HIV PREVENTION

MESSAGES FOR CANADIAN ABORIGINAL YOUTH

FINAL REPORT MARCH 2004

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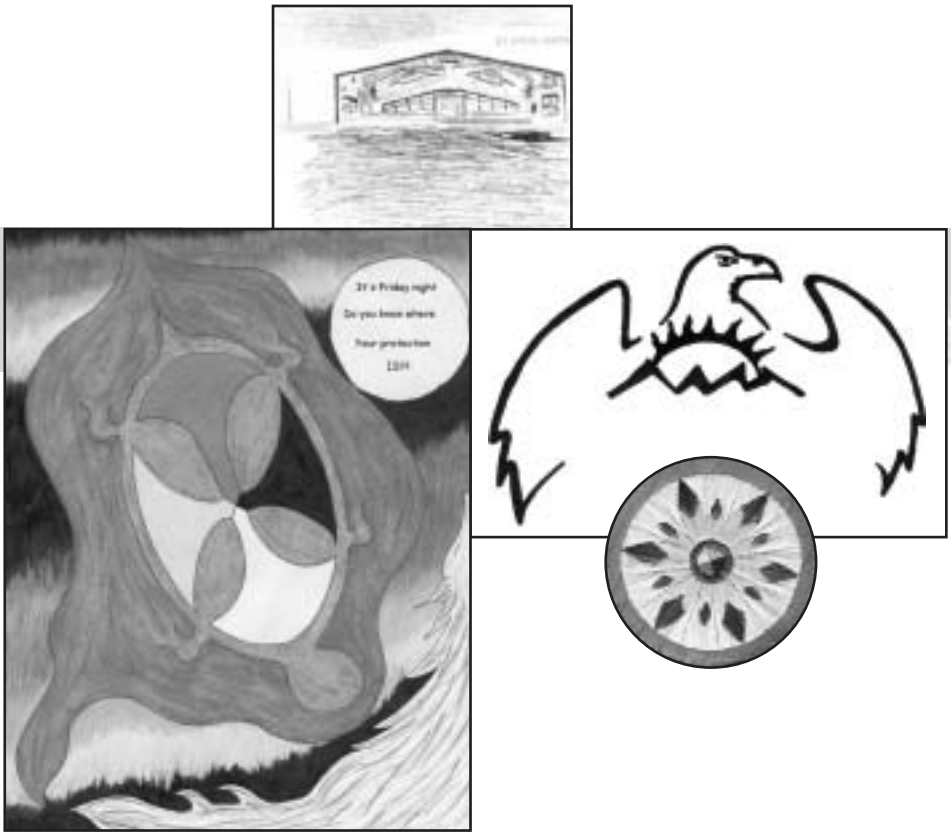

THE CANADIAN ABORIGINAL AIDS NETWORK (CAAN)

OVERVIEW

Established in 1997, CAAN:

- is a National and not-for-profit organization.
- represents over 160 member organizations and individuals.
- provides a National forum for members to express needs and concerns.
- provides relevant, accurate and up-to-date information on issues facing Aboriginal people living with and affected by HIV/AIDS in Canada.
- is governed by a twelve member National Board of Directors and operated by a four member Executive.

MISSION STATEMENT

The mission of the Canadian Aboriginal AIDS Network is to provide leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS regardless of where they reside.

ACKNOWLEDGEMENTS

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DISCLAIMER

Funding for this project was provided by Health Canada. The views expressed herein are solely those of the author and do not necessarily reflect the official position of Health Canada.

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Health Canada Santé Canada

THE QUICK PIC...

This is the final report of a selected literature review and survey on HIV prevention messages for Canadian Aboriginal youth. The information in this report will help Aboriginal communities, Aboriginal youth and youth workers strengthen an existing prevention message, design a new one, or adapt an existing message for use in their own communities.

Surveys were collected from 35 Aboriginal and non-Aboriginal organizations and AIDS service organizations from across Canada. Participants provided information on the range of prevention messages that are currently being offered to First Nations, Métis and Inuit youth; on the groups most in need of prevention messages; and their recommendations on how best to design and deliver HIV prevention messages for Canadian Aboriginal youth.

Key findings of this report indicate that there are a limited number of First Nations, Métis and Inuit prevention messages being offered to Aboriginal youth. Of the messages that are available, a pan-Aboriginal approach is sometimes being taken that is often ineffective. In particular, Inuit youth are being lost in this approach.

Aboriginal youth under the age of 15 and injection drug users are the groups most in need of HIV prevention messages but they are among the least likely to be receiving them. Prevention education must begin before youth become sexually active, and it must address injection drug use.

Peer education is thought to be the most effective approach to HIV prevention but it is among the least common approaches being used by organizations. One possible reason for this is that peer education presents many challenges that more mainstream approaches do not.

Few organizations are familiar with prevention work that takes place outside of their city or region. When asked to comment on prevention initiatives that are taking place across Canada, survey participants did not feel qualified to respond.

Aboriginal and non-Aboriginal organizations lack the funding and human resources they need to design and develop culturally appropriate prevention messages for Aboriginal youth. Organizations recognize their responsibility to youth but they do not have the time or the money to develop youth-specific messages.

In order to address some of these concerns, a series of recommendations is given on how to design effective messages and an inventory of existing national and international resources and prevention initiatives that can be adapted for use in Aboriginal communities is included.

The recommendations of this report are as follows:

- More Aboriginal, youth-specific services and prevention programs need to be developed and maintained. Rural areas, isolated areas and on-reserve need special attention.
- More targeted prevention messages that recognize the unique cultures of First Nations, Métis and Inuit youth need to be developed and maintained.
- When developing a prevention message for Aboriginal youth it can not be assumed that traditional teachings will be effective. The entire context of the target population must be considered.
- Prevention initiatives must target those younger than 15 years old.
- Youth prevention messages must focus on IDU, and Aboriginal communities must be educated that IDU is a problem.
- A national conference on Aboriginal youth and HIV prevention should be held to allow youth and youth workers to meet and discuss on-going prevention initiatives.
- A coordinated, national strategy for Aboriginal youth HIV prevention should be developed.
- More money must be made available to organizations to design, deliver and maintain youth prevention messages.

Prevention of HIV transmission is more than just stopping the spread of a disease. It's the preserving of the past, maintaining the present and ensuring the future of Aboriginal peoples in Canada.

— Sonia Isaac-Mann, BSC, MSC

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SECTION 1
INTRODUCTION

1.1 WHAT IS THIS REPORT ABOUT?

This is the final report of a research project entitled HIV Prevention Messages for Canadian Aboriginal Youth. In these pages, you will find:

- a review of selected literature dealing with HIV prevention for Canadian Aboriginal youth and youth around the world;
- a set of recommendations for designing and delivering HIV prevention messages for Aboriginal youth; and
- an inventory of existing youth-specific HIV prevention initiatives and resources that can be adapted for use in Aboriginal communities.

In this project, we have defined 'youth' as those between the ages of 15-29. The terms 'youth', and 'young people' are used interchangeably.

The term 'Aboriginal' refers to First Nations (status and non-status), Métis, and Inuit peoples.

1.2 WHO SHOULD READ THIS REPORT?

This report is written for anyone interested in developing an HIV prevention message for Aboriginal youth or strengthening an existing one. First Nations, Métis and Inuit youth, youth workers, and community leaders will find this report useful. It highlights peer-driven and peer-involved prevention models and encourages youth to help other youth make safer, healthier choices.

1.3 HOW DID THIS PROJECT GET STARTED?

At CAAN's third annual general meeting, CAAN was directed by its membership to develop a research project that addressed youth and HIV/AIDS on a national level. HIV prevention was chosen as a focus in recognition that HIV infections are increasing among Canadian Aboriginal youth. Of the 459 confirmed Aboriginal AIDS cases and 691 new Aboriginal HIV infections in 2002, youth accounted for 24.6% and 27.9% respectively (CIDPC 2003: 35-40).[1] This is an approximate increase of 8% from 1998, and roughly 10% higher than youth infections in the non-Aboriginal population.

1.4 WHY FOCUS ON PREVENTION?

HIV infection is 100% preventable. In fact, prevention is still the only cure for AIDS. That it continues to spread at increasing rates among Aboriginal youth does not mean that HIV prevention is ineffective. Rather, it suggests a dangerous denial and lack of action on the part of governments and community leaders. Research shows that effective prevention strategies *can* change the way this epidemic impacts Aboriginal youth, but governments, communities, and individuals *must* get involved, take action, and support those who are infected and affected by HIV/AIDS (DeCarlo & Coates 1998; Groseclose et al 1995; ICAD 2001).

1.5 WHY FOCUS ON YOUTH?

Working with youth to stem the tide of HIV infection in First Nations, Métis and Inuit communities is an essential part of confronting the HIV/AIDS epidemic (CAAN 2003a; CAAN 2003b) and one of the most promising approaches. In every case of a country that has reduced or stopped the rate at which HIV is spread, the most spectacular reductions have been among youth (UNICEF, UNAIDS & WHO 2002:7).

[1]These are only the *reported* cases. Many other Aboriginal people are thought to be infected but do not know it or do not report it. Only some provinces record the ethnicity of positive test reports. A full 71% of confirmed AIDS cases in Canada do not have ethnic identifiers (CIDPC 2003).

Youth are particularly vulnerable to HIV infection for a variety of reasons that targeted prevention and education can address. For example:

- Many Aboriginal youth are sexually active before the age of 15, when they do not have the knowledge, the means, or the maturity to practice safer sex (Myers et al 1993: 22-23).
- Youth is often a time of experimentation with drugs and alcohol, and abuse of these substances sometimes leads to unplanned or unwanted sex, and often without a condom (OFIFC 2002; James-Traore et al 2002:4).
- Youth have a tendency to think "it will never happen to me" (UNAIDS 2001), so they are less likely to be consistent with safer sex practices (Myers et al 1993: 28 & 46;) or safer drug injection practices.

While these are only some of the factors that increase the vulnerability of Aboriginal youth to HIV infection, they clearly indicate that targeted prevention and education are necessary.

However, the news is not all bad. While HIV infection rates are high among Aboriginal youth, the vast majority of Aboriginal youth are not infected. The challenge is to keep them this way. Working with youth offers many opportunities for changing the rate at which HIV is spread in the future (CAH 2002a). For example:

- Given a safe and supportive environment, youth are often more open than adults to discussing taboo subjects such as sex and substance abuse.
- Youth are often less set in their values and behaviours than adults, and are more willing to change if they understand the reasons for doing so.
- Youth who adopt safer, healthier behaviours, perspectives and expectations while young, are likely to carry these into their adulthood and are more likely to keep themselves and others free of HIV (Rivers and Aggleton 2002).

These factors combine to make youth an essential target for HIV prevention messages. They also make youth-specific prevention messages a promising and effective approach to confronting the HIV/AIDS epidemic.

1.6 WHAT WERE THE GOALS OF THIS PROJECT?

The goals of this two-year project were as follows:

1) to review selected national and international literature dealing with HIV/AIDS among Aboriginal/ Indigenous youth;
2) to identify existing prevention strategies that can be adapted for Canadian Aboriginal youth;
3) to make recommendations for Aboriginal communities and community organizations who wish to design and deliver their own HIV/AIDS youth prevention messages;

1.7 HOW WAS THE RESEARCH DONE?

Project objectives were met through two main methods of data collection: 1) a selected literature and program review[2]; and 2) a survey of Canadian Aboriginal and mainstream AIDS Service Organizations.

All research activities were carried out by the project coordinator. However, a National Steering Committee (NSC), comprised of six (6) Aboriginal youth, and one (1) non-Aboriginal youth from AIDS Service Organizations (ASOs) and Aboriginal AIDS Service Organizations (AASOs) across Canada, provided continual guidance and advice. There were an equal number of males and females on the NSC, representing Métis, Inuit and First Nations. All regions of Canada, with the exception of the North, were represented. An Aboriginal youth research assistant was instrumental in the survey analysis, program research and production of the final report.

[2]The literature search was limited to sources found on the internet, within CAAN's library or known to CAAN's network of researchers.

SECTION 2
CANADIAN ABORIGINAL YOUTH & HIV/AIDS

2.1 CANADIAN ABORIGINAL YOUTH AND HIV/AIDS – AN OVERVIEW[3]

Aboriginal youth are overrepresented in the HIV/AIDS statistics. Currently, 30% of Aboriginal HIV infections are in youth between 20-29 years old (compared to only 20% in the non-Aboriginal population), and research indicates that the potential for the virus to spread among youth is enormous (CIDPC 2003:37). A majority (70%) of Aboriginal youth are sexually active by the time they reach 15 years of age, but very few (less than 20%) use condoms consistently (Myers et al., 1993). This is confirmed by high rates of sexually transmitted diseases and teen pregnancies (OFIFC 2002: 58) which are often seen as predictors for HIV infection.

However, being Aboriginal is not what puts youth at risk of HIV infection. Unlike the majority of non-Aboriginal youth, Aboriginal youth must deal with a number of socioeconomic factors that increase their vulnerability to HIV. As a result of colonization and the residential school system, violence, poverty and racism are commonplace in the lives of many Aboriginal youth (Barlow 2003). Learning to cope with these hardships sometimes leads to behaviours that put Aboriginal youth at risk. For example, common coping mechanisms for Aboriginal youth are migration to urban centres, street involvement and injection drug use. All of these are associated with high risk behaviours such as trading sex for food, shelter or drugs; alcohol and substance abuse; inconsistent condom use; sex with more than one partner; and sharing needles or other drug use equipment (Miller et al 2002; Neron and Roffey 2000).

To stop the spread of HIV among Aboriginal youth, HIV prevention and education is essential and it must address these socioeconomic issues that put Aboriginal youth at risk in the first place.

2.2 HIV PREVENTION MESSAGES FOR CANADIAN ABORIGINAL YOUTH[4]

Youth prevention efforts have been on-going in Aboriginal communities; however, little effort has been made to document these initiatives.[5] To help fill this gap in information, CAAN conducted the HIV Prevention Messages for Aboriginal Youth survey. The purpose of this survey was to explore the range of HIV prevention activities that are currently available to First Nations, Métis and Inuit youth in Canada. Specifically, the goals of the survey were as follows:

- To determine which sub-groups of Aboriginal youth are being targeted by prevention messages and which sub-groups are most in need;
- To identify the prevention strategies that are being used, (ex., media campaigns, street theatre, AIDS 101, etc.) and which strategies are most effective;
- To understand the barriers to HIV prevention for Aboriginal youth and how to overcome them.
- To develop recommendations for Aboriginal communities who want to strengthen their own HIV prevention program or adapt an existing one for use in their own community.

2.3 SURVEY RESULTS

The survey was divided into four main sections:

- Background Information
- Existing Prevention Messages (what's currently being done)
- Future Prevention Messages (what needs to be done)
- Barriers and Recommendations (how it should be done)

2.3.1 BACKGROUND INFORMATION

Of the organizations who responded to the survey, 54% represented a region within a province or territory, 26% represented a province or provinces, 17% were municipal

[3]For a lengthier discussion of the socioeconomic context of Canadian Aboriginal youth and HIV see CAAN 2003c.
[4]See Appendix E for details of survey design and analysis.
[5]A targeted literature search turned up one article on HIV/AIDS prevention for Aboriginal youth, and 3 articles on culturally appropriate HIV/AIDS interventions for Aboriginal communities. Another 7 articles were found that discussed Native American interventions.

and 3% were national in scope (Table C.1). The majority of surveys were received from Ontario (40%), followed by BC (17%), Alberta (14%), Manitoba (8.6%), Saskatchewan, Quebec, Nova Scotia (5.7% each), and finally, Newfoundland (2.9%) (Table C.2). That no surveys were received from New Brunswick, Prince Edward Island, Yukon, Northwest Territories or Nunavut, points to a larger problem of limited Aboriginal HIV/AIDS services in some provinces and territories. For example, there is only one Aboriginal AIDS Service Organization in the entire Atlantic Region.

Forty-five percent (45%) of all respondents identified as Aboriginal service organizations (Table C.3). To break this down further, 81% of Aboriginal organizations said they served Status First Nations clients, 75% served non-Status First Nations clients, 87.5% served Métis clients and 75% served Inuit clients (Table C.4). Interestingly, the non-Aboriginal organizations who serve Aboriginal clients reported serving each of these sub-groups in almost the same proportions, with the exception of Inuit. Only 26% of non-Aboriginal organizations reported having Inuit clients (Table C.6). This supports anecdotal evidence that Inuit are marginalized and underserved outside of Inuit communities.

Among Aboriginal service providers, only 28.6% said they specialized in serving Aboriginal youth (Table C.7). Youth on and off reserve and in urban and rural areas received equal attention (by 77% of respondents) while only 33% of respondents said they were reaching out to youth in Inuit and Métis communities (Table C.8). Interestingly, 88.5% of organizations who said they did not specialize in serving Aboriginal youth, said that Aboriginal youth used their services (Table C.9). First Nations and Métis were well represented among youth who used non-Aboriginal youth services (88% and 85% respectively), while Inuit youth were again underrepresented (42%) (Table C.10). The survey did not allow for respondents to put forward reasons for why particular groups were accessing their services and others were not. However, that Aboriginal youth are accessing non-Aboriginal services in such great numbers points to the lack of Aboriginal, youth- specific services in Canada (Maracle 2002).

Finding #1 – There is an insufficient number of Aboriginal youth-specific or youth-friendly AIDS prevention programs and services to meet the rising demand. Aboriginal youth are seeking services from non-Aboriginal organizations or migrating to urban centres to access the services they need.

2.3.2 PREVENTION MESSAGES

A primary goal of the survey was to identify the target groups currently being served, and those most in need. The responses indicate that a broad range of prevention messages are being offered, but in order to be effective in reducing the spread of HIV amongst Aboriginal youth, more messages need to be available, more funding needs to be available, and the focus of Aboriginal, youth-specific prevention work must shift.

Culture-based Messages

Eighty percent (80%) of all respondents said they were involved in delivering prevention messages to Aboriginal youth (Table C.11). Ninety-three percent (93%) of these messages were meant for First Nations youth, 82% were meant for Métis youth and 53% targeted Inuit youth (Table C.12). While these numbers confirm that there is an imbalance in the groups being targeted, a larger issue is that several respondents expressed concern over what seems to be a pan-Aboriginal approach that masks the diversity between First Nations, Métis and Inuit youth. This lack of First Nations, Métis or Inuit specific messages for youth was noted by several respondents (Appendix D.8).

There are only a handful of Inuit specific HIV/AIDS prevention/awareness/education initiatives.

