DePoy & Bolduc, 1992). For example, Healing Our Spirit (a community, aboriginal-based HIV/AIDS organization in British Columbia) uses a medicine wheel, which “represents many things, including the four areas of holistic health—the physical, emotional, mental and spiritual” (Marsden et al., 5).

Migration is also considered a culturally specific factor which contributes to the spread of HIV/AIDS. There is a high rate of migration patterns between reservations and other aboriginal communities (Weaver, 1999) as well as travel between rural communities and urban centers (Conway et al., 1992; DePoy & Bolduc, 1992). Sullivan (1991), found that this migration into urban centers is associated with binge drinking and multiple sexual partners among some Navajo. Similarly, Hall et al. (1990) found that it is not uncommon for aboriginal peoples in their study to have sexual partners on and off of their reservations. They argue that if HIV is contracted outside of a reservation and then brought into a reservation community through circular migration patterns it could be devastating to the community.

Another culturally specific risk factor associated with increased vulnerability to HIV infection is the pervasiveness of gossip. Due to the small size of some aboriginal communities and their geographical isolation, the lack of privacy and anonymity can be a problem when it comes to HIV testing. Although the women in Mill’s (2000) research wanted, and tried, to keep their HIV diagnosis private, many experienced a rapid spread of the news of their diagnosis through their communities. Discrimination, stigma and exclusion were common experiences for the women. DePoy & Bolduc (1992) found that negative attitudes towards people with HIV might lead to a lack of openness about the
subject. Furthermore, the lack of privacy in rural, aboriginal communities can affect an individual’s decision to be tested for HIV, or to attend HIV/AIDS prevention and educational programs.

Discussion

The ‘undiagnosed iceberg’ we have encountered in the aboriginal HIV/AIDS surveillance data is alarming, however it is beginning to be addressed. Aboriginal organizations addressing the impact of HIV/AIDS on aboriginal peoples have been established. Healing Our Spirit (www.healingourspirit.org) and the Canadian Aboriginal AIDS Network (www.caan.ca) provide cultural sensitive education and research.

On a federal level, Health Canada has been working with Aboriginal organizations to increase the accuracy of HIV/AIDS surveillance data (The Centre for Health Promotion, 2000). Together with First Nations peoples, Health Canada improved the First Nations and Inuit Regional Health Surveys by changing some of the questions and methodological approach so to have a better representation of the prevalence of HIV/AIDS in the aboriginal population (Indian and Northern Affairs Canada, 2004b). Health Canada also funded a community-based knowledge, attitude, and behavior study conducted by the Two-Spirited Peoples of the First Nations. Four hundred two-spirited men were interviewed on how HIV/AIDS education and prevention is received in their communities and how culture and attitudes can put two-spirited men at risk (The Centre for Health Promotion, 2000). Studies such as these lead to an increased understanding of

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10 “The term "Two-Spirited" originates from the First Nations recognition of the traditions and sacredness of people who maintain a balance by housing both the male and female spirit” (Deschamps, 1998: 16). ‘Two-spirited’ can also be used be define queer aboriginal people as a preference over western terms like queer, gay, lesbian.
the unique issues facing aboriginal peoples, and subsequently contribute to the improvement of surveillance and prevention programs. These joint efforts between government and aboriginal grassroots organizations have improved surveillance as well as established a framework for collaborative action.

Stereotypes of aboriginal peoples affect policy decisions and perceptions of HIV/AIDS risk factors. Weaver (1999) gives an example of an aboriginal woman who lived in a rural community in the United States. The doctors she saw did not consider HIV to be a cause of her health problems because they “believed the HIV/AIDS was not a likely possibility in a rural, midwestern area” and “that Native Americans were not at much risk of infection” (Weaver, 1999: 29). This example represents how stereotypes of aboriginal people can result in late diagnosis and treatment of HIV.

Lambert (1993) states that “[a] concise portrait of HIV and AIDS within the aboriginal community is difficult to present. Just as there are different customs and traditions among tribes, so are there different ways by which this issue is being addressed” (Lambert, 1993: 28). He points to the importance of dealing with the impact of AIDS holistically; looking at the pandemic’s physical, mental, emotional, and spiritual aspects, as well as the financial and psychosocial aspects. Similarly, Depoy and Bolduc (1992) suggest that in order to develop effective HIV prevention programs it is important to acknowledge and understand social roles. There is diversity among rural communities and aboriginal peoples, such as different familial and gender roles and norms. This must be taken into account in order to develop a relevant and effective prevention program. Unfortunately, we did not find detailed, holistic approaches to HIV prevention in the literature surveyed.
Several solutions and suggestions for addressing HIV/AIDS in aboriginal communities were available in the literature. First, the Edmonton Journal (1993) argues that a solution to the complexity of the problems HIV/AIDS poses on aboriginal communities can be found by funding comprehensive studies to determine the epidemiology of HIV among aboriginal people. A common suggestion in the literature to prevent the further spread of HIV is to involve aboriginal health-care workers in strategic planning and community education programs that are culturally sensitive (Binder, 2000; Mill, 2000; Weaver, 1999; Brassard et al., 1996; LeMaster & Connell, 1994; Edmonton Journal, 1993; 1993; DePoy & Bolduc, 1992; Metler et al., 1991; Sullivan, 1991).

‘Culturally-sensitive’ programming is not often defined and less often implemented.

Mill (2000) makes a distinction between biomedical, traditional aboriginal and alternative treatments for HIV. Of the women interviewed by Mill (2000), all but one used traditional and/or alternative treatment, such as healing circles, sweat lodges, and seeking treatment from traditional healers. Even those who engaged in biomedical treatment also used other healing practices. Mill’s (2000) focus is on aboriginal women, therefore she does not engage in a comparison with non-aboriginal women who use traditional aboriginal treatments. Mill (2000) goes on to say that aboriginal treatments and traditions were important to the women who participated in her study, even if they lived in or were raised as children in non-aboriginal areas and cultures. Likewise, Sullivan (1991) found that both traditional and biomedical health systems were used among the Navajo population she explored. The choice of treatment depended upon how HIV/AIDS is defined and access to treatments. Definitions of HIV/AIDS are not static
(Sullivan, 1991) therefore different HIV treatment options need to be available for aboriginal peoples with HIV (Mill, 2000).

Mill (2000) found that once aboriginal women were diagnosed with HIV they were often drawn to their aboriginal culture, wanting a better understanding. The HIV positive women in Alberta that Mill (2000) interviewed used a variety of techniques to look after their health. Staying healthy was emphasized and Mill relates this to “aboriginal focus of restoring the body’s balance” (Mill, 2000: 51). The aboriginal women interviewed by Mill (2000) felt that there was a purpose for them to be infected with HIV. Some felt the reason for their infection was “part of the Creator’s plan for them”, while others felt they had contracted HIV because they deserved it (Mill, 2000: 46). The women discuss how having HIV helped them to stop using drugs and alcohol and helped them to learn how to take care of their selves. Most of the women felt that there were positive outcomes associated with them having HIV, such as perceiving themselves and their lives more positively.

Because of the use of these diverse healing practices, and because of the various implications of contracting HIV, the results suggest that it is imperative for prevention efforts be developed at the local level, tailored to the needs of each community, and grounded on empirical and cultural knowledges. Even one model for all aboriginal peoples would be inappropriate. Instead, it is necessary to develop programs locally, taking into consideration social, political, cultural and historical contexts. Therefore, “[n]o one culturally based model of service delivery is appropriate for all indigenous people” (Weaver, 1999:32).
Such programs and services should be sustainable and accountable by aboriginal communities to ensure their relevance and continuation. Aboriginal people must be involved in every stage of the prevention programs, from recognizing their community’s vulnerability, to planning a suitable and effective program, to executing the program itself and evaluating its relevance and efficacy along the way. Aside from being responsive to the unique health and social needs of aboriginal peoples, prevention programs should be comprehensive and accessible to the targeted community.