Nothing is happening in my community for Métis youth – lost in a big city.

Although [we] serve a diverse community of women, youth and particularly Aboriginal youth, are largely invisible. We aren't necessarily reaching them.

Finding #2 – Current prevention messages tend to treat Aboriginal people as a homogeneous group. These kinds of messages are not effective.

When asked about the use of traditional teachings, 57% of respondents said they included Elders or Traditional teachings in their work (Table C.17). The most common ways of using Elders in prevention work is as advisors, role models and teachers, and those who used them spoke highly of their experiences (Appendix D.5).

However, for a variety of reasons, not all organizations use Elders or Traditional Teachings (Appendix D.6), nor do they plan to in the near future.

We would love to have more traditional teachings but soon as anyone starts talking culture, the teens tune them out. This area was strongly influenced by residential school (shame was taught in relationship to culture, so teens won't let us talk culture or if we do we lose credibility with the adolescents).

Do not assume all Aboriginal youth are interested in traditions. Offer both traditional and urbanized programs (Appendix D.16).

Not all Aboriginal youth are interested in the Medicine Wheel or Tree of Creation. So know your audience. Speak to them and find out what they want (Appendix D.17).

Finding #3 – It is important to understand that 'cultural' does not always mean 'traditional'. Not all youth will respond to prevention messages that use Traditional Teachings or Elders as a cultural component.

Age groups

In terms of particular target populations, the available prevention messages cover a broad range of sub-groups. Messages that target 15-19 year olds were very popular (96.3%) followed closely by the 20-24 year old group (92.6%) and the 25-29 year old group (81.5%). Twenty-two percent (22%) of respondents said their prevention messages targeted youth under 15 years old (Table C.13). However, when asked what age groups are most in need of prevention messages, these numbers shifted significantly. Only 85.7% of respondents said that the age group most in need was 15-19, 71.4% said 20-24, and 51.4% said that 25-29 year olds were most in need. Notably, 40% of respondents felt that youth under 15 years old were the age group most in need of prevention messages (Table C.29). This respondent echoes the feelings of others (Appendix D.11):

Message needs to be given earlier and more often, before youth have experience in unsafe practices.

Finding #4 – Prevention messages for 15-29 year olds are still necessary, but Aboriginal youth are engaging in unsafe sex practices before the age of 15.

Risk Group

The most common risk groups for targeted prevention messages were:

1) straight females (92.6%),
2) straight males and two-spirited females (88.9%),
3) two-spirited males and injection drug users (IDU) (85.2%), and
4) street-involved youth (81.5%) (Table C.14).

However, when asked what risk group is most in need of prevention messages, respondents indicated the following list of priorities:

1) straight females, injection drug users and street involved youth (88.2%)
2) straight males (82.4%),
3) bisexual males (79.4%) and
4) two-spirited males (76.5%).

While the difference in percentages between these two lists is slight, the shift in priorities is significant because it reflects the reality of HIV transmission among Aboriginal people. The main mode of HIV transmission is IDU (64%), and straight females account for roughly 50% of those infected. That these two groups are listed as those most in need of prevention messages indicate that Aboriginal people and organizations are very aware of the problems they have in relation to HIV, and they know that something must be done to target these groups. They are not denying these problems exist, as is sometimes suggested by non-Aboriginal organizations.

Don't want to talk about IDU * Aboriginal Org? Crosstabulation

	Aboriginal Organization	Non-Aboriginal Organization
Don't want to talk about IDU (checked)	7	13
Total cases	16	18
Total Percent	43%	72%

This table shows the difference in perception between Aboriginal and non-Aboriginal organizations in relation to IDU in Aboriginal communities. Seventy-two percent (72%) of non-Aboriginal organizations think that Aboriginal people do not want to talk about IDU, compared to 43% of Aboriginal organizations who see this as a barrier to prevention education.

Finding #5 – IDU is the risk group most in need of prevention messages.

Finding #6 – While there is some unwillingness in Aboriginal communities to acknowledge this as a problem, non-Aboriginal organizations see this as a bigger barrier to effective prevention than Aboriginal organizations.

Prevention Approach

Among survey respondents, the most common types of prevention work were:

1) condom distribution (96.4%),
2) community outreach (92.9%),
3) prevention education (82.1%) and
4) AIDS 101 (78.6%).

Sexual and reproductive health education (64.3%), peer education and needle exchange (53.6% each) were slightly less common. However, when asked what the most effective approaches were to HIV prevention, respondents indicated a different order of preference:

1) Peer education (94.3%)
2) Condom distribution (85.7%),

3) Sexual and Reproductive Health Education and Community Outreach (77.1%),

4) Street outreach and Life Skills (71.4%).

Interestingly, prevention education (68.6%), AIDS 101 and needle exchange (65.7%) were thought to be slightly less effective. It's important to note here that many of these categories overlap and can be used in conjunction with other approaches. For example, AIDS 101 can be taught by peers or by professionals, and needle exchange can be a part of street outreach. For this reason, it is not advisable to put too much weight on the prioritization of various approaches.

However, having said that, Peer Education deserves special attention. Peer education is listed as the most effective approach to HIV prevention by 94.3% of respondents, and when asked to make recommendations on how to design prevention messages for Aboriginal youth, an overwhelming majority of respondents (79%) recommended having peers create the message or be involved in creating it (Appendix D.16 & D.17).

> *Peer created messages – find out what is important for them. Engage the Aboriginal youth and have them develop preventative campaigns that are relevant to them.*
>
> *I believe strongly that all prevention messages for Aboriginal youth need to come from a peer-based program.*

Given that peer education has so much support from the survey respondents, it is somewhat surprising that only 53.6% of respondents currently use this approach. A possible explanation for this is that peer education is sometimes difficult to carry out. Organizations who wish to use this approach must be prepared to deal with the multiple challenges of working with peer educators. This often means giving up on adult ideas of how things should work. However, the rewards of working with youth are also well-documented.

> *Peer education programs by far would be the answer. Peers listen to peers.*
>
> *Youth teaching youth provides an environment of understanding. No assumptions or fewer assumptions can be made based on age.*
>
> *Enlist the help of youth – they know what will interest the youth.*

Finding #7 – Peer education can be challenging but this is overshadowed by the rewards and education benefits to youth. Peer education is the overwhelming choice for HIV prevention.

Barriers and Recommendations

In a series of questions that asked about youth-specific prevention messages in the community, region and country, the overwhelming response was that there are not enough prevention messages for First Nations, Métis or Inuit to reverse the trend of rising rates of HIV/AIDS among youth (Table C.19-C.27 & Appendix D.8-D.10).

> *I think there is a lot going on, but not enough. The numbers are rising and youth are not taking it seriously.*
>
> *Youth in general are not getting the awareness messages they need. Most think it still only affects LGBT Two-Spirited or IDU communities.*
>
> *We believe that an increase in available programs is needed. Many communities have no access to programs.*

Finding #8 – There are not enough First Nations, Métis or Inuit prevention messages to reverse the trend of rising rates of HIV/AIDS among youth.

Finding #9 – Many respondents were not aware of prevention work for Aboriginal youth outside their city or region.

When asked to explain why there is a lack of prevention messages for First Nations, Métis and Inuit youth, the most common reason given was lack of funding. Almost 80% of respondents listed lack of money, lack of resources or both as a primary reason for not delivering Aboriginal, youth-specific prevention messages (Table C.15 & Appendix D.1, D.8, & D.9).

> *We have an educational program but no manpower to deliver it.*
>
> *We are the only ASO for our region, consisting of two growing cities and a large rural area. With only 3 staff, there is only so much we can do.*
>
> *The largest barrier is inconsistent funding which leads to inconsistent projects, high turnover in staff, less effective initiatives, limited abilities, etc.*
>
> *We have a very large region, a small staff and of course funding is limited.*

Finding #10 – Aboriginal youth are over represented in the HIV/AIDS statistics in Canada, yet there is a consistent and wide-spread lack of funding and human resources available to fight this epidemic.

Recommendations for Effective Prevention Messages

The final section of the survey asked for recommendations on how to design and deliver prevention messages for Aboriginal youth (Appendix D.26 & D.27). The findings of this section are consistent with recommendations made by other researchers and are already implied in the findings above.

1) *Know your target group* – clear messages to a clearly defined sub-group are more effective than blanket messages targeting all Aboriginal youth. First Nations, Métis and Inuit youth have different messaging needs, as do IDU, sexually active youth and those who are not yet sexually active.

2) *Involve leaders in the community* – this increases community participation in the project, and builds capacity and awareness in the community (Brassard 1996).

3) *Involve members of your target population from the very beginning* – this increases the likelihood that the message will be effective, it builds capacity among youth, and increases the likelihood that initiatives will be maintained (Brassard 1996; Crown et al 1993; Majumdar et al 2004).

4) *Use peer education strategies* – as noted above, peer education was overwhelmingly favoured by survey respondents. This will be discussed in greater detail in the section entitled "Charting a Course of Action".

5) *Aim to motivate and empower rather than instruct or teach* – HIV prevention should be about empowering youth to make positive behavioral change and healthy life choices that will reduce their risk of becoming infected. Telling youth what to do or how to behave is an ineffective approach because it takes away their power to make their own choices. Motivating and encouraging youth to make changes builds self-confidence, self-esteem and life skills.

6) *Use the language and social codes of your target group* – Use language and venues that youth relate to and are familiar with. For example, use video games, comic books, colorful graphics, rap songs or other popular music to get your message across. Disseminate your message at sporting events, rock concerts, skate parks, bars and other places youth hang-out.

7) *Make your message culturally appropriate* – this is essential to achieving in-depth and sustainable change in youth behaviour, however, be careful not to equate 'culture' with 'tradition'. Traditional teachings are appropriate in some settings and not in others. Let the community decide what is culturally appropriate.

8) *Use real images and positive language* – HIV prevention should be about showing youth a safer, healthier way to live their lives, not about scaring them. Using real images and positive language can help combat the fear and stigma associated with HIV. For example, a picture of a real person with HIV is more effective than a model. A positive message such as 'protect yourself because you're worth it', is more effective than scare tactics (Sullivan 1991).

9) *Use the language of the group you are targeting* – Even the best prevention message will be ineffective if people can not understand it. Messages that have been translated into Inuktituut or Cree or Ojibway, etc., will be more effective than messages in English only.

10) *Use a Human Rights Approach* – HIV/AIDS prevention and education is an issue of human rights. Youth have the right to knowledge, information and services that will save their lives and keep them free of HIV. Governments and political leaders who set policies and make decisions on spending need to be held accountable for their lack of commitment to HIV/AIDS prevention.

11) *Build in an evaluation process from the beginning of your initiative* – evaluations are an excellent way of measuring progress and success. By evaluating your message from the very beginning, you can make small or large changes that might impact the success of your message. It will also help you and others develop your next prevention initiative (Cooper et al 2000; Majumdar 2004).

12) *HAVE FUN!* – Youth are much more likely to pay attention when they are interested, engaged, and having a good time. Use humour to deliver your message. Schedule prevention and education workshops around other social events that youth will enjoy.

The next section focuses on International Youth and HIV/AIDS Prevention. Examples are given of prevention initiatives from the International community that can be adapted for use with First Nations, Métis or Inuit communities.

SECTION 3
INTERNATIONAL YOUTH & HIV/AIDS

3.1 INTERNATIONAL YOUTH AND HIV/AIDS – AN OVERVIEW

High rates of HIV infection are not unique to Canadian Aboriginal youth. Of the estimated 42 million people who were living with HIV/AIDS at the end of 2002, approximately 1/3, or 12 million, of those were youth (UNESCO 2002). Young people between the ages of 15-24 now account for 50% of new infections world-wide (James-Traore 2002) and each day almost 7000 youth become newly infected (CAH 2002b). Most of these young people will die before their 35th birthday (Avert 2003) because less than $^{1}/_{4}$ of youth at highest risk of HIV infection have access to even basic information or services (UNICEF, UNAIDS & WHO 2002; UNAIDS 2003).

Latest estimates from UNAIDS indicate that 70% of the world's youth living with HIV/AIDS live in the developing countries of sub-Saharan Africa (UNICEF, UNAIDS & WHO 2002). However, when looked at on a per capita basis, the world's indigenous youth are also highly and disproportionately affected and infected by HIV (Farrell et al 1999; Matiation nd). Canada's Aboriginal people are among them.

3.2 INDIGENOUS YOUTH ARE AT GREATEST RISK

There are approximately 300 million indigenous people living in more than 70 countries worldwide (HDN KC Team 2002). Roughly 100 million of these are under 25 years old (UNICEF, UNAIDS & WHO 2002). While the diversity amongst Indigenous groups is great, there are also a number of structural similarities. Indigenous people tend to be economically disadvantaged; landless, displaced from their ancestral lands, or live in rural locations; have lower educational attainment rates than the dominant society in which they live; and have more health issues than their non-indigenous counterparts. Their traditional language is often threatened, their traditional culture is often compromised, and they struggle to retain their traditional knowledge (Farrell et al 1999).

Most of these situations can be attributed to colonization and the individualized and systemic discrimination that colonization has resulted in. Most of these situations can also be said to contribute to the HIV vulnerability of indigenous peoples worldwide.

In order to fully participate in society, indigenous people and members of ethnic minority groups must learn to negotiate social, economic, political, and educational barriers that the dominant society places in their path. A prime example of this systemic discrimination is the lack of targeted, culturally appropriate, HIV prevention messages for the majority of the worlds indigenous people, and particularly, indigenous youth (HDN KC Team 2002; Farrell et al 1999).[6]

3.3 YOUTH HIV/AIDS PREVENTION IN THE INTERNATIONAL COMMUNITY

On an individual basis, International HIV/AIDS Organizations have been calling for more youth prevention programs for years. Recently however, organizations are beginning to join forces in an effort to mobilize greater resources for this essential prevention effort (UNICEF 2002; UNESCO & UNAIDS 2001; IPPF 2002). Perhaps the most ambitious effort to date has been by the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS held in 2001. At this meeting, UNGASS members recognized that youth are among the hardest hit by the HIV/AIDS epidemic and agreed that prevention programs targeted at youth are the key to stopping the spread of HIV/AIDS. A 'Declaration of Commitment' was prepared that committed all signatories to ensuring that by 2005,

> At least 90% of young men and women aged 15-24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health care providers (UNICEF 2002).

This means that UNGASS members and their partners have made an unprecedented commitment to designing and delivering effective youth-specific HIV prevention messages worldwide. The challenge now is for member countries to meet their targets.

[6]Other examples of systemic discrimination that contribute to HIV vulnerability among indigenous youth are: lack of social supports when individuals are forced to leave their home communities in search of employment or economic opportunity; inaccessible or culturally inappropriate health services; street-involvement due to migration from their home community; poverty, and illness (Matiation nd).

3.4 CHARTING A COURSE OF ACTION

Just as there are many ways of becoming infected with HIV, there are many approaches to preventing it. HIV/AIDS is too large and complex a problem for only one solution. A joint publication by UNICEF, UNAIDS, and WHO (2002) suggests various approaches to HIV prevention that can be adapted for use in any country. Each of the prevention strategies can stand alone as an independent prevention initiative, or it can be used in conjunction with others. Each of these approaches is outlined below, along with an example of a prevention initiative from the international community that can be adapted for First Nations, Métis and / or Inuit youth. Where possible, HIV prevention programs for Indigenous youth are highlighted.

1) Anti-Fear, Stigma and Discrimination Campaigns

Fear of stigma and discrimination from families, friends, and community is a powerful force *against* change. It discourages questions and honest conversations about sensitive topics, and keeps people locked in unhealthy behaviors. Breaking the silence, secrecy and shame that sometimes surrounds HIV/AIDS is essential in correcting wrong assumptions about who can get HIV, in clearing confusion about how HIV can be transmitted, and in motivating people to think differently about people who are HIV infected (UNAIDS 2001).

In countries such as Uganda and Thailand, where there has been strong political leadership and willingness to discuss HIV openly, the infection rates among youth have dropped dramatically. In Uganda, rates of youth infection have gone from 28% in the early 1990s to 5% in 2003 (POZ 2003b:24). Thailand has had similar success (POZ 2003a:11).

An excellent example of a break the silence campaign is **Africa Alive**!. This is an innovative, multi-level approach to HIV/AIDS awareness that uses popular media and entertainment avenues such as concerts, rap sessions, sporting events, internet, radio, TV, games, and comics to get youth (and adults) talking about HIV. Events are organized on community and national levels, and messages are aimed at youth between the ages of 10-24, both in and out of school.

A common feature of Africa Alive! events is role-model training workshops. In these workshops, artists, media, sports and music personalities that are popular with youth receive training in HIV/AIDS education, and are shown ways of integrating HIV/AIDS prevention messages into their work. Recent role-modeling workshops in Zambia and Uganda have resulted in highly successful rap concerts and soccer tournaments where condoms were freely distributed and HIV prevention messages were chanted by the crowds.

For more information on Africa Alive! and the success of role-modeling workshops, go to www.africaalive.org.

2) Education and Awareness Campaigns

Part of the reason that young people are vulnerable to HIV is that many of them do not have access to the information or knowledge that would help to protect them from becoming infected. For instance, vast majorities of the world's youth have no idea how HIV is transmitted, and in many parts of the world, upwards of 60% of youth cannot name even a single method of self-protection (UNAIDS and WHO 2002; UNICEF 2002).

School-based education and prevention programs have proven track records and easy access to youth.[7] However, many of the world's youth have never gone to school, or have stopped going for a variety of reasons. These youth tend to engage in more high-risk behaviours than their counterparts who remain in school (AIDS Action 2000), and they are more difficult to reach with generic HIV prevention messages.

An example of a prevention initiative that provides young people with up-to-date knowledge and information that is not school-based is **YES! (Youth Empowerment System)** in Peru. YES! stations were designed and constructed by youth. They were set up in parks or plazas that were already popular with youth, and offered them a place to talk about sexual and reproductive health (SRH) issues and receive accurate information on HIV. YES! stations were managed and operated by youth who developed a number of culturally appropriate and age appropriate educational materials. They ran rap sessions, discussions, private counseling and clinical referrals. They were particularly effective in reaching younger youth, between the ages of 10-14.

For more information on how to establish YES! stations in your community, see http://www.ippf.org/resource/pdf/HIV_learning_field.pdf.

[7]See Stewart et al 2001 for an excellent discussion of the pros and cons of school-based programs.

3) Life-Skills Education

Ensuring that youth have the necessary knowledge to protect themselves from HIV is important. However, it is equally important that they have the skills they need to turn this knowledge into practice. There are many reasons that youth might not abandon high-risk activities even though they know they are putting themselves and others at risk. Social and cultural norms (Farrell et al 1999), peer pressure (Myers et al 1993), socioeconomic factors (CAH 2002b), and the typically adventurous and reckless attitude of youth, play a large part in youth decisions to consciously engage in high-risk behaviours such as penetrative sex without a condom and sharing injection drug equipment.

Life Skills Education has proven to be an effective means of reducing risky behaviour by helping youth turn knowledge of HIV prevention into action. This kind of intervention teaches such skills as negotiation and conflict resolution; how to discuss difficult topics with friends, partners, and parents; job skills; self-confidence; healthy sexuality; healthy boundaries; self-respect; and respect for others.

Ginew/Golden Eagle is an after-school youth development program for urban Native American youth and their parents or guardians. The program serves over 400 youth per year (5 to 18 years old) and teaches them life skills, such as how (and why) to say no to drugs and alcohol; how to deal with negative emotions; how to build resilience; and how to make healthy decisions. The program encourages learning about Native Traditions, and uses culturally appropriate activities to "nurture and strengthen the mind, body, emotions and spirit" (Chase and Clement 2000:1).

A two-year follow-up evaluation of this program found significant differences between those who went through the program and those who did not. Ginew graduates were more likely to:

- feel that Native values were important;
- to have a close friend to talk to; and
- to believe that they could make it through difficult times.

For more information on Ginew/Golden Eagle, see www.maicnet.org/GoldenEagle/default.html.

Another excellent example of Life Skills Education is **Go Grrrls**. This is a curriculum-based after school program that promotes positive psychosocial development for young adolescent girls. Topics covered include, establishing a healthy body-image, understanding sexuality, and developing healthy peer relationships. Evaluations found that this program impacts positively on participant's assertiveness, self-liking and competence.

For more information, or to obtain a Go Grrrls workbook, see http://www.public.asu.edu/~lecroy/gogrrrls/body.htm.

4) Youth-Friendly Services

Hospitals and clinics can be intimidating places, and especially so for young people. Youth-friendly health services help to create a comfortable atmosphere for youth and relieve the anxiety that is often associated with seeking medical attention. Ideally, they are conveniently located and provide youth with a full range of information and services, including HIV prevention. Youth centers that provide health information and limited medical services are an effective alternative (James-Traore et al 2002:19).

In **Zambia**, 63 youth-friendly clinics are staffed by more than 200 peer educators. Nurses and health practitioners provide medical treatment, but peer educators provide information on HIV/AIDS, STIs and pregnancy. They also act as 'middle men' for youth who come to the clinic, and offer support on relationships, rape and other issues (UNICEF, UNAIDS & WHO 2002:30-31).

For more information on this project see http://www.scouting.org.za/resources/aids/youthcampaign.html.

5) Voluntary Testing and Counseling (VTC)

Recent estimates indicate that the vast majority of HIV positive youth do not know they are infected, and do not know the HIV status of their sexual partners (CAH 2002a). Less than 10% of teens who become infected in the United States undergo testing to learn their HIV status (AIDS Action 2000), and roughly 25% of all those who are infected globally get tested (POZ 2003d: 28).

Voluntary testing and counseling (VTC) is thought to be an effective prevention strategy for many reasons. When testing and counseling are combined, it is a win-win situation. It provides an opportunity for those being

tested to learn about HIV prevention (POZ 2003c: 26-27), and also to learn their HIV status. A negative test result acts as an incentive for people to stay that way, while a positive test result encourages people to protect their partners (POZ 2003d:28).

VCT for youth should be done in a youth-friendly environment that is conveniently located and ensures confidentiality (Horizons 2001). In Uganda, this is accomplished through mobile VCT units that travel to rural locations to test local citizens (POZ 2003c: 26-27).

For recommendations on how to attract youth to VCT, see http://www.popcouncil.org/horizons/ressum/vct_youth.html.

6) Peer-Education

Peer education is among the most popular and most effective approaches to HIV/AIDS education (UNAIDS/World Economic Forum/United Nations Foundation 2002). It recognizes that youth are influenced by the behaviour of other youth and uses positive youth role models to encourage positive behaviour change. Learning is participatory and supportive rather than hierarchical, and youth gradually become empowered to make safer choices through the mutual process of discussing, asking questions, and trying things out with their peers. Peer educators are not expected to be professionals. They are only expected to share the knowledge they have and to be supportive of their peers (AFN 2004).

In Yunnan, China, the **Yunnan Red Cross** trained peer educators to educate youth on life skills needed to make safer choices in relation to HIV infection, injection drug use, and adolescent reproductive health. The project trained 78 peer educators who gave workshops to 1300 youth. 90% of program participants said they acquired a good understanding of HIV/AIDS, learned to protect themselves from HIV infection, and significantly improved their attitudes towards people living with HIV/AIDS (UNESCAP 2003).

For more information on this peer education strategy, please see http://www.unesco.org/education/educprog/pead/GB/AIDSGB/AIDSGBtx/BestPrac/China.html.

7) Engage young people who are living with HIV/AIDS (PHAs).

One of the most enduring misconceptions about HIV/AIDS is that 'it can't happen to me'. However, nothing could be further from the truth, because HIV truly does not discriminate. Among the most effective ways to get this message out to youth is to engage young PHAs to share their experience of being infected. By speaking out, PHAs can challenge the stigma that is associated with HIV by showing that HIV can infect anyone. They can impress on youth the need to practice safe behaviours consistently, and they can role model healthy, productive lives with HIV.

In a rural district outside Chiang Mai, Thailand, **The Clear Skies Project** was created by youth PHAs to advocate and provide support for people living with HIV/AIDS. They train family members to look after those who are sick; provide education to health care workers who work with PHAs; and speak at conferences and schools "on the realities, risks and pains of HIV infection" (UNAIDS 1998:11). They have been very successful in changing youth attitudes toward PHAs from discrimination to compassion.

For more information on this project, please see http://www.scouting.org.za/resources/aids/youthcampaign.html.

8) Create safe and supportive environments.

Providing youth with the tools and information to protect themselves from HIV is only half the battle. Youth must feel that their health (sexual and otherwise) is worth protecting, and for that to happen, they must feel safe and supported at school, at home and in their communities. Violence, sexual abuse and sexual exploitation must not be tolerated at any level, and parents, schools and communities must be given the tools and the resources to create a caring and supportive environment. More subtle forms of discrimination, such as promoting early sexual activity, and devaluing education, can be equally damaging (James-Traore 2002:9).

Among the most effective ways to influence policies, social norms, and cultural practices is through mass marketing or media campaigns that directly involve youth in the planning and implementation stages. An example from Namibia is a comic book series called **Popya**, that tells the story of a young girl who goes on the radio to talk about her experience of being infected with HIV by

her uncle. The comic tackles issues of sexual exploitation, stigma, and misinformation (Strika Entertainment Ltd nd).

9) Reach out to those most at risk.

Marginalized youth, such as those who are street-involved, use injection drugs (IDU), trade sex for money, drugs, or accommodations, are out of school, in jail, or in abusive relationships are those most at risk of HIV infection. These are difficult populations to reach with prevention messages but the effort must be made for two reasons: 1) to provide information on HIV prevention to those who may not have it, and are most in need, and 2) to keep a concentrated epidemic (an epidemic that is limited to one group of people, such as injection drug-users) from spilling over into the general population.

The **Programa Integrado para Marginalidade Social** (PIM Project) offers counseling, anti-drug programs, vocational courses, and income generating opportunities to the most vulnerable and socially excluded youth in Rio de Janeiro, Brazil. The aim of this project is to lift youth out of poverty and to teach them the life skills they need to protect themselves against HIV.

For more information on this project, see http://www.unaids.org/html/pub/Topics/Partnership-Menus/PDF/BRAZILyoung_en_pdf.pdf.

10) Strengthen partnerships

The key to successful HIV prevention for youth is partnerships (World Bank Group 2003). Combining ideas and resources with another, or several other, organizations such as government, boards of education, the private sector, non-governmental organizations (NGOs), and community groups, means a more effective prevention program, and one that is farther reaching. Partnerships can happen at a community level, at an international level, and any combination in between. NGOs such as UNAIDS often partner with regional governments and community groups to bring HIV education to those most in need. However, private industry can also be an excellent partner.[8]

The concept of partnership is firmly established in HIV/AIDS work, however, the **Family Planning Association of Nepal** (FPAN) is a good example of an organization whose work has benefited from seeking partnerships with other agencies. Their goal of increasing access to sexual and reproductive health (SRH) information for young Nepalese women was accomplished by asking local agencies to integrate SRH information into their services and programs.

For more information on FPAN, see http://www.ippf.org/resource/pdf/HIV_learning_field.pdf.

[8]Levi-Strauss, Coca Cola and Microsoft have all established funding pots for HIV/AIDS (Morrison and Summers 2003: 180).

SECTION 4
CONCLUSIONS AND RECOMMENDATIONS

4.1 CONCLUSIONS

The goals of this project – to review selected literature, to present the results of a survey on prevention messages for Aboriginal youth, to make recommendations for developing an effective prevention message, and to create an inventory of existing prevention messages that can be adapted for use in Aboriginal communities – have been met. While there is very little research related to Aboriginal youth and HIV prevention, data collected through the HIV Prevention Messages for Canadian Aboriginal Youth survey has helped to fill this gap in knowledge.

Specifically, the survey found that more prevention messages for First Nations, Métis and Inuit youth are needed if the rising rates of infection are to be stopped. The focus of prevention messages needs to be on injection drug use and Aboriginal communities need to be educated that IDU is a problem. The best way to deliver a prevention message is using peer education. Involving youth in every step of the design and development of prevention messages is an effective approach to designing effective messages. Organizations are generally not aware of prevention efforts that take place in other parts of the country because there is no mechanism for this. Organizations are already resource poor, and it is beyond their means to keep current with the prevention campaigns of other regions in Canada. Finally, a lack of consistent funding was cited as the biggest reason for not engaging in prevention efforts for Aboriginal youth. While almost all organizations see this as necessary, they do not have the resources to dedicate to it.

Two sets of recommendations followed from the survey. One set of recommendations were directed at creating effective prevention messages for Aboriginal youth, while the other set of recommendations were policy related and meant to influence the direction of prevention efforts.

To make it easier for organizations to implement effective youth prevention, an inventory of Aboriginal youth resources and programs was created and included in this report. To supplement this, 10 prevention initiatives from around the world were highlighted that Aboriginal communities can draw from when designing or strengthening a prevention message for Aboriginal youth. While these examples were drawn from the international community, they were chosen for their ability to be adapted for use by any country.

4.2 RECOMMENDATIONS

1) **More Aboriginal, youth-specific services and prevention programs need to be developed and maintained. Rural areas, isolated areas and on-reserve need special attention.** Aboriginal youth are not getting the prevention messages and services they need to protect themselves and to stop the spread of HIV among youth.

2) **More targeted prevention messages that recognize the unique cultures of First Nations, Métis and Inuit youth need to be developed and maintained.** Prevention messages that treat Aboriginal youth as one homogenous group are not effective. Messages must be targeted and culturally appropriate.

3) **When developing a prevention message for Aboriginal youth, 'culturally appropriate' must not be misunderstood as 'traditional'.** Not all youth are interested in traditional teachings or respond to them. This must be considered before designing a prevention message for any particular group.

4) **Prevention initiatives must target those younger than 15 years old.** Aboriginal youth are often sexually active before the age of 15 so prevention messages must reach them before unsafe practices have begun.

5) **Youth prevention messages must focus on IDU, and Aboriginal communities must be educated that IDU is a problem.** IDU accounts for 64% of HIV infections in the Aboriginal community and a large portion of these are youth. Prevention messages must target IDU populations, and Aboriginal communities must be educated that IDU is a problem.

6) **A national conference on Aboriginal youth and HIV prevention should be held to allow youth and youth workers to meet and discuss on-going prevention initiatives.** Organizations report that

they are not aware of prevention work that is happening on a national level or in other regions of the country. A national conference would allow for the exchange of opinions, views, experiences and knowledge of what works and what does not.

7) **A coordinated, comprehensive national strategy for Aboriginal youth HIV prevention should be developed and implemented.** This would provide a framework for local organizations to work under and reduce the sense of working in isolation that many organizations report.

8) **More money must be made available to organizations to design, deliver and maintain youth prevention messages.** The current level of funding is not sufficient to meet the demand for youth-specific prevention messages. Governments must make more money available for this purpose and must recognize their responsibility to Aboriginal people and Aboriginal youth in particular.

SELECTED ORGANIZATIONS AND RESOURCES RELATED TO ABORIGINAL YOUTH AND HIV/AIDS

*Indicates that the organization, program or resource is Aboriginal specific.

**Indicates that the program or resource has content specific to Aboriginal youth.

Underlined organizations are those that participated in the survey.

NATIONAL ORGANIZATIONS AND RESOURCES

***Assembly of First Nations (AFN)**
1 Nicholas Street, Suite 1200
Ottawa, ON K1N 7B7
Ph: (613) 241-6789
Fx: (613) 241-5808
Web: www.afn.ca

The AFN works from a policy level to improve issues that affect the lives of Aboriginal people. They have produced several resources on Aboriginal youth and HIV/AIDS, including:

- *Beating the Challenge: HIV/AIDS Resource Guide* (1997)
- *Beating the Challenge: First Nations Youth HIV/AIDS Education Manual* (1998)
- *Eagles' Challenge: A Peer Education Training Manual for First Nations Youth on HIV/AIDS and Related Issues* (2004)

Canadian AIDS Society (CAS)
309 Cooper St. 4th Floor
Ottawa, ON K2P 0G5
Ph: (613) 230-3580
Fx: (613) 563-4998
Email: CASinfo@cdnaids.ca
Wed: www.cdnaids.ca

CAS is comprised of 115 HIV/AIDS community-based organizations from across the country. They have an energetic youth program that is inclusive of Aboriginal youth. Their website is a valuable source of information.

***The Canadian Inuit HIV/AIDS Network (CIHAN)**
Pauktuutit Inuit Women's Association
131 Bank St. 3rd Floor
Ottawa, ON K2A 1W8
Ph: (613) 238-3977
Web: www.pauktuutit.ca

CIHAN has produced many excellent resources for Inuit and Inuit youth, including:

- Lifesavers – 'traditionally flavoured' condoms (ex., cloudberry, seal, etc.)
- AIDS puzzle created by and for Inuit youth
- HIV/AIDS resources in Inuktitut

CIHAN also sponsors AIDS Walks in Inuit communities and Arctic Health Fairs. Their website contains a list of HIV/AIDS videos for Inuit and Aboriginal communities.

***Métis National Council (MNC)**
350 Sparks St., Suite 201
Ottawa, ON K1R 7S8
Toll Free:1-800-928-6330
Ph: (613) 232-3216
Fx: (613) 232-4262
Web: www.metisnation.ca

MNC has an enthusiastic youth council and a demonstrated commitment to the fight against

HIV/AIDS. Among the Métis-specific resources they have created are:

- *Métis Youth Talking Circles on HIV/AIDS: The Guide* (no date)
- *HIV/AIDS: The Basic Facts for Métis Communities* (2003)

PROVINCIAL ORGANIZATIONS AND RESOURCES

YUKON, NORTHWEST TERRITORIES AND NUNAVUT

****Blood Ties Four Directions Centre**
4230F-4th Ave
Whitehorse, Yukon Y1A 1R8
Ph: 1-877-333-2437 or (867) 633-2437
Fx: (867) 633-2447

Blood Ties Four Directions Centre serves clients from the Yukon and Northern B.C. They provide education on HIV/AIDS, advocacy and harm reduction. The Supper Club, a community drop-in, and outreach are important services for Aboriginal youth.

BRITISH COLUMBIA

****North Island AIDS Society**
North Island AIDS Society
355-6th St.
Courtenay, BC V9N 1M2
Ph: (250) 338-7400
Email: niac9@shaw.ca

North Island's youth prevention methods include professional and peer education on HIV/AIDS at schools, Friendship Centres, youth groups and on-reserve. Male and female condoms are provided to communities (urban and on-reserve). In-house and mobile needle exchanges, and harm reduction programs are provided for youth.

***AIDS Society of Kamloops**
P.O. Box 1064, 437 Lansdowne St.
Kamloops, BC V2C 6H2
Ph: (250) 372-7585
Web: www.aidskamloops.bc.ca

The society's HIV/AIDS prevention work for youth provides education through presentations at high schools, youth groups and youth organizations. Condoms and needle exchange are provided. Outreach is offered to rural communities, and a support service is offered to those affected by HIV/AIDS.

***Okanagan Aboriginal AIDS Society**
101-266 Lawrence Avenue
Kelowna BC V1Y 6L3
TF: 1-800-616-2437
Ph: (250) 862-2481
Fx: (250) 862-8662
Web: www.oaas.ca

This organization provides information and support to Aboriginal communities regarding HIV/AIDS, Hepatitis C and harm reduction.

****Tillicum Haus Native Friendship Centre**
927 Haliburton St.
Nanaimo, BC V9R 6N4
Ph: (250) 753-8291
Fx: (250) 753-6560
Web: http://www.tillicumhaus.ca/std.htm

In addition to their HIV/AIDS program, Tillicum Haus has partnered with a youth group from Swaziland to create a community prevention program using traditional story-telling techniques and 7 foot puppets (*AIDS ONE TIME* video is available).

****Chee Mamuk Aboriginal Program**
STD/AIDS Control BC Centre for Disease Control
655 12th Ave. W.
Vancouver BC V5Z 4R4
TF: 1-877-667-6668
Fx: (604) 775-0808
Web: http://bccdc.org

Chee Mamuk provides education and training to BC's Aboriginal people on HIV/AIDS and sexually transmitted diseases through workshops, training, health fairs and research. They have created excellent Aboriginal, youth-specific resources from their youth initiatives:

- Chako, Coming of Age Program (video and guidebook are available)
- Youth Strengthening the Circle Project (peer education, video and game are available)

****Healing Our Spirit**
202-2425 Quebec St.
Vancouver, B.C. V5T 4L6
Ph: 604-872-8885
Fx: 604-872-8805
Web: www.healingourspirit.org

Their mandate is to provide support to those affected by HIV/AIDS, and to prevent and reduce the spread of the virus by increasing awareness amongst First Nations peoples (rural and urban) through culturally appropriate methods. Among the resources they have created are:

- The H.A.P.P.Y. Workshop (for youth, by youth)
- Sharing the Spirit Workshop (video and youth facilitators manual are available)

****Vancouver Native Health Society**
441 East Hastings St.
Vancouver, BC V6A 1P5
Ph: (604) 254-9937
Fx: (604) 254-9948
Web: http://www.vnhs.net

This organization supports and serves Native people with HIV/AIDS, by providing a drop-in, lunches or food through their food bank program, home healthcare for specified residences, and rent supplements. The Youth Safe House is a short term project aimed at offering at-risk street youth, between the ages of 13-15, a safe environment to live in. See website for more details.