Culturally based techniques have already been established in some aboriginal communities. They include condom jewelry with traditional designs, elders discussing safe sex with youth, and theater productions to raise awareness (DePoy & Bolduc, 1992). Since aboriginals in the Northwest Territory of Canada have a more oral tradition, information on HIV/AIDS was delivered door to door, through radio broadcasts, public speeches, and audiotapes. In addition to this, an Inuit woman living with HIV/AIDS shared her story with people in many northern indigenous communities (Weaver, 1999). Similarly, all of the HIV positive women Mill (2000) interviewed are involved in their communities doing voluntary work.

Behavioural change remains the dominant HIV prevention technique (Mill, 2000; Depoy & Bolduc, 1992). Although we do not deny this aspect is important, we, like many authors, argue that it is essential that social issues (such as poverty and racism) be addressed in order to engage in effective HIV prevention (Mill, 2000; Weaver, 1999). For example, if sex work is the only way someone can make money, addressing poverty is as central to prevention as is condom use.
It is necessary to include socio-cultural factors in HIV prevention strategies. Mill (2000) argues that recognizing and addressing socio-cultural risk factors to HIV infection can improve the effectiveness of prevention strategies that focus on behavioral change. She points out that the literature on HIV/AIDS and aboriginal peoples continues to lack discussions and definitions of culturally sensitive HIV programs.

DePoy and Bolduc (1992) found that perceptions of how the HIV infection is spread are not necessarily related to biomedical expertise, but to socio-cultural beliefs. This suggests that prevention programs based in biomedical discourses may not be as effective as programs developed by aboriginal community members that acknowledge and include socio-cultural aspects of specific communities. For example, if a community does not recognize homosexuality, such as the Navajo community examined by Sullivan (1991), designing an HIV prevention program around homosexuality is not effective. In other words, “it would be difficult for the tribe to mount an educational campaign about a behavior it did not recognize” (Sullivan, 1991:245). Further, Sullivan (1991) argues that the cooperation of aboriginal leaders is essential in HIV prevention. The teachings of elder tribal members are highly valued among some aboriginal peoples and should be accessed as a possible means of introducing HIV risk-reduction education (Lambert, 1993).

In the biomedical model HIV is regarded as disease, which by definition does not include socio-cultural aspects of sickness or one’s experiences with sickness. Mill (2000) found that the HIV positive women she interviewed perceived HIV, not as a disease, but as an illness that “included individual, familial, and societal responses to their HIV infection” (Mill, 2000: 53). Thus, consistency is not always present between aboriginal
people’s conceptions of HIV/AIDS and biomedical models of disease and treatment. For example, in the biomedical model, how individuals are treated for HIV depends on laboratory blood tests (Mill, 2000). In contrast, some of the women interviewed by Mill (2000) said they would not engage in treatment for their HIV until they felt sick. This conception of an illness needing to be present symptomatically before treatment is sought is also found in other aboriginal communities (Mill, 2000). Because of such inconsistencies, Mill (2000) argues that “[t]o achieve congruence with aboriginal views, treatment programs should be based on the maintenance of health, including its physical, emotional, mental, and spiritual aspects” (Mill, 2000: 54).

Several organizations have already been established with aims to improve aboriginal health information, develop research capacity, and inform public health policy with the goal of improving health of aboriginal peoples (Reading & Nowgesic, 2002). Such organizations include Healing Our Spirit, The Canadian Institutes of Health Research Institute of Aboriginal People’s Health, Canadian Aboriginal AIDS Network, and The National Native Health Association.

**Conclusion**

There is evidence in the literature that aboriginal peoples are at a higher risk for HIV infection than the general population. However, the epidemiology of the infection among the different aboriginal peoples is not clear. From our literature review, we identified four risk factors that contribute to aboriginal peoples increasing vulnerability of HIV/AIDS. These factors are the prevalence of sexually transmitted diseases, the prevalence of
substance abuse, the prevalence of social problems, and specific cultural factors, such as migration.

The government, community organizations, and voluntary groups must initiate programs of awareness, which must be based in aboriginal communities. New, innovative approaches are in demand if the AIDS pandemic is to be kept from destroying aboriginal communities.
Bibliography