Youth Community Outreach AIDS Society (YouthCO)
#205-1104 Hornby Street
Vancouver, BC V6B 1V8
Ph: 1-877-YOUTHCO or (604) 688-1441
Fx: (604) 688-4932
Confidential Support Line (604) 808-7209
Email: information@youthco.org
Web: www.youthco.org

YouthCO is a non-profit organization working with youth ages 15 - 29 in addressing HIV, Hepatitis C and related issues. They provide prevention education and support services to youth living with or affected by HIV and/or Hepatitis C. They strongly believe in the merit of peer based programming, supporting positive youth, and culturally relevant prevention messages for Aboriginal youth.

AIDS Vancouver Island (AVI)
1601 Blanshard St.
Victoria, BC V8W 2L5
Ph: (250) 384-2366
Email: info@avi.org
Web: http://avi.org

AVI gives over 400 presentations per year in local schools on HIV/AIDS prevention methods. They distribute condoms and provide outreach to those who need it. They have worked with First Nations groups on HIV education and Train-the-Trainer programs.

ALBERTA

****Alberta Native Friendship Centre Association**
Suite 700, 10707-100 Avenue
Edmonton, Alberta T5J 3M1
Ph: (780) 423-3138
Fx: (780) 425-6277
Web: www.albertafriendshipcentres.ca/hivaids.htm

Wiya Wapaki is an Aboriginal HIV/AIDS Awareness and Prevention program with a strong youth component. Among the culturally appropriate resources they have produced are:

- *Wiya Wapaki* Newsletters
- *Journey Through The Wheel* (2003) – a facilitator's manual for train-the-trainer workshops.
- HIV/AIDS prevention posters

Street Works
C/O Boyle Street Co-op
10116-105 Street
Edmonton, AB T5H 0K2
Ph: (780) 424-4106
Fx: (780) 425-2205

Streetworks believes in the promotion of healthy living. Some of the services offered include supporting their clients and educating the public on HIV/AIDS, distributing condoms, street outreach and more.

Wood Buffalo HIV/AIDS Society
205-10012 A Franklin Ave.
Fort Mc Murray, AB T9H 2KG
Ph: (780) 743-9200
Email: lgwbhas@telus.net

Wood Buffalo goes to local schools to educate kids on Hepatitis C and HIV. They have a successful outreach program for Aboriginal communities and youth that promotes education and awareness of HIV/AIDS.

HIV West Yellowhead Society/AIDS Jasper
Box 2427
Jasper, Alberta T0E 1E0
Ph/Fx: 780-852-5274
Email: ed@hivwestyellowhead.com
Web: www.hivwestyellowhead.com

This organization provides free condoms, education on methods of HIV/AIDS prevention, referrals, and an extensive library of resources on various issues relating to HIV/AIDS.

SASKATCHEWAN

File Hills Qu'Appelle Tribal Council
Starblanket Reserve
P.O. Box 985
Fort Qu'Appelle, SK S0G 1S0
Ph: (306) 332-8295
Fx: (306) 332-1811

The Health/Nurse Educator makes presentations to schools on HIV/AIDS and human sexuality and provides condoms to 11 communities. Youth are reached through culture camps where they are taught about HIV/AIDS and methods of prevention.

All Nations Hope AIDS Network (ANHAN)
Scotia Bank Building
1504 B Albert Street
Regina, SK S4P 2S4
Ph: 1-877-210-7622 or (306) 924-8427
Web: http://www.allnationshope.ca/

This is the only Aboriginal ASO in Saskatchewan (the Regina Friendship Centre also offers youth HIV/AIDS programs). ANHAN supports those living with HIV/AIDS, and work to prevent the spread of HIV and Hep C through peer education, harm-reduction programs, and referrals and support services for those affected.

Rainbow Youth Centre
977 McTavish St.
Regina, SK S4T 3V2
Ph: 306-757-9743
Fx: 306-757-9759
Email: Rainbow@accesscom.ca
Web: www.rainbowyouth.com

This centre provides services and programs for youth, such as teen pregnancy programs, employment programs and recreational activities, and street outreach and support for Aboriginal youth.

MANITOBA

Red Prairie AIDS Project
Brandon Friendship Centre
836 Lorne Ave
Brandon, MB R7A 0T8
Ph: (204) 729-8112 or 727-1407
Email: redpraire@yahoo.ca

This organizations youth prevention work includes presentations on HIV, Train the Trainer programs for individuals and organizations, providing information on prevention methods to the public, and distribution of posters, pamphlets and condoms.

Sexuality Education Resource Centre (SERC)
2nd Floor, 555 Broadway Ave.
Winnipeg, MB R3C 0W4
Phone: (204) 982-7800
Fax: (204) 982-7819
Web: www.serc.mb.ca

SERC is a community-based, non-profit, pro-choice organization committed to promoting universal access to comprehensive, reliable information and services about sexuality and reproductive health issues. SERC and Kali Shiva AIDS Services (below) have partnered to produce the following resources on sexual health, harm reduction and HIV/AIDS:

- *Harsh Reality: Ideas for Youth by the Youth Working Group* (2001)
- *Harsh Reality 2: More Ideas for Youth by the Youth Working Group* (2002)

These guides are developed by youth for youth, and are excellent sources of information on youth-issues.

****Nine Circles Community Health Centre**
705 Broadway
Winnipeg MB R3G 0X2
Ph: (204) 940-6000
Fx: (240) 940-6027
Email: NineCircles@NineCircles.CA
Web: www.ninecircles.ca

The Aboriginal, culture-based HIV/AIDS programs run by Nine Circles include:

- Circle Room Ceremonies
- Cultural Awareness Training
- Cultural Support
- Sweat Lodge

The *Manitoba Aboriginal AIDS Task Force (MAATF)* and *Kali Shiva AIDS Services* are also a part of Nine Circles.

ONTARIO

AIDS Committee of Simcoe County
80 Bradford St. Suite 336
Barrie, ON L4N 6S7
Ph: (705) 722-6778
Email: acschopetroupe@rogers.com
Web: www.acsc.ca

This organizations youth prevention work includes "safe sex" drop-ins at local high schools and at their office, condom distribution and a youth theatre troupe called "HOPE". HOPE is comprised of at risk youth and other interested youth.

AIDS Committee of London (ACOL)
#120-388 Dundas St.
London, ON N6B 1V7
Ph: (519) 434-1601
Fx: (519) 434-1843
Email: aidslondon@www.dc.com

This organization provides outreach, needle exchange, and harm reduction programs in partnership with another local youth service organization. Their prevention messages are delivered through education of safer IDU and sex practices. They have a youth group for GLBT youth from the ages of 14-24.

****Wabano Centre for Aboriginal Health**
299 Montreal Road
Ottawa, ON K1L 6B8
Ph: (613) 748-7668 ext.22
Fx: (613) 748-7802
Web: www.wabano.com

Wabano offers HIV/AIDS education and prevention to the community through "The Stories Are My Teachers" program. This culture-based program promotes healthy choices and informs people of high risk behaviours through the use of performing arts. For youth programs, please contact them directly.

****Ontario Métis Aboriginal Association**
452 Albert St. E., 2nd Floor
Sault Ste. Marie, ON P6A 2J8
TF: 1-877-696-6466
Ph: (705) 272-2562
Web: www.omaa.org

OMAA's HIV/AIDS program includes workshops on HIV/AIDS that have been presented at schools, communities (on reserves and in urban areas), and correctional institutions. An OMAA employee co-wrote the AIDS song "Somebody's Dressed to Die".

AIDS Niagara
111 Church St.
St. Catherines, ON L2R 3C9
Ph: (905) 984-8684

This organization's prevention programs for youth include Train-the-Trainer workshops on HIV/AIDS, needle exchange and peer support. They work with local Friendship Centres, and train staff on issues related to HIV/AIDS.

***Anishnawbe Health Toronto**
255 Queen Street. E.
Toronto, ON M5A 1S4
Ph: (416) 360-0486
Fx: (416) 365-1083
Email: reception@aht.ca
Web: http://www.aht.ca/test/index.html

This Aboriginal health centre provides anonymous HIV testing, needle exchange and a Native Talking Circle for those living with HIV/AIDS and/or those affected by the virus.

****Native Child and Family Service of Toronto (NCFST)**
464 Yonge St., Suite 201
Toronto. ON M4Y 1W9
Ph: (416) 969-8510
Fx: (416) 969-9251
Web: www.nativechild.org

The NCFST has an active youth program that includes a youth drop-in, HIV/AIDS awareness and support for those living with the virus, street outreach, and outreach services to correctional institutions.

****Ontario Aboriginal HIV/AIDS Strategy**
2nd Floor, 43 Elm St.
Toronto, ON M5G 1H1
Ph: (416) 944-9481
Email: strategy@2spirits.com

The strategy was implemented to address the needs of Ontario's Aboriginal people infected and affected by HIV/AIDS through a holistic approach. Their youth prevention work includes promoting healthy living, production of a peer education manual, HIV 101, mentoring programs, life skills and much more. Contact them directly for more information.

****2-Spirited People of the 1st Nations**
43 Elm St. 2nd Floor
Toronto, ON M5G 1H1
Ph: (416) 944-9300
Email: info@2spirits.com

This organization provides workshops on HIV/AIDS and healthy sexuality to Aboriginal youth and staff at Native organizations. Drop-in, community dinners and a movie are weekly events within this organization. Staff talks to youth directly about safe sex and distributes condoms, posters and pamphlets that increase awareness of HIV/AIDS.

Voices of Positive Women
66 Isabella St., Suite 105
Toronto, ON M4Y 1N3
Ph: (416) 324-8703
Email: voices@vopw.org
Web: www.vopw.org

This organization works in conjunction with Positive Youth Outreach to provide a safe, comfortable environment for young women to gather socially. Peer support is provided, and HIV positive woman give talks to communities to increase awareness of HIV/AIDS.

AIDS Thunder Bay
217 Algoma St.
Thunder Bay, ON P7A 8A9
Ph: (807) 345- 1516
Web: www.aidsthunderbay.org

This organizations prevention includes peer education and awareness, and harm reduction programs. Programs and resources they have created include:

- *Smart Choices Outreach Project and Evaluation* (SCOPE) – aimed at raising awareness of high risk activities at bars and in the community
- *Injection Drug Use Outreach* (IDUO) – uses peers to teach harm-reduction
- Social marketing tools (posters) in bus shelters, bathrooms and billboards

See their website for specific examples of poster campaigns.

QUEBEC

****Native Friendship Centre of Montreal (NFCM)**
2001 St. Laurent Boulevard
Montreal, Que. H2X 2T3
Ph (514) 499-1854
Fx: (514) 499-9436

Urban Aboriginal HIV/AIDS Support Service
The goal of this project is to provide information and increase awareness of HIV/AIDS to the urban Aboriginal community of Montreal, and to support those infected/affected by HIV/AIDS through the promotion of a positive community. NFCM provides education and prevention workshops, healthy sexuality workshops, youth drop-in, community HIV/AIDS information gatherings, and street outreach.

NEW BRUNSWICK

AIDS New Brunswick
65 Brunswick Street
Fredericton, NB E3B 1G5
TF: 1 800-561-4009
Ph: (506) 459-7518

This organization seeks to support people living with HIV/AIDS, and prevent the spread of HIV/AIDS by providing leadership and resources, promoting healthy living, and non-discriminatory policies. The

Youth Advisory Committee distributes HIV/AIDS materials (pamphlets, stickers for HIV/AIDS info line), and maintains a youth-centred section on the AIDS New Brunswick website.

NOVA SCOTIA

****Healing Our Nations**
Atlantic First Nations AIDS Task Force
45 Alderney Dr. Suite 607
Dartmouth, NS B24 2N6
TF: 1-800-565-4255
Email: prevention@accesswave.ca
Web: www.healingournations.ca

This organizations prevention messages for Aboriginal youth includes AIDS 101, promotion of HIV/AIDS at Health Fairs and Youth Fairs, interaction with youth, discussions with community about high risk activities, and using games to teach life skills. They have an excellent website that contains information on HIV/AIDS, Medicine Wheel teachings, and links to other ASOs in Nova Scotia, New Brunswick and PEI.

Mainline Needle Exchange
Mainline Needle Exchange
2158 Gottingen St.
Halifax, NS B3K 3B4
Ph: (902) 423-9991
Email: main2@micmaccentre.ca

This organization promotes healthy living and respects the choices of their clients. They run many prevention programs in the outlying areas of Halifax, including needle exchange, condom distribution, peer counseling, anonymous HIV/AIDS testing, and food bank outreach programs.

PRINCE EDWARD ISLAND

AIDS PEI
10 St. Peters Road
Charlottetown, PEI C1A 5N3
TF: 1-800-314-2437
Ph: (902) 566-2437
Fx: (902) 626-3400
Email: info@aidspei.com

AIDS P.E.I. believes in supporting people living with HIV/AIDS and developing effective prevention programs. They offer an anonymous HIV/AIDS information line, food bank, support funds, massage therapy and peer support.

NEWFOUNDLAND AND LABRADOR

****HIV/AIDS Labrador Project**
Labrador Friendship Centre
49 Grenfell Street
P.O. Box 767, Stn. "B"
Happy Valley – Goose Bay, LB
A0P 1E0
TF: 1-800-806-9980
Ph: 709-896-5144
Fx: 709-896-8731
Email: hiv-aidslabradorproject@superweb.ca

This project is designed raise awareness of HIV/AIDS in the Labrador area through a number of initiatives. Projects are focused on youth, and presentations are made at schools, youth centres, youth gatherings, and various Aboriginal communities. "Fear Factor" competitions, in which competitors must answer questions related to HIV/AIDS to pass to the next level, are always popular with community youth and families.

INTERNATIONAL RESOURCES ON THE WEB

Family Health International
www.fhi.org

FHI/UNAIDS Best Practices in HIV/AIDS Prevention Collection
This is a collection of 20 HIV prevention initiatives from developing countries that have met UNAIDS 'Best Practice' criteria. The strategies presented here are innovative, effective and comprehensive, and can be adapted for use in Aboriginal communities.

***The National Native American AIDS Prevention Centre**
Web: www.nnaapc.org

The Centre's main goal is to prevent the spread of HIV and improve the quality of life for Native Americans, Alaskan Natives and Native Hawaiians. Their website includes links to other Native American AIDS organizations.

***NDN Rights**
http://ndnrights.org/

This is a Native American site devoted to sharing information on HIV/AIDS amongst Aboriginal peoples in North America. It includes a list of Aboriginal-specific HIV/AIDS projects in the United States.

UNAIDS
www.unaids.org

HIV/AIDS and Human Rights: Young People in Action
This is a 'kit of ideas for youth organizations' that is grounded in a human rights approach. It offers ideas for peer education strategies, HIV prevention and advocacy.

****U. S. Department of Health and Human Services – Indian Health Service**
http://www.ihs.gov/MedicalPrograms/aids/hiv-coe-native-american-aids-specific-resources.asp

HIV Centre of Excellence
This website contains links to Native American AIDS-specific sites and resources. One of the links leads to a young Native American Peer Education Theatre Troupe called The Ogitchidag Gikinooamaagad Players.

Youth AIDS
www.youthaids.org

This organization works in 40 countries around the world to protect and educate youth about HIV/AIDS through the use of popular culture. With the support of popular celebrities like Ashley Judd, Missy Elliot and Quincy Jones, Youth AIDS hopes to raise awareness of HIV/AIDS among young people around the world. Links to six Youth AIDS campaigns around the world are provided.

For more International and Native American resources, please see the section entitled "Charting a Course of Action".

APPENDIX A
NATIONAL STEERING COMMITTEE MEMBERS

Jamie Myrah
Peer Education Program Coordinator
YouthCO AIDS Society
Vancouver, BC

Suzanne Nyce
Sunfire Aboriginal Youth Project
Healing Our Spirit BC Aboriginal HIV/AIDS Society
Vancouver, BC

Ashley Norton
Hepatitis C/Peer Education Coordinator
All Nations Hope AIDS Network
Regina, SK

Angelina Amaral
Youth Education Coordinator
Healing Our Nations
Fredericton, NB

Franco Buscemi
Youth Intervenor
Inuit Tapiriit Kanatami
Ottawa, ON

Raymond Harper
Red Praire AIDS Society
Brandon, MB

Dale Unrau
Red Prairie AIDS Society
Brandon, MB

APPENDIX B

December 5, 2003

Dear **Youth Worker,**

We would like to ask for your help in completing the enclosed survey on **HIV/AIDS Prevention Messages For Aboriginal Youth In Canada.** Your contribution is important because HIV/AIDS is a serious problem for Aboriginal youth, and well-designed prevention messages can help stop the spread of HIV.

The survey should take about 30 minutes of your time, and your answers will be used to develop recommendations for Aboriginal organizations wanting to start or strengthen HIV/AIDS prevention programs in their own communities.

The Canadian Aborignal AIDS Network (CAAN) is asking for your help in identifying effective prevention messages for Aboriginal youth. You and your organization will not be identified in our report unless you ask to be. No one, besides the project coordinator, will be able to link you and your organization with the information you provide.

Please take some time to fill out this survey, and return it to us by January 9, 2003.

For more information on the survey or project, please contact Tracey Prentice at 1-888-285-2226, ext 108, or traceyp@caan.ca or by telephone at 1-888-285-2226 or 1-613-567-1817, ext. 108.

Many thanks,

Tracey Prentice, Project Coordinator
"HIV/AIDS Prevention Messages for
Canadian Aboriginal Youth"
Canadian Aborignal AIDS Network

QUICK FACTS ABOUT HIV/AIDS AND ABORIGINAL YOUTH

- Almost 30 % of new Aboriginal HIV infections are in youth between 20-29 years old;
- 24.6% of Aboriginal AIDS cases are in youth under 30;
- Aboriginal youth are more likely to contract HIV and develop AIDS than non-Aboriginal youth;
- Aboriginal youth are younger than non-Aboriginal youth when they become infected.

APPENDIX B

HIV/AIDS PREVENTION MESSAGES FOR CANADIAN ABORIGINAL YOUTH SURVEY

COMPLETING THIS SURVEY

BEFORE YOU START!

Your answers to this survey will help other organizations design and deliver effective HIV/AIDS prevention messages to Aboriginal youth in Canada. The survey will take about 30 minutes to complete.

Please read each question carefully before answering. Answer as many questions as you can.

When you are finished, put your completed survey in the return envelope. Postage is pre-paid.

Please mail it back to us by JANUARY 9, 2004.

Definitions
Aboriginal is defined as First Nations, Métis and Inuit people. Some questions will ask you to specify the group you are referring to.

Youth are defined as people aged 15 to 29.

START HERE!

Part One: Information about your organization

1. Put a checkmark (√) in the box beside the item that best describes the geographic area your organization serves. Check only one box.

- ❑ All of Canada
- ❑ More than one province (such as Atlantic provinces or Prairie provinces)
- ❑ One province or territory (such as Manitoba or Nunavut)
- ❑ A region within one province or territory (such as Northern Ontario or Labrador)
- ❑ A city (such as Edmonton or Vancouver)
- ❑ A community (such as Davis Inlet)

2. Where is the head office of your organization?

- ❑ British Columbia
- ❑ Alberta
- ❑ Saskatchewan
- ❑ Manitoba
- ❑ Ontario
- ❑ Quebec
- ❑ Nova Scotia
- ❑ New Brunswick
- ❑ Prince Edward Island
- ❑ Newfoundland/Labrador
- ❑ Nunavut
- ❑ North West Territories
- ❑ Yukon

3. **Does your organization specialize in serving Aboriginal people?**

- ❑ Yes → **If YES, what population does your organization serve? (Check ALL that apply)**
  - ❑ First Nations – Status
  - ❑ First Nations – Non-status
  - ❑ Métis
  - ❑ Inuit
- ❑ No → **If NO, do Aboriginal people sometimes use your services?**
  - ❑ Yes → **If YES, what population does your organization serve? (Check ALL that apply)**
    - ❑ First Nations – Status
    - ❑ First Nations – Non-status
    - ❑ Métis
    - ❑ Inuit
  - ❑ No
  - ❑ Don't know

4. **Does your organization specialize in serving Aboriginal youth?**

- ❑ Yes → **If YES, where are the youth you serve MOSTLY located? (Check ALL that apply)**
  - ❑ On reserve
  - ❑ Off reserve
  - ❑ In Inuit communities
  - ❑ In Métis settlements
  - ❑ In cities
  - ❑ In rural areas (under 1,000 people)
  - ❑ In remote locations (fly-in access only)
- ❑ No → **If NO, do Aboriginal youth use your services? (Check ONE.)**
  - ❑ Yes → **If YES, what population does your organization serve? (Check ALL that apply)**
    - ❑ First Nations – Status
    - ❑ First Nations – Non-status
    - ❑ Métis
    - ❑ Inuit
  - ❑ No
  - ❑ Don't know

Part Two: Existing HIV/AIDS Prevention Messages

Your answers to these questions will give us valuable information about the messages you are sending to Aboriginal youth about HIV/AIDS.

5. Is your organization involved in HIV/AIDS prevention for Aboriginal youth?

❑ Yes → **If you answered YES, complete questions 6, 7, 8 (this page) AND 9, 10, 11 (next page).**

6. Which Aboriginal group are you trying to reach? (Check ALL that apply.)

- ❑ First Nations
- ❑ Métis
- ❑ Inuit

7. Which age group are you trying to reach? (Check ALL that apply.)

- ❑ 15–19 years
- ❑ 20–24 years
- ❑ 25–29 years
- ❑ Other (please explain) _____

8. Which <u>risk group</u> is your prevention message trying to reach? (Check ALL that apply)

- ❑ Heterosexual (straight) females
- ❑ Heterosexual (straight) males
- ❑ Two Spirit (gay) males
- ❑ Two Spirit (lesbian) females
- ❑ Bisexual males
- ❑ Bisexual females
- ❑ Transgender people
- ❑ Pregnant or breast-feeding women
- ❑ Injection drug users
- ❑ Street-involved youth
- ❑ Other (please explain) _____

❑ No

If you are NOT involved in HIV/AIDS prevention for Aboriginal youth, please explain why. Check any of the answers below that apply, or write your own answer.
THEN SKIP TO PAGE 6, QUESTION #12

- ❑ We do not serve Aboriginal youth.
- ❑ Other organizations are doing it so we don't need to.
- ❑ We never thought of it.
- ❑ We don't know what to do.
- ❑ We don't have the money.
- ❑ We don't have the staff.
- ❑ I don't know.
- ❑ Other (please explain) _____

9. Which of the following BEST describes your organization's prevention work? (Check ALL that apply.)

- ❑ Peer education program
- ❑ Sexual and reproductive health education
- ❑ Needle exchange program
- ❑ Street outreach
- ❑ Community outreach
- ❑ Poster campaign
- ❑ Media campaign (such as radio or TV)
- ❑ Internet project (such as a website or chat room)
- ❑ Street theatre
- ❑ Giving out condoms
- ❑ Life-skills education
- ❑ Drop-in centre
- ❑ Prevention education programs
- ❑ AIDS 101
- ❑ Healthy boundaries program
- ❑ Other (please explain) _____

10. Does your youth prevention work involve Elders or traditional teachings?

- ❑ Yes → **If YES, please answer these questions. Attach extra pages if needed.**

  How are Elders or traditional teachings involved?

  _____
  _____
  _____
  _____

  How does your prevention work benefit youth?

  _____
  _____
  _____
  _____

- ❑ No → **If NO, does your organization plan to involve Elders or traditional teachings in future HIV/AIDS prevention messages for youth?**

  - ❑ Yes
  - ❑ No
  - ❑ Don't know

  Please explain: _____
  _____
  _____
  _____

11. **Briefly describe your organization's HIV/AIDS youth prevention work. Attach extra pages if needed.**

12. **Below we ask you to comment on how much HIV/AIDS prevention work for youth is going on in your community. We ask you to comment on First Nations, Métis, and Inuit youth. Check the box that completes the statement best for each group. If youth in that group do not live in your community, leave it blank.**

In my COMMUNITY, prevention work for:

First Nations youth is:	**Métis** youth is:	**Inuit** youth is:
❑ More than enough	❑ More than enough	❑ More than enough
❑ Enough	❑ Enough	❑ Enough
❑ Not enough	❑ Not enough	❑ Not enough
❑ Not happening	❑ Not happening	❑ Not happening
❑ I don't know	❑ I don't know	❑ I don't know

Your comments: _____

13. **Below we ask you to comment on how much HIV/AIDS prevention work for youth is going on in your REGION. We ask you to comment on First Nations, Métis, and Inuit youth. Check the box that you feel completes the statement best for each group. If youth in that group do not live in your region, leave it blank.**

In my REGION, prevention work for:

First Nations youth is:	**Métis** youth is:	**Inuit** youth is:
❑ More than enough	❑ More than enough	❑ More than enough
❑ Enough	❑ Enough	❑ Enough
❑ Not enough	❑ Not enough	❑ Not enough
❑ Not happening	❑ Not happening	❑ Not happening
❑ I don't know	❑ I don't know	❑ I don't know

Your comments: _____

14. **Below we ask you to comment on how much HIV/AIDS prevention work for youth is going on ACROSS CANADA. We ask you to comment on First Nations, Métis, and Inuit youth. Check the box that you feel completes the statement best for each group.**

ACROSS CANADA, prevention work for:

First Nations youth is:	**Métis** youth is:	**Inuit** youth is:
❑ More than enough	❑ More than enough	❑ More than enough
❑ Enough	❑ Enough	❑ Enough
❑ Not enough	❑ Not enough	❑ Not enough
❑ Not happening	❑ Not happening	❑ Not happening
❑ I don't know	❑ I don't know	❑ I don't know

Your comments: _____

Part Three: The Future of HIV/AIDS Prevention Messages for Canadian Aboriginal Youth

Your answers to the following questions will help us to see where the gaps are in HIV/AIDS prevention messages. This will help organizations decide where to focus in their prevention work.

Please give us your opinion:

15. Which or these Aboriginal groups is MOST in need of prevention messages? (Check ONE.)

- ❑ First Nations
- ❑ Métis
- ❑ Inuit
- ❑ Don't know

16. Which age groups are most in need of prevention messages? (Check ALL that apply.)

- ❑ 15 –19 years
- ❑ 20 –24 years
- ❑ 25–29 years
- ❑ Other (Please explain) _____
  _____
- ❑ Don't know

17. The following groups of Aboriginal youth are at-risk for HIV/AIDS. Which groups do you feel are most in need of prevention messages? (Check ALL that apply.)

- ❑ Heterosexual (straight) females
- ❑ Heterosexual (straight) males
- ❑ Two Spirit (gay) males
- ❑ Two Spirit (lesbian) females
- ❑ Bisexual males
- ❑ Bisexual females
- ❑ Transgender people
- ❑ Pregnant or breast-feeding females
- ❑ Injection drug users
- ❑ Street-involved youth
- ❑ Other (Please explain) _____
  _____
- ❑ Don't know

18. Which kinds of prevention work do you feel are MOST effective for Aboriginal youth? Check ALL that apply. Use the space below to explain your choices.

- ❑ Peer education program
- ❑ Sexual health education
- ❑ Needle exchange program
- ❑ Street outreach
- ❑ Community outreach
- ❑ Poster campaign
- ❑ Media campaign (such as radio or TV)
- ❑ Internet project (such as websites or chat rooms)
- ❑ Street theatre
- ❑ Giving out condoms
- ❑ Life-skills education
- ❑ Drop-in centre
- ❑ Prevention education programs
- ❑ AIDS 101
- ❑ Healthy boundaries programs
- ❑ Other (please explain below)
- ❑ Don't know

Your comments: _____

Part Four: Design and Delivery of HIV/AIDS Prevention Messages for Canadian Aboriginal Youth

Your answers to the following questions will help organizations that want to start or strengthen HIV/AIDS prevention programs for youth.

19. HIV/AIDS prevention messages for Aboriginal youth can be hard to design and deliver. In your opinion, which of the following are the most important reasons for this? (Check ALL that apply.)

- ❑ We don't have enough money.
- ❑ We don't have enough staff.
- ❑ We don't know how to do it.
- ❑ Some people do not think HIV is a problem for Aboriginal youth.
- ❑ In our community, people do not want to talk about sex.
- ❑ Some people in our community do not want **us** to talk about sex.
- ❑ Many people do not want to talk about injection drug use.

Your comments: _____

20. Do you know of any funding sources for Aboriginal Youth HIV/AIDS prevention work?

- ❑ Yes → **If YES, please share what you know. Use extra pages if needed.**
- ❑ No

21. **What advice would you give to Aboriginal communities about how to design HIV/AIDS prevention messages for youth? Use extra pages if needed.**

1) _____

2) _____

3) _____

22. **Suggest three good ways to start talking to Aboriginal communities about preventing HIV/AIDS in the youth. Use extra pages if needed.**

1) _____

2) _____

3) _____

23. **Do you have any other comments? Please make them here.**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

24. **The Canadian Aboriginal AIDS Network is making a national list or inventory of HIV/AIDS prevention programs for Aboriginal youth. Would you like your organization's work to be included? If so, please give the following information:**

Organization name: _____

Address: _____

Contact person: _____

Telephone: ( ) _____

Organization e-mail: _____ Website: _____

THANK YOU!

... for your time and for your valuable contribution to this survey.

Please put your completed survey in the stamped, addressed envelope that we provided. Mail it back to us by JANUARY 9, 2004.

For more information on this project, contact:

Tracey Prentice, Project Coordinator
Canadian Aboriginal AIDS Network
602-251 Bank Street
Ottawa, ON K2P 1X3
TF: 1-888-285-2226
PH: 1-613-567-1817, x108
Email: traceyp@caan.ca

APPENDIX C
FREQUENCY TABLES

Geographic Area					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	All of canada	1	2.9	2.9	2.9
	More than one province	3	8.6	8.6	11.4
	One province or territory	6	17.1	17.1	28.6
	Region within one province or territory	19	54.3	54.3	82.9
	City	6	17.1	17.1	100.0
	Total	35	100.0	100.0	

Table C.1: This table shows the geographic area that the organizations we surveyed serve. For example, only one organization served all of Canada while 19 organizations served a region within a province or territory (Q1)

Head Office					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	BC	6	17.1	17.1	17.1
	AB	5	14.3	14.3	31.4
	SK	2	5.7	5.7	37.1
	MB	3	8.6	8.6	45.7
	ON	14	40.0	40.0	85.7
	QC	2	5.7	5.7	91.4
	NS	2	5.7	5.7	97.1
	NFLD	1	2.9	2.9	100.0
	Total	35	100.0	100.0	

Table C.2: This table shows the number of organizations within each province. For example, 6 of the organizations we surveyed are located within the province of British Columbia, while 1 of the organization we surveyed is located within Newfoundland. (Q2)

Aboriginal Org?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	16	45.7	45.7	45.7
	No	19	54.3	54.3	100.0
	Total	35	100.0	100.0	

Table C.3: This table shows the number of organizations who identify themselves as serving mainly Aboriginal clients. 16 of the 35 organization surveyed were Aboriginal service providers, while 19 of the 35 were not. (Q3)

Groups served?			
	Count	Percent of Responses	Percent of Cases
FN-Status	13	25.5	81.3
FN-Nonstatus	12	23.5	75.0
Métis	14	27.5	87.5
Inuit	12	23.5	75.0
Total responses	51	100.0	318.8

19 missing cases; 16 valid cases

Table C.4: This table shows the political groups that organizations said they served. For example, 13 of the organizations surveyed said they serve FN-status, and 12 said they served Inuit. (Q3YESmultiple)

Aboriginal Users?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	19	54.3	100.0	100.0
Missing	NA	16	45.7		
Total		35	100.0		

Table C.5: This table shows the number of non-Aboriginal organizations who have Aboriginal clients. Significantly, all 19 of the 19 non-Aboriginal organizations we surveyed said they sometimes serve Aboriginal clients. (Q3NO)

Groups who use service			
	Count	Percent of Responses	Percent of Cases
FN-Status	16	32.0	100.0
FN-Nonstatus	15	30.0	93.8
Métis	14	28.0	87.5
Inuit	5	10.0	31.3
Total responses	50	100.0	312.6

19 missing cases; 16 valid cases

Table C.6: This table shows the Aboriginal political groups that use the services of non-Aboriginal organizations. For example, 16 of the organizations that identified themselves as not being Aboriginal-specific said that FN-status individuals used their services. 5 of the organizations said that Inuit individuals use their services. (Q3NOYESmultiple)

Serve Aboriginal Youth?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	10	28.6	28.6	28.6
	No	25	71.4	71.4	100.0
	Total	35	100.0	100.0	

Table C.7: This table shows the number of organizations we surveyed that specifically serve Aboriginal youth. Only 10 of the 35 organizations surveyed said they have Aboriginal youth-specific programming. (Q4)

Where are youth located?			
	Count	Percent of Responses	Percent of Cases
On Reserve	6	18.2	66.7
Off Reserve	7	21.2	77.8
Inuit Communities	3	9.1	33.3
Métis Settlements	3	9.1	33.3
Cities	7	21.2	77.8
Rural Areas	7	21.2	77.8
Total responses	33	100.0	366.7

26 missing cases; 9 valid cases

Table C.8: This table indicates the number of organizations surveyed who stated where the Aboriginal youth they serve are located. For example, 6 organizations out of the 33 that responded said the aboriginal youth they serve are from on reserve, while only 3 organizations said the youth they serve are from Inuit communities. (Q4YESmultiple)

Aboriginal Youth Users?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	23	65.7	88.5	88.5
	Don't know	3	8.6	11.5	100.0
	Total	26	74.3	100.0	
Missing	NA	9	25.7		
Total		35	100.0		

Table C.9: This table indicates the number of organizations surveyed who said that Aboriginal youth use their services. For example, 23 organizations said they have Aboriginal clients who use their services, and 3 organizations said they did not know. (Q4NO)

Youth groups served?			
	Count	Percent of Responses	Percent of Cases
FN-Status	20	31.3	95.2
FN-Nonstatus	17	26.6	81.0
Métis	18	28.1	85.7
Inuit	9	14.1	42.9
Total responses	64	100.0	304.8

14 missing cases; 21 valid cases

Table C.10: This table indicates the number of organizations surveyed whose services are being utilized by status and non-status First Nations, Métis and Inuit peoples. For example, 20 organizations said that status First Nations peoples access their services, while 9 organizations said Inuit peoples use their service. (Q4NOYESmultiple)

Youth Prevention?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	28	80.0	80.0	80.0
	No	7	20.0	20.0	100.0
	Total	35	100.0	100.0	

Table C.11: This table indicates how many of the organizations we surveyed are involved with HIV/AIDS prevention for Aboriginal youth. For example, 28 out of 35 organizations said they were involved with HIV/AIDS prevention for Aboriginal youth. (Q5)

Group reaching out to?			
	Count	Percent of Responses	Percent of Cases
FN	26	40.6	92.9
Métis	23	35.9	82.1
Inuit	15	23.4	53.6
Total responses	64	100.0	228.6

7 missing cases; 28 valid cases

Table C.12: This table indicates the number of organizations surveyed whose services are aimed at reaching First Nations, Métis and Inuit youth. For example, of the 28 organizations that responded, 26 said they were trying to reach First Nations youth, whereas, only 15 said they were trying to reach Inuit youth. (Q6multiple)

Age group trying to reach?			
	Count	Percent of Responses	Percent of Cases
Age 15-19	26	31.3	96.3
Age 20-24	25	30.1	92.6
Age 25-29	22	26.5	81.5
Other age group — under 15	6	6.8	22.2
Other age group — over 29	5	5.7	18.5
Other age group — Elders/seniors	4	4.5	14.8
Total responses	83	100.0	307.4

8 missing cases; 27 valid cases

Table C.13: This table indicates the number of organizations surveyed who are trying to reach a specific age group with their prevention messages. For example, 26 organizations responded by saying they are trying to reach people between the ages of 15-19, while 10 said they were trying to reach an age group other than the age ranges specified in the survey. (Q7multiple)

Risk group trying to reach?			
	Count	Percent of Responses	Percent of Cases
Straight female	25	11.0	92.6
Straight male	24	10.5	88.9
Two-Spirit male	23	10.1	85.2
Two-Spirit female	24	10.5	88.9
Bisexual male	21	9.2	77.8
Bisexual female	21	9.2	77.8
Transgender	21	9.2	77.8
Pregnant or breast-feeding	18	7.9	66.7
Injection drug user	23	10.1	85.2
Street-involved youth	22	9.6	81.5
Other	6	2.6	22.2
Total responses	228	100.0	844.4

8 missing cases; 27 valid cases

Table C.14: This table indicates the number of organizations surveyed who are trying to reach a specific risk group. For example, 25 organizations responded by saying they are trying to reach straight females, while 6 organizations said they were trying to reach a risk group other than the ones specified in the survey. (Q8multiple)

Why we do not serve Aboriginal youth			
	Count	Percent of Responses	Percent of Cases
Don't have the money	4	40.0	57.1
Don't have the staff	2	20.0	28.6
Other	4	40.0	57.1
Total responses	10	100.0	142.9

28 missing cases; 7 valid cases

Table C.15: This table indicates the number of organizations surveyed who stated why they are not involved in HIV/AIDS prevention for Aboriginal youth. For example, 4 out of the 10 organizations that responded to this question said they were not involved with HIV/AIDS prevention for Aboriginal youth because they do not have the money. (Q5NOmultiple)

Description of prevention work				
	Count	Perscent of Responses		Perscent of Cases
Peer Education	15	6.8		53.6
SRH	18	8.2		64.3
Needle Exchange	15	6.8		53.6
Street Outreach	12	5.5		42.9
Community Outreach	26	11.9		92.9
Poster Campaign	14	6.4		50.0
Media Campaign	8	3.7		28.6
Internet Project	7	3.2		25.0
Street Theatre	2	0.9		7.1
Condoms	27	12.3		96.4
Life Skills	13	5.9		46.4
Drop-in	13	5.9		46.4
Prevention Education	23	10.5		82.1
AIDS 101	22	10.0		78.6
Healthy Boundaries	4	1.8		14.3
Total responses	219	100.0	782.1	

7 missing cases; 28 valid cases

Table C.16: This table indicates the method of prevention that the organizations we surveyed are involved in. For example, 27 organizations said that they distributed condoms, 15 said they involved in peer education, and 2 organizations said they used street theatre to get their prevention message across to youth. (Q9multiple)

Elders?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	16	45.7	57.1	57.1
	No	12	34.3	42.9	100.0
	Total	28	80.0	100.0	
Missing	NA	7	20.0		
Total		35	100.0		

Table C.17: This table shows the number of organizations who use Elders or Traditional Teachings in their prevention work. For example, 16 of the 35 organizations surveyed said their prevention work involved Elders or Traditional Teachings. The 7 cases that are missing are organizations who answered NO to Q5 and therefore were not supposed to answer this question. (Q10)

Elders in future?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	6	17.1	50.0	50.0
	No	1	2.9	8.3	58.3
	Don't know	5	14.3	41.7	100.0
	Total	12	34.3	100.0	
Missing	NA	23	65.7		
Total		35	100.0		

Table C.18: This table shows the numbers of organizations surveyed who are not currently using Elders or Traditional Teachings in their work, but hope to do so in the future. For example, 6 organizations say they will use them in the future and 5 said they are not sure. (Q10NO)

FN prevention in community					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not enough	25	71.4	71.4	71.4
	Not happening	3	8.6	8.6	80.0
	I don't know	3	11.4	11.4	91.4
	Youth from this group do not live here	3	8.6	8.6	100.0
	Total	35	100.0	100.0	

Table C.19: This table shows how the organizations we surveyed rate the amount of HIV/AIDS prevention work that is being done for First Nations youth in their **community**. For example, 25 out of the 35 organizations surveyed felt that there was not enough prevention work going on in their communities for First Nations youth, and 3 organizations said that First Nations youth do not live in their community. (Q12fn)

Métis prevention in community					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not enough	20	57.1	57.1	57.1
	Not happening	4	11.4	11.4	68.6
	I don't know	7	20.0	20.0	88.6
	Youth from this group do not live here	4	11.4	11.4	100.0
	Total	35	100.0	100.0	

Table C.20: This table shows how the organizations we surveyed rate the amount of HIV/AIDS prevention work that is being done for Métis youth in their **community**. For example, 20 of the 35 organizations surveyed responded that there was not enough prevention work going on in their communities for Métis youth, and 4 organizations said that Métis youth do not live in their community. (Q12Métis)

Inuit prevention in community					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.9	2.9	2.9
	Enough	1	2.9	2.9	5.7
	Not enough	15	42.9	42.9	48.6
	Not happening	3	8.6	8.6	57.1
	I don't know	9	25.7	25.7	82.9
	Youth from this group do not live here	6	17.1	17.1	100.0
	Total	35	100.0	100.0	

Table C.21: This table shows how the organizations we surveyed rate the amount of HIV/AIDS prevention work that is being done for Inuit youth in their **community**. For example, 15 of the 35 organizations surveyed responded that there was not enough prevention work going on in their communities for Inuit youth, and 6 said that Inuit youth do not live in their community. (Q12Inuit)

FN prevention in region					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not enough	23	65.7	67.6	67.6
	Not happening	4	11.4	11.8	79.4
	I don't know	5	14.3	14.7	94.1
	Youth from this group do not live here	2	5.7	5.9	100.0
	Total	34	97.1	100.0	
Missing	NR	1	2.9		
Total		35	100.0		

Table C.22: This table shows how the organizations we surveyed rate the amount of HIV/AIDS prevention work that is being done for First Nations youth in their **region**. For example, 23 out of the 35 organizations surveyed responded that there was not enough prevention work going on in their region for First Nations youth and 2 organizations said that First Nations youth do not live in their region. (Q13fn)

Métis prevention in region					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not enough	19	54.3	55.9	55.9
	Not happening	3	8.6	8.8	64.7
	I don't know	9	25.7	26.5	91.2
	Youth from this group do not live here	3	8.6	8.8	100.0
	Total	34	97.1	100.0	
Missing	NR	1	2.9		
Total		35	100.0		

Table C.23: This table shows how the organizations we surveyed rate the amount of HIV/AIDS prevention work that is being done for Métis youth in their **region**. For example, 19 out of the 35 organizations surveyed responded that there was not enough prevention work going on in their region for Métis youth and 3 organizations said that Métis youth do not live in their region. (Q13Métis)

Inuit prevention in region					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not enough	17	48.6	51.5	51.5
	Not happening	1	2.9	3.0	54.5
	I don't know	9	25.7	27.3	81.8
	Youth from this group do not live here	6	17.1	18.2	100.0
	Total	33	94.3	100.0	
Missing	NR	2	5.7		
Total		35	100.0		

Table C.24: This table shows how the organizations we surveyed rate the amount of HIV/AIDS prevention work that is being done for Inuit youth in their **region**. For example, 17 of the 35 organizations surveyed responded that there was not enough prevention work going on in their region for Inuit youth and 6 responded that Inuit youth do not live in their region. (Q13Inuit)

FN prevention in Canada					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not enough	24	68.6	72.7	72.7
	Not happening	1	2.9	3.0	75.8
	I don't know	7	20.0	21.2	97.0
	6	1	2.9	3.0	100.0
	Total	33	94.3	100.0	
Missing	NR	2	5.7		
Total		35	100.0		

Table C.25: This table shows how the organizations we surveyed rate the amount of HIV/AIDS prevention work that is being done for First Nations youth **across Canada**. For example, 24 out of the 35 organizations surveyed responded that there was not enough prevention work going on across Canada for First Nations youth (6 = youth from this group do not live here). (Q14fn)

Métis prevention in Canada					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not enough	20	57.1	60.6	60.6
	Not happening	1	2.9	3.0	63.6
	I don't know	11	31.4	33.3	97.0
	6	1	2.9	3.0	100.0
	Total	33	94.3	100.0	
Missing	NR	2	5.7		
Total		35	100.0		

Table C.26: This table shows how the organizations we surveyed rate the amount of HIV/AIDS prevention work that is being done for Métis youth **across Canada**. For example, 20 out of the 35 organizations surveyed responded that there was not enough prevention work going on across Canada for Métis youth (6 = youth from this group do not live here). (Q14Métis)

Inuit prevention in Canada					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not enough	21	60.0	63.6	63.6
	I don't know	12	34.3	36.4	100.0
	Total	33	94.3	100.0	
Missing	NR	2	5.7		
Total		35	100.0		

Table C.27: This table shows how the organizations we surveyed rate the amount of HIV/AIDS prevention work that is being done for Inuit youth **across Canada**. For example, 21 out of the 35 organizations surveyed responded that there was not enough prevention work going on across Canada for Inuit youth and 12 responded that they did not know. (Q14Inuit)

Political group most in need?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	First Nations	13	37.1	38.2	38.2
	Inuit	1	2.9	2.9	41.2
	Don't Know	10	28.6	29.4	70.6
	All of the above — postcoded	10	28.6	29.4	100.0
	Total	34	97.1	100.0	
Missing	NR	1	2.9		
Total		35	100.0		

Table C.28: This table indicates the Aboriginal group that the organizations we surveyed think is most in need of HIV/AIDS prevention message. For example, 13 of the 35 organizations surveyed stated that First Nations was the Aboriginal group most in need of prevention messages and 10 organizations said that all groups needed prevention. (Q15)

Age most in need			
	Count	Percent of Responses	Percent of Cases
Age most in need — 15-19	30	26.8	85.7
Age most in need — 20-24	25	22.3	71.4
Age most in need — 25-29	18	16.1	51.4
Age most in need — other	18	16.1	51.4
Age most in need — other — under 15	14	12.5	40.0
Age most in need — other — over 29	3	2.7	8.6
Age most in need — other — Seniors/Elder	4	3.6	11.4
Total responses	112	100.0	320.0

0 missing cases; 35 valid cases

Table C.29: This table indicates the age group that the organizations we surveyed feel is most in need of prevention messages. For example, 30 organizations surveyed felt that prevention messages are most in need between the ages of 15-19. (Q16multiple)

Risk group most in need			
	Count	Percent of Responses	Percent of Cases
Straight female	30	11.5	88.2
Straight male	28	10.8	82.4
Two-Spirit male	26	10.0	76.5
Two-Spirit female	19	7.3	55.9
Bisexual male	27	10.4	79.4
Bisexual female	23	8.8	67.6
Transgender	20	7.7	58.8
Pregnant or breast-feeding	23	8.8	67.6
Injection drug user	30	11.5	88.2
Street-involved youth	30	11.5	88.2
Other — incarcerated youth	3	1.2	8.8
Other — sex trade workers	1	0.4	2.9
Total responses	206	100.0	764.7

1 missing case; 34 valid cases

Table C.30: This table indicates the risk group that the organizations we surveyed feel is most in need of prevention messages. For example, 30 organizations surveyed felt that straight females are most in need of prevention messages. (Q17 Multiple)

Most effective prevention messages			
	Count	Percent of Responses	Percent of Cases
Peer Education	33	9.9	94.3
SRH	27	8.1	77.1
Needle Exchange	23	6.9	65.7
Street Outreach	25	7.5	71.4
Community Outreach	27	8.1	77.1
Poster Campaign	13	3.9	37.1
Media Campaign	14	4.2	40.0
Internet Project	11	3.3	31.4
Street Theatre	17	5.1	48.6
Condoms	30	9.0	85.7
Life Skills	25	7.5	71.4
Drop-in	20	6.0	57.1
Prevention Education	24	7.2	68.6
AIDS 101	23	6.9	65.7
Healthy Boundaries	20	6.0	57.1
Other	1	0.3	2.9
Don't know	1	0.3	2.9
Total responses	334	100.0	954.3

0 missing cases; 35 valid cases

Table C.31: This table indicates the type of prevention message that the organizations we surveyed feel are the most effective for Aboriginal youth. For example, out of 35 organizations surveyed, 33 feel that peer education is the most effective kind of prevention (Q18 multiple)

Reason for difficulty delivering message			
	Count	Percent of Responses	Percent of Cases
Not enough money	23	19.7	67.6
Not enough staff	22	18.8	64.7
Don't know how	10	8.5	29.4
HIV not a problem	14	12.0	41.2
Don't want to talk about sex	13	11.1	38.2
Don't want us to talk about sex	15	12.8	44.1
Don't want to talk about IDU	20	17.1	58.8
Total responses	117	100.0	344.1

1 missing case; 34 valid cases

Table C.32: This table indicates what the organizations we surveyed believe to be the most important reasons for why prevention messages for Aboriginal youth are hard to design and deliver. For example, 23 organizations rate "not having enough money" as a problem, and 10 organizations said they would not know how to effectively design and deliver prevention messages for Aboriginal youth. (Q19multiple)

Funding					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	13	37.1	38.2	38.2
	No	21	60.0	61.8	100.0
	Total	34	97.1	100.0	
Missing	NA	7	2.9		
Total		35	100.0		

Table C.33: This table indicates the number of organizations we surveyed that responded to our questions regarding possible sources of funding for Aboriginal youth HIV/AIDS prevention. Only 13 organizations said they knew of any funding sources and 21 organizations said they did not. (Q20)

APPENDIX D
RESPONSES TO OPEN ENDED QUESTIONS

NOTE: The following list contains only the responses that were provided by organizations. If a particular survey number does not appear under a particular question (Q) it means that the organization did not respond to that question. For more detailed information please refer to Appendix B (Survey Instrument) and Appendix C (Frequency Tables)

APPENDIX D.1

Q5, NO If you are not involved in HIV/AIDS prevention work for Aboriginal youth, please explain why.

6. We have an Aboriginal staff member but we are a mainstream ASO. We will in conjunction with N'Amerind Friendship Centre access Elders by referring at this time.

16. Not in our jurisdiction.

17. Anyone is available to access our services. We have an IDU component, with needle exchange; we are partnered with a youth drop in centre for HIV/AIDS and drug basic info, we do general education sessions at schools in the community. We don't specialize in any particular ethnic or religious groups or age in this area. We do not have the resources. Also, there is a small Aboriginal population in our region, as compared to other particular groups, i.e. South Asian, Afro-Caribbean. So if we had the chance to specialize programs it would have to be a larger group that we serve.

21. Nos clientèles prioritaires ont été les femmes, avec des subventions nous pourrons sensibiliser les jeunes.

    [Our priority clients are usually women. Both with funding we could sensitize youth.]

33. Des partenaires le font, nous les soutenons.

    [Our partners are involved and we support them.]

APPENDIX D.2

Q7. Which age group are you trying to reach? Other.

1. Younger than 15 yrs. too

2. All ages.

5. School age children, all youth.

9. 12-19 years.

14. All ages.

15. Women all ages.

22. Any age, younger or older.

24. Youth, via Elders.

27. Grades 5 and up pending on who asks.

28. Also, 29+.

30. Parents.

APPENDIX D.3

Q8. Which risk group is your prevention message trying to reach? Other.

1. Guys in jail.

5. All school age children; counselors and teachers.

8. Those in group homes.

19. Prisoners, sex trade workers.

20. Older women 40+.

30. Inmates.

APPENDIX D.4

Q9. Which of the following best describes your organizations prevention work? Other.

5. Train the Trainer for community members.

9. Go Grrrls.

12. Forum Theatre / Hep. C / Train-the-Trainer.

14. AIDS Manual- Basic Facts.

19. Harm reduction training.

20. Develop print resources.

24. Training of peer counselors.

27. Risk Reduction, advocate, prescriptions to HIV positive persons (APHA's).

35. Not popular- youth mentorship program.

APPENDIX D.5

Q10. Does your youth prevention work involve Elders or Traditional teachings? If yes, (a) how are Elders or Traditional teachings involved? (b) How does your prevention work benefit youth?

2. (a) Elders are on our Advisory Committee, as well as involved in youth activities to guide us.
(b) Provide them with information about HIV/AIDS through a variety of ways.

4. (a) They speak to the youth communities.
(b) We interact with the youth instead of talking to them.

5. (a) Elders are always present at any community program; asked for their support, teachings.
(b) Yes, but there is a dire lack of direct services like on site testing.

8. (a) We involve HIV+ Aboriginal people and the health coordinator from one of the Aboriginal groups to review our programs and ensure they are culturally sensitive.
(b) Awareness and prevention.

10. (a) Annual roundance.
(b) Volunteering.

11. (a) We have an Elder on our National Steering Committee.
(b) Awareness – Community AIDS fairs – projects done by youth. Winning projects have been reproduced into various products and distribution.

13. (a) Elders are a part of our youth projects for prayers, guidance, support, teachings.
(b) Information about STDs, HIV and Hepatitis. Awareness that youth are an important part of the community, Role modeling and peer education.

14. (a) Give us advice, prayers, dialogue, recommendations.
(b) Awareness- spread the word.

15. (a) In the peer mentor training in the North, an elder was brought in to do a healing circle and we discussed Aboriginal communities needs for women and HIV.
(b) Our work is not only prevention for HIV women of all ages, but empowerment for women who are HIV+. It is prevention in the sense of harm reduction/ risk reduction, self care models. It is not just youth specific though.

19. (a) Use of traditional teachings to get message across. Prison work involves Elders, traditional healers and teachers.
(b) Give them hope for the future so they will protect themselves. Give them pride in themselves.

20. (a) Individual consultations on Aboriginal traditional perspectives on sexuality and reproductive health issues. Integration of Aboriginal traditional values and perspectives in the work being done within our organization and in the communities served.

(b) Builds cultural competency capacities for people working with Aboriginal youth (education). Promotes understanding of sexuality reproductive health issues that have a direct impact on youth.

24. (a) Elder education through workshops/presentations. They in turn are able to work with their own youth in their own community.
(b) People make good decisions when given good culturally appropriate information and resources.

27. (a) Use manuals and teachings based around the medicine wheel and traditional healing.
(b) By sending out a youth to talk to other youth.

30. (a) Elders present at gatherings.

34. (a) Speakers are invited and some volunteers also provide discussion of experience.
(b) The experience shared by positive elders serves well as a reality presentation.

35. (a) Use Medicine Wheel in AIDS 101, maintain list of elders willing to work with APHAs.
(b) Transfer of traditional teachings/ knowledge to youth.

APPENDIX D.6

Q10. If no, does your organization plan to involve Elders or Traditional teachings in future HIV/AIDS prevention messages for youth? Please explain.

1. Yes, we will use them when time is appropriate, often confined to 1 hr. presentations. Use in trainings, events, for prayers, smudging, feasts, etc.

7. Yes. Has to have involvement for effectiveness.

9. Would love to have more traditional teachings [but] soon as anyone starts talking culture, the teens tune them out. This area was strongly influenced by residential school (shame was taught in relationship to culture, so teens won't let us talk culture or if we do we loose credibility with the adolescents).

12. We do not serve Aboriginal youth specifically and therefore do not target our messages to them or offer expertise as such.

22. We would love to have Elders help, but unfortunately it is often difficult to find an Elder who is comfortable with both HIV/AIDS and Two-Spirit People. Their homophobia becomes our problem.

25. If possible.

28. Would love to use elders in these messages…time is of the essence.

29. Don't have staff, time, resources to make this priority.

31. We have partnered with a healing circle but it is in the planning stage.

32. Need to contact elders.

APPENDIX D.7

Q11. Briefly describe your organization's HIV/AIDS prevention work.

1. HIV 101 presentations to whoever requests. HIV Train the Trainer to individuals who also work in other social service organizations. Provide prevention information to those who want it. Network with orgs. looking for info, services, etc. Posters, pamphlets, condoms, etc.

2. In 2000 the Labrador Friendship Centre was approached by health officials to run a HIV/AIDS project by Aboriginal people. Our target group was communities with a special interest in youth because the numbers are rising. We do a lot of work in schools and with youth in family centres, youth centres, special events such as youth gatherings. We did a summer program geared toward youth with special fear factor competitions to get youth involved. We take the coastal boat because that is how you travel in the summer.

4. Interaction with them, be at their level.

5. As Health Educator/Nurse Educator – I speak to all grades, in all schools of the FHQTC (which involves eleven schools) on HIV/AIDS/Human Sexuality. There is also summer culture camps

that cross section of youth are taught about HIV/AIDS spread and prevention. A one day workshop on this subject was given to a Lifeskills program in 18-25 age groups. Condoms are supplied to 11 communities. In Health Hat at Ft. Qu'Appelle, a presentation at Treaty 4 celebration in September was available to approx. 4,000 students from town and surrounding area. There was one peer counseling program in one school with a potential for two more. We had 2 Train the Trainee seminars in 2 communities.

7. AVI Education provides over 400 school-based prevention presentations every year in Vancouver Island; website avi.org; outreach to PSEs / gay bars; condom/lube distribution; collaboration with First Nations groups (HIV education provision, Train-the-Trainer); Speakers Bureau (HIV+).

8. We are a small agency covering all of Northern AB. We do HIV 101 and Hep. C in the schools in their area. We will be meeting with principals from an outlying area and a school board to determine what programs will best meet the needs of their students.

9. Present to grade 7's, 8's, 9's- personal living skills class (PLS). Present to grade 10's, 11's, 12's CALM class. Various presentations done for local youth groups. Presentations = information sharing and the distribution of condoms. Had "Persons Living with HIV Society" send a presenter who was living with HIV/AIDS who presented in all the schools in this region. Had a play about HIV/AIDS presented at all local schools (Azmuth theater from Edmonton). Presently working on a HIV/AIDS awareness poster contest winner will be displayed on placemats during HIV/AIDS awareness week in December next year. Was handing out condoms in schools until they found out we aren't allowed to distribute condoms even though STI stats are high amongst our youth.

10. Needle exchange, street outreach, condom availability, testing, education, support, universal precautions.

11. You would have to see our project reports.

12. Peer run organization for youth 15-29 around issues relating to HIV/AIDS and HCV.
(1) Support programs for positive youth-HIV/HCV
   — One-on-one support, harm reduction, social activities, advocacy, outreach to "at risk" youth.
(2) Education program, on going
   — Speaker's Bureau.
   — Trained peer educators doing prevention workshops/presentations in schools and with other youth organizations.
   — Forum Theatre Troupe.
   — Interactive workshops around issues relating to HIV vulnerability, skills building.
   — Outreach, information and harm reduction, tools at variety of youth venues.
   — Print/media resources, various materials available and on website.
   — Education programs, project (Hep.C, rural Train-the-Trainer, curriculum building, Young Women's Awareness Campaign).

13. We provide workshops to youth throughout the province on HIV, STDs and Hepatitis. We also educate front-line staff and community to start testing, needle exchanges, condom distribution. See attached sheets on two of our youth projects.

14. We have held talking circles, workshops during national conferences, promotional materials distributed, condoms handed out.

15. Voices has a partnership with Positive Youth Outreach, where HIV positive young women get together socially. We have a Peer Mentor program, where HIV+ women do peer support, speak in the community and HIV awareness and public education work. Voices staff facilitates workshops for community agencies that need info. on women and HIV, including youth issues.

18. Pamphlets.

19. Harm reduction for IDUs- peer educational manual, HIV101, sexuality-healthy sexuality training, health promotion, grief and bereavement work, life skills, mentoring programs, etc.

20. Youth and STI/HIV Prevention Working Group, see Harsh Reality 1 and 2, and Sex and Prevention Pamphlets (we are known to CAAN).

22. I have done: workshops (HIV/AIDS, Healthy Sexuality) are done for the youth programs at the Native agencies (Native Canadian Centre, Native

Child and Family Services, Na-Me-Res), posters and pamphlets are dropped off, we have regular drop-in community dinner and movie (Thurs.), We have condoms available all over the place – I make a point of talking about safer sex to youth that come around.

23. ACAP funded 4 year program to educate LGBTTs youth 14-25 about HIV prevention.

24. Youth prevention thru education in schools, alternative youth groups, friendship centres, on reserve. Delivered by Aboriginal registered social worker. Condoms (male/female) are provided both in office and in community (on reserve, friendship centres, schools, youth centres) at no cost. Needle exchange/harm reduction programs in office and mobile. Train youth for peer support/education.

27. Advocate for people, for programs, resources. Info sharing, needle exchange, harm reduction, condom distribution, working with Aboriginal people, communities and youth. Youth educator does most presentations to youth.

28. Working with Friendship Centres, staff trainings, workshops, Train the Trainer.

30. Prevention and education in urban and rural communities using local AIDS committee theatre troupe (see attached brochure), education done in schools also.

31. We provide presentations on HIV and HIV related issues; pre-test counseling, links with local doctors and specialists, free condom access, needle exchange and support for people living with HIV. We also have a resource library complete with books, videos, pamphlets and internet links. We make ourselves available to ALL groups. We offer an outreach program Friday evenings.

32. We conduct safer sex drop ins at local high schools on a regular basis. At risk youth and interested youth have formed a theatre troupe whose prevention message is focused on HIV/AIDS. Offer "drop-ins" at our office to talk about sex and condom use.

34. Our education program is taken to schools at all levels. Provision of condom and needle exchange is taken to various community agencies and location. We participate in speaks at Aboriginal youth groups and associated youth service agencies. Client services also provides outreach services to rural areas with contacts made through rural community agencies. We also offer support services to youth affected by HIV/AIDS.

35. AIDS 101 is main conduit. Presence at health fairs/youth fairs. Use games to teach life skills. Interact with youth, engage with them, informal discussions with community youth about high risk activity. Discuss situation first and gear presentations to that.

APPENDIX D.8

Q12. Below we ask you to comment on how much HIV/AIDS prevention work for youth is going on in your community. We ask you to comment on First Nations, Métis, and Inuit youth. Your comments.

1. Cross cultural education is needed in this whole damn town, never mind just Aboriginal HIV prevention. 4 years of programming seems to just providing a good base for work to come.

2. We run the Métis and Innu program and supplement prevention work. Métis work is being done but First Nations are hard to reach because they have so many other issues to contend with, ie. suicide, survival. Hard to reach First Nations contact because they are always changing.

4. What is your meaning of enough!

5. I believe that there should be a counselor Nurse available to the students who are sexually active and that there should be on site testing available. We asked for a grant for this purpose but were turned down!

8. We have an educational program but no manpower to deliver it. Our staff will be taking a Train the Trainer program in the hopes that we can train, First Nations, Metis and Inuit volunteers to teach HIV 101 and Hep. C 101 in their communities.

9. My position does not cover federal land (reserve). My position involves 5 communities and I drive by the reserves on the way to the communities I work in. The health region won't allow me to go

on reserve as they are concerned that the reserve is "double dipping". I have major issues at the lack of services being provided to the reserves. Assumption and Meander can not access any of Northern Lights services unless they come to the hospital. On reserve we have very high #'s of STI's, teen pregnancy etc. yet they aren't getting any services. I have been called numerous times by Tall Cree, Beaver Nations and Ane Tha to present on HIV/AIDS, family violence, suicide etc. but I am not allowed even though the communities were willing to pay Northern Lights for my services. Soon as I am able to accumulate some time off and acquire some resources I am going to do a little contract work for the reserves. But it will still not be enough.

11. More training, more coordination and more motivation needed.

14. There are some programs but Aboriginal youth do not attend or take serious. Nothing is happening in my community for Métis youth – lost in big city.

15. Although Voices serves a diverse community of women, youth and particularly Aboriginal youth are largely invisible. We aren't necessarily reaching them, which is why I checked "not enough".

16. There are only a handful of Inuit specific HIV/AIDS prevention/awareness/education initiatives.

17. We are the only ASO for our region, consisting of two growing cities and a large rural area. With only 3 staff, there is only so much that we can accomplish.

18. The programs and pamphlets are geared for older people.

19. The Aboriginal community generally is not taking HIV seriously as a threat to our future existence!!

20. Our organization recognizes the huge need in the community that exists, the gap in services/ resources to address the needs. We recognize our responsibility to the Seventh Generation.

21. Tout comme pour les autres groupes dans les communautés les jeunes ne sont pas encore trop sensibilisés au VIH/SIDA, la formation est souvent à refaire ou répéter.

    [Like all other groups in communities, youth are not very well sensitized to HIV/AIDS. The training often has to be re-done or repeated.]

22. The youth are still getting pregnant, STD's and HIV. This tells me that not enough is getting done, that the youth are not putting the message into action and changing their behavior.

23. Can't evaluate this.

24. She has not identified any Inuit youth.

27. More money is needed, we are building partnerships with other youth drop-in centres and youth orientated programs and centres. Communities need to open their eyes that they are affected and need to help stop the spread of HIV/AIDS.

31. We do not require youth to identify themselves as First Nations, Métis or Inuit, but do know that these groups have access to our programs.

32. Native youth are not very involved in our community. Very few attend workshops or get actively involved with Native community agencies.

33. La prévention auprès des jeunes des Premières Nations serait inexistante à mon avis dans notre région, si ce n'est des activités créées au Village Huron et par le Centre d'Amitié Autochtone.

    [Prevention for First Nations youth will be non-existent as far as I'm concerned in our region if it focuses only on activities at Huron Village and by the Native Friendship Centre.]

34. Although we have some services in the community on an education and outreach basis, there are many shortfalls in prevention work that is related to lack of funding and lack of interest from community leaders.

35. Always room for improvement. Youth involvement is a way to address that, but not always easy because of stigma, discrimination, fear.

APPENDIX D.9

Q13. Below we ask you to comment on how much HIV/AIDS prevention work for youth is going on in your region. We ask you to comment on First Nations, Métis, and Inuit youth. Your comments.

1. Need more. Often people are trained to teach HIV, but are scared to do it or don't know how to start. Stigma, discrimination, still problematic. Many still don't think HIV is a problem. Many 1st Nations are unwilling to look at their local IDU problems too.

2. We have done some successful Train the Trainers. Inuit programs are run through communities that is often partnership with to deliver.

4. Define enough.

5. It is a very important message; to a very high risk group – it is not enough until statistics start improving!

6. There is a lot of work to be done for our brothers and sisters.

8. There is some prevention work going on but our area covers 28% of the province and only 2% of the population – much is First Nations, Métis and Inuit. The travel costs are prohibitive for doing extensive work. Cut backs in funding to the public health so far also impact the amount of prevention work being done.

9. Sorry, please see question #12. I answered question 13 in question #12. I think that we do a great deal of HIV/AIDS prevention work in this community but we could use more especially for the Mennonite youth who generally don't get permission to participate in any HIV/AIDS prevention programs, also for the large number of home school teens. In this community it is difficult to reach all youth as many youth are being home schooled as our schools academic/social reputation is very poor. As far as standard education in comparison to the province we rate as one of the poorest. Sorry, what I'm trying to say is on the govt. exams we had the lowest grades. The drop out rate is high because of all the employment opportunities. A youth can work in gas or forestry for $15-$20 an hour at the age of 16, its difficult to keep them in school.

11. Region to us means Inuit Regions in the Arctic. Same comment as #12.

14. Probably a lot, but I am not sure.

15. Again, I don't see HIV programming that reaches Aboriginal youth specifically, except for the HIV/Hep. C health fairs that run from the Inuit Women's Association in Ottawa. This is a problem since many Aboriginal youth are at high risk for HIV and Hep.C, among other stuff.

16. There are very few initiatives in Inuit communities that focus on HIV/AIDS. The largest barrier is inconsistent funding which leads to inconsistent projects, high turn over in staff, less effective initiatives, limited abilities, etc.

18. I said in the former comment, not enough info for young people.

23. I feel that we can't evaluate as we're one ASO in a region with many communities including 3 reserves.

24. Funding $ are decreasing. Area is rural/remote and expensive to deliver services.

27. More work needs to be done relating to Aboriginal youth in schools. Prevention needs to be stressed on reserve in schools and in all schools. It will never be enough until it has stopped infecting people.

31. We have a very large region, a small staff and of course funding is limited. As we evolve we are reaching more.

32. We have several Native Friendship Centres and circles, however it don't seem to be utilized well by youth.

33. Voir commentaires précédents.

    [See preceding comments.]

34. Once again, the various rural communities are not aware of the extent of HIV/AIDS related issues. The leadership needs to get directly involved and be seen to do so. Awareness and prevention needs to be accepted as a need by the leadership.

35. We need to do more. Also need to find more creative ways to relay information. Youth are AIDSed out. Need to reach them/practice.

*CAAN should hold educators conference to come up with more effective ways to get message across.

APPENDIX D.10

Q.14 below we ask you to comment on how much HIV/AIDS prevention work for youth is going on across Canada. We ask you to comment on First Nations, Métis, and Inuit youth. Your comments.

1. Hard to gauge this. Don't see national campaigns happening.

4. Please define enough.

5. Let's really get serious and make a difference.

6. There are some organizations such as the Ontario Aboriginal HIV/AIDS Strategy but there is still a lot of work to be done.

7. Questions 12/13/14: Obviously there is not enough services when we have an epidemic of HIV and Hep C among Aboriginals.

14. I think there is a lot going on, but not enough, the numbers are rising and youth are not taking it serious.

16. I am not sure how much is happening but I would like to know how effective the current prevention work is.

17. Youth in general are not getting the awareness messages they need. Most think it still only affects LGBT 2-Spirited or IDU communities.

21. Si elle existe, elle n'est pas très diffusée...

    [If it exists it is not well disseminated.]

24. It's never enough as we can see from stats on HIV infection rates in Aboriginal youth.

27. Never going to be enough until the virus is contain[ed]. Until governments on all levels recognize this as a serious issue.

31. We believe that an increase in available program is needed. Many communities have no access to programs.

32. Recently at a national conference I was able to observe programs for native youth that were being used well.

33. Les stratégies existent, mais les jeunes migrent beaucoup et se retrouvent dans les situations à risque lorsqu'ils sont en dehors de leurs communautés. Je ne connais pas bien ce qui se fait comme éducation sexuelle en amont, c'est-à-dire dès le jeune âge, dans ces communautés.

    [The strategies exist but the youth migrate a lot and find themselves in risky situations when they are outside their communities. I don't know what is done at the level of sexual education at this time, from a young age, in these communities.]

34. Awareness and prevention must be taken as an important step to increase community involvement. Leadership must take a leadership role!!!

35. No opportunity to see what else is going on.

APPENDIX D.11

Q16. Which age groups are most in need of prevention messages? Other.

1. Younger and older.

2. 10-14. May make a difference.

4. You started too high, start 10 yr. old.

5. School age grades 4 and up.

6. Elders.

8. Homeless.

9. 12 years +, most 13, 14 year olds report having sex. I know 13 year olds aren't old enough to consent but they are still having sex.

11. And younger. Inuit and others are often sexually active well before 15.

12. 11-14.

14. 15-29. Younger age group having sex- older youth have alcohol and drug problems, which impacts HIV/AIDS numbers.

15. Younger even (younger then 15).

16. Start embedding the message in our children and build on it until they are no longer in this world.

17. Seniors- they have not had the same messages.

20. Children under 15, older people, ALL.

24. Message needs to be given earlier and more often, before youth have experience in unsafe practices.

25. Below 15 so when they start having sex they know how to protect themselves.

27. Children ages 10+.

34. Youth in school.

35. 16-24 women IDU.

APPENDIX D.12

Q17. The following groups of Aboriginal youth are at-risk for HIV/AIDS. Which groups do you feel are most in need of prevention messages? Other.

2. People who live in crowded environments.

6. Sex trade workers.

7. At risk when incarcerated, unwanted sexual activity.

11. Many apply so I would choose don't know which are 'most'.

12. Rural youth, off reservation youth.

16. Youth with low self-esteem. All youth.

17. Seniors.

19. Prisoners (youth offenders).

20. All equally.

24. All Aboriginal youth!

27. Children as well, due to abuse and unhealthy home environments.

30. Inmates/those in the justice system.

APPENDIX D.13

Q18. Which kinds of prevention work do you feel are most effective for Aboriginal youth? Your comments.

1. These are areas I would love to expand into, but have tried different examples of each. The more creative plan (yet simple) seem to be the most effective. And it nearly always seems that the info is new to each group that participates.

2. HIV positive presenters. We are building a program that started in 2000 to provide education and awareness around the topic of HIV/AIDS. Since that time we have expanded to include training. Having an Aboriginal HIV positive person present seems to be effective. Since our beginnings we have expanded to include sexual health because our concern is not that we have a high # of HIV positive youth but that we have a high # of STDs, 10 times the national average and this could lead to HIV/AIDS in our population. We want to pass on the info to youth then summarize it and pass it on to the community in a way they are comfortable with.

6. All are needed on a basis of continuance, these messages need to be in the forefront and not hidden away.

7. Giving out condoms with good accurate information.

8. I think it is important to talk to Aboriginal people to determine what they feel best meets their needs. I would like to see more Aboriginal participation on our board and more direction from Aboriginal people.

9. I recently had the opportunity to hear from two youth (17 year old males) present H.A.P.P.Y on HIIV/AIDS and condom use. I think that was the most effective way to present materials. Peer education programs by far would be the answer. Peers listen to Peers. Guest speakers living with HIV/AIDS seems to be a great influence also. The youth gave a lot of great feedback on the guest speaker, I also noticed that the youth remembered and reported many details about HIV/AIDS and guest speaker.

14. Stronger more serious messages need to be noticeable, by all means of communication to reach all age groups. TV/Ad campaigns during key programs such as "Survivor, Friends, Price is Right". Internet gives more of an anonymous way to communicate if questions need to be asked.

15. Peer education is an effective way to reach youth. Engaging youth in creative ways of problem solving and popular education (i.e. Street Theatre) is also great! I think sexual education and life skills (i.e. negotiating safer sex, building a sense of self) are crucial to prevention. Making risk reduction tools (clean needles, condoms) free and easy to access is important. Youth aren't going to stop using drugs and having sex so they need to be able to do so safely and then make health choices for themselves. Youth feel comfortable communicating over the internet.

16. Youth teaching youth provides an environment of understanding. No assumptions or fewer assumptions can be made based on age. Sexual health education, everyone should know about sexual health for HIV, STDs, cancer, etc. Community initiatives displays community support, shows that there is little to no stigma. Giving out condoms for the sake of giving out condoms is never too popular. If and when condoms are given out, information should be provided too. Having condoms available is definitely a good idea but it requires strategy to avoid conflicts with parents and youth, youth and youth, etc.

19. Geared to youth, developed by youth, delivered by youth.

20. Whatever works. Must be diverse strategies and flexible.

21. Il est prouvé que l'éducation par les pairs fonctionne bien et particulièrement auprès des jeunes (voir programme P.E.P.). Par contre, il faut informer les jeunes en milieu scolaire et non seulement sur le VIH/SIDA. Il faut leur donner des informations de base sur la santé sexuelle, l'estime de soi, le respect de soi et de l'autre… Trop de jeunes sont ignorants de ce qu'est une sexualité saine et par conséquentils se mettent dans des situations où ils courent un risque élevé de contracter certaines maladies. Il faut aussi rendre de plus en plus accessible les moyens de protection et de prévention tels que les préservatifs, l'échange de seringues… Toutes les autre propositions mentionnées ci-haut sont aussi valables mais avec une bonne base on peut aller plus loin dans le renforcement des bonnes habitudes et l'acquisition de connaissances plus approfondies du VIH et du SIDA.

    [It is proven that peer education works well and particularly amongst youth (See PEP program). However, youth should be informed in school circles, not only around HIV/ADIS, but basic knowledge and sexual health, self-esteem, self-respect and respect of the other. Too many youth are ignorant about what is healthy sexuality and consequently will put themselves in high risk situations of contracting certain diseases. Means of protection and prevention should be made more accessible, ex. condoms, needle exchange. All the other means of prevention mentioned above are also valuable, but with a good foundation we can go even further in reinforcing good habits and acquiring more knowledge on HIV/AIDS.]

22. Youth appreciate honesty. Explicit honesty about sexual health. They respond best when you are in front of them. A poster is left to their interpretation (and mockery). I find posters generally don't stay with them. Youth will listen to peers, but we have to make sure that the peers are well educated. Youth also appreciate role playing using humor to learn about negotiation and communication skills.

24. [Peer Education] most valuable and appropriate. Storytelling, Elders. Message needs to be varied in its delivery (theatre, printed material, audio visual) to address learning styles and in location, take the message to the youth by the youth. Use elders/story telling to get message across. Use peers/personal stories – establish community 'heroes'/role models. Message needs to be introduced earlier. Educate little ones about needles/condoms, re: what to do if you find one. Info and resources (age appropriate) and before kids have experience engaging in high risk behaviour. Teach respect for self/others.

26. This education needs to be made available in all ways to all people.

27. Teaching about abstinence and risk reduction. Talking and dealing with abuse. Talking and dealing with addictions, gambling, drugs, alcohol, sex, substance. Need to have billboards and advertisements on T.V., more support in schools. Campaign for people to get testing.

30. All available medias should be used, no one solution is right for everyone.

31. If we educate our youth we arm them for the future. Knowledge empowers them to make better choices. They need to know their options, by providing condoms and needles we assist them in prevention. By having a safe, non-judgmental place to go for information, support and products we extend a hand and an opportunity to help our youth make choices.

32. Marginalized youth need services more than any other, since often they have very few resources, and are made to feel ashamed of their identity. Being native is made difficult for youth by society, being a 2-spirited native is much much more difficult due to stereotypes and discrimination attached with the minorities. MORE INFO NEEDED FOR MINORITIES.

33. Quoique tous les points pourraient s'appliquer, je crois qu'en priorité :
    - les jeunes doivent avoir un accès gratuit et facile aux préservatifs et aux méthodes de protection (seringues)
    - Ils doivent recevoir une éducation complète en ce qui concerne la sexualité
    - Ils doivent être exposés à des messages adaptés à leur culture
    - Toute la communauté doit se conscientiser à propos du problème et aux moyens d'y faire face.

    [Even though I think all the points could be applicable, in priority:
    - Youth have to have easy and free access to condoms and methods of protection (needles).
    - They should receive a complete education on sexuality.
    - They should be exposed to messages adapted to their culture.
    - The entire community should develop consciousness about this problem and a way of dealing with it.]

34. All of the programs above fail to draw attention to the need for leaders to carry the message and be seen to carry the message. Its about taking shame out of HIV and helping youth to redefine their hope for a future. Youth in many communities see themselves as unimportant and having no voice. Leaders need to give youth a voice in the community. It's not all about doing, its about speaking and being heard.

35 [Poster campaign] in bathroom, [Media campaign] local on-reserve radio, [Giving out condoms] lobby for female condoms, [Healthy boundaries programs] experience of telling young women "no" is ok. Chat-line for HIV+ youth. National Aboriginal chat line/hot line.

APPENDIX D.14

Q19. HIV/AIDS prevention messages for Aboriginal youth can be hard to design and deliver. In your opinion, which of the following are the most important reasons for this? Your comments.

1. Money and staff together, need more. And staff with the 'balls' to deliver, the education. Often people are afraid to do the education b/c "what will people think?"

2. Hard to get translator who are willing to deliver message. We have high STI rates just people cannot see correlation.

7. Relevant prevention has to involve Aboriginal people at grassroots level in design and implementation.

8. The most easily accessible place to reach Aboriginal youth would be schools and it is not always easy to get into the schools. I think it is far more effective for Aboriginal person to deliver these messages to the Aboriginal people rather then a white person.

14. Posters, Ads, outreach, all kinds of messages are out there and has been for years. Issues such as alcoholism where youth are more willing to have unprotected sex and use drugs improperly need to be linked with HIV/AIDS. More money is needed to show the connections of socio-economic impacts and HIV/AIDS.

15. I checked the 1st 3 boxes because 1 and 2 are true for our organization in terms of delivery Aboriginal specific programming. 3 full time staff for the entire province is not enough. Another barrier is that none of our staff is Aboriginal to Canada– we need input from Aboriginal Canadians to do this work effectively. Another issue is that most of our Aboriginal members are in Northern Ontario, while Voices is in Toronto. We don't see these members as much and the demand for Aboriginal-specific programming is not voiced as much.

16. HIV has a growing infection rate but a dying profile. The HIV profile needs to be revived for the messages to be heard and taken seriously.

21. Bien que le manque d'argent et le tabou entourant encore le VIH rendent difficile la mise en place de messages de prévention, je crois que plusieurs groupes qui ont émis des messages n'ont pas su atteindre le public cible. Il faut que les jeunes se sentent concernés et qu'ils se retrouvent dans ces messages. Il faut impliquer des jeunes dans la création de ces messages.

    [Even though lack of money and the fact that HIV is still taboo makes prevention messages difficult, I think that several groups that came up with messages did not know how to reach the public. Youth should feel concerned and should find themselves in these messages. Youth should be included in the creation of prevention messages.]

24. Although we have an Aboriginal R.S.W, no time/ funding to really concentrate on Aboriginal youth.

27. People are ignorant to the fact that their relatives, friends are into the street life and or drug scene. These people are pushed away and are denied support from their community. Programs for youth need to be designed by youth. Engaging youth to be a part of a HIV/AIDS project is sometimes hard due to the stigma from others. Like if you do HIV/AIDS work people ask "do you have AIDS?"

31. We have doors closed on us by people who think by us talking about HIV/AIDS and sex we are promoting "sex" for youth, that we are giving them "ideas". By offering condoms we want the youth to have "sex".

32. At my agency we do know how to talk about prevention for Aboriginal youth, and community members want that. We just don't have the staff to facilitate these messages due to funding restraints.

34. Leaders are already being paid to speak. Now they need to speak about HIV/AIDS because it affects their leadership. Youth need to be included in policy decisions.

35. Taboo from Residential school/ sex is bad. Fine with other people talking about it. IDU is increasing over last 10 years. In last year requests for education increasing.

APPENDIX D.15

Q20. Do you know any funding sources for Aboriginal youth HIV/AIDS prevention work?

1. Yes. Just Health Canada.

3. Yes. Canadian Aboriginal AIDS Network, Ontario Aboriginal AIDS Network.

7. Health Canada, VIHA (Vancouver Island Health Authority).

9. I am only aware that the Federal govt alotts $1900 per reserve to go towards HIV/AIDS education. Barb Bowditch mentioned the grant in a presentation she did on Needle Exchange program.

11. You already know what we know – Health Canada.

12. Yes. Health Canada – ACAP, provincial/regional health authorities, private foundations: i.e. Vancouver Foundation.

14. Yes. Health Canada for First Nations and Inuit.

16. No. Not for youth specifically.

19. Health Canada, Provincial Ministries of Health.

20. Health Canada, provincial dept. of health and others, private foundations/funders and others.

21. Santé Canada, DGSPSP et DGSPNI financent plusieurs projets.

[Health Canada, DGSPSP and DGSPNI finance several projects.]

24. Yes. But we are unable to access $ as we are not specifically an Aboriginal organization. We are exploring partnership options.

27. Yes. Health Canada. AIDS walk good fundraising for your community, also raises awareness.

APPENDIX D.16

Q21. What advice would you give to Aboriginal communities about how to design HIV/AIDS prevention messages for youth?

1. 1) Involve the youth. Let them design it.
   2) Hook up with the (closest) community rep. who works with HIV.
   3) Challenge youth to involve all age levels.

2. 1) Have focus groups with youth to see if that is the message that youth want sent out.
   2) Go to youth to help you design the message. Fun contests, etc. so the message comes from the youth.

3. 1) Honest and straightforward information – youth can tell if things are 'sugar-coated'.
   2) Peer-created messages – find out what is important for them. Engage the Aboriginal youth and have them develop preventative campaigns that are relevant to them.

4. 1) Educate yourself before you talk to youth.

5. 1) Start with youth worker, have him or her do the Train the Trainer workshop- then help him to incorporate prevention message in every activity they do with the youth.
   2) Peer to Peer Ed. is great, but it only can occur after there is initial teaching at school. Find a very dedicated teacher and 2 or 3 dedicated students and Train them; support them as they set up their program; help them with resources.
   3) Have on site testing and counseling even if it is just once a month.

6. 1) Make sure it is developed and disseminated by youth.

7. 1) Community-driven.
   2) Culture-based (while still acknowledging diversity within community).
   3) Healthy support team is in place (counseling, public health, etc.).

8. 1) Interactive programs are effective. Be honest, factual, and admit when you don't have answers.

9. 1) Ask the youth. If possible form a youth advisory community to give their input on what they think would be appropriate.
   2) The Aboriginal adult community would have to be aware first. It doesn't appear that the adults have a great deal of knowledge on HIV/AIDS prevention messages.
   3) a) Peer-educators (co-facilitators).
      b) Poster-placemat contest after numerous presentations (huge prize. Sorry we aren't functional enough to appreciate internal gratification.).
      c) Persons living with HIV/AIDS guest speaker, preferably a heterosexual guest speaker.

10. 1) Ask the youth directly [what] they want.
    2) Work with Elders and the youth.

11. 1) Involve youth and elders.
    2) Be creative.
    3) Focus test.

12. 1) I believe strongly that all prevention messages for Aboriginal youth need to come from a peer-based program.
    2) Information needs to be 'culturally' relevant and meaningful in the context of the daily lived experience of various sub-groups of Aboriginal youth.
    3) Skills-building (communication conflict resolution, problem solving, decision making, self-esteem) need to be integrated into the process of increasing / exchanging knowledge.

13. 1) Peer-education – ask the youth. Involve them in prevention efforts.
    2) Include Elders and front-line workers to provide guidance and support.
    3) Have money resources to carry out the project.

14. 1) Stronger messages – like the smoking ads on TV where a man lost his 40 yr old son to

cancer from smoking – harsh realities need to be shown.
2) Show that anyone is at risk – show pictures of babies, youth, male/female, show that HIV/AIDS is not prejudice.
3) Use PHAs who are dealing with the virus as spokesman to youth, go to schools, youth conferences.

15. 1) Get youth involved in every step of the process. Make them an integral part of the work.
2) Use youth language/culture to communicate prevention messages.
3) Make it fun, interactive – not a lecture. Youth hate being told what to do. Focus on self-esteem and capacity-building rather than good-bad behaviour.

16. 1) Ask Aboriginal youth what the message should be.
2) Remember your message doesn't have to pan-Aboriginal because it won't be Aboriginal anymore.
3) Be clear and honest with your messages. If your message is for FN then say it's for FN, if its for Métis then say its for Métis, if its for Inuit then say its for Inuit, if it's for a region then say its for a region, etc.

19. 1) Ask youth for help. Engage youth in the process.
2) Get them to design and develop programs. Get them to do the delivery!
3) Hire them for this!

20. 1) Ask youth. Involve them in program design and implementation.
2) Be patient.

21. 1) Impliquer des jeunes dans la création de messages. C'est la première étape et la plus importante pour arriver à les rejoindre dans leurs valeurs et leur langage.

[1) Get youth involved in the creation of youth messages. It is the first step and the most important step to understand their language and their values.]

22. 1) Be honest about sex and sexuality. Don't sugar coat anything.
2) Never say "just don't do it". Never say, "wait until you're married". Youth are going to have sex. Give them as much information as possible that is going to help them.
3) Use humor. Don't use complicated language. Use cartoons for scenarios.

23. 1) Work with as many community partners that are already doing part of this work.

24. 1) Use peers/elders.
2) Educate to reduce stigma/discrimination of HIV + persons.
3) Vary method of message delivery to address the variety of learning styles.

25. 1) Get youth involved – by youth for youth.
2) Offer youth incentive $$ for designing messages.

26. 1) Secure funding.
2) Secure people.
3) Deliver message all ways possible.

27. 1) Encourage and engage in all levels of development of initiatives. Let youth speak on behalf of themselves.
2) Don't be discriminatory. Give youth a safe environment to talk and see what they want to do in regards to programs and raising awareness/prevention.
3) Let all youth who want to participate, participate. The more diverse the better.

28. 1) Be available.

30. 1) Be interactive, involve youth in every stage of development.
2) Free food and activities work!

31. 1) Enlist the help of the youth – they know best what will interest the youth.
2) Respect beliefs. Do not assume all Aboriginal youth are interested in traditions. Offer both traditional and urbanized programs.
3) Be consistent. Say what you mean and mean what you say. Open, honest and factual information presented in a non-judgmental situation works best.

32. 1) Involve the youth – utilize their experiences.

2) Make program youth-friendly. Use ways that you use, e.g., theatre, art, talking with other youth, parties.
3) Be consistent. It takes a long time for the youth to begin accessing services.

33. 1) Utilisez les jeunes (programmes par les pairs).
2) Faites-le tôt et constamment (messages radios, campagnes scolaires, concours, préservatifs disponibles).
3) Il n'existe pas une seule façon d'en parler aux jeunes. Utilisez-en le plus possible (humour, drame, VIH = mort, etc.).
4) Oubliez les moyens très coûteux qui ont peu d'impact (ex. campagnes télé).

[1) Use youth (peer education programs).

2) Do it early and all the time (radio messages, school campaigns, competitions, condom distribution).

3) There isn't one way to talk to youth. Use all ways possible (humour, drama, HIV=death, etc.).

4) Forget about costly ways that have little impact (ex. Television campaigns).]

34. 1) Gather youth in one place and ask them about what can be done.
2) Begin leadership in the discussion and include them in getting the message to the community.
3) Develop a team made up of youth, elders, and leaders to assist in HELPING all who are ill in the community.

35. 1) Involve youth. Messages should be youth-driven about issues that are important to them.
2) Do the work! Even if they say they're not interested, do the work, get the message out there. Be consistent.
3) Use their language.

APPENDIX D.17

Q.22 Suggest three good ways to start talking to Aboriginal communities about preventing HIV/AIDS in the youth.

1. 1) Just do it (with a condom!) Find someone not afraid to talk about it.
2) Bug the leaders to promote prevention.
3) Have a troupe travel around doing presentations.

2. 1) Peer education – present material to youth, let them digest it and present it back in a way they choose, i.e., drama.
2) Respect their opinions by having them sit on advisory comities wherever possible.
3) Hold events that also combine social interaction, i.e. HIV/AIDS Fear Factor. The goal is to teach them information but it is done in an interactive way. You do a presentation and then you talk to them individually for them to answer a skill testing question about HIV/AIDS to move on to T.V. Fear Factor events. Events must be cultural, i.e., log holding, endurance challenge and a eat gross out food.

3. 1) Show them that there is a need, poster campaigns.
2) Community forums about the issues – ask for input. Create some sort of report from the discussions and look for ways that the community can act on the issues.

4. 1) Educate yourself.
2) Hire people who knows of this virus.

5. 1) The best way is to invite them to an information meeting. Talk about numbers and who's at risk, ask them how they would deal with it!
2) Talk about Africa- everybody's heard about that, we have the potential for same situation.
3) Have workshops for intergenerational survivors of residential schools. Start healing the whole community.

6. 1) Get the Elders involved.
2) Get the counsels involved in both understanding and awareness.
3) Let the community help with the info., get all involved in getting the message out there.

7.
1) Reach out to local Aboriginal groups and partner to visit remote Aboriginal communities.
2) Getting into more remote communities.
3) Make own prevention materials more relevant to Aboriginals.

8.
1) You have to make contacts in Aboriginal communities and then build a trusting relationship between gov't and them before developing any programs.
2) Programs should be developed with consent from Aboriginal people. I attended Treaty Days, their Health Fairs and work with Kimamow Ataskanow.
3) When I visit the outlying communities, I talk to the people, go to their museums, ask questions about their culture and gain a better understanding of their ways.

9.
1) Most importantly is to hire someone from community, train them and have them discuss HIV/AIDS prevention programs for youth with the rest of the community. If the person isn't from the community they may not listen.
2) It isn't the same for all communities though. Some communities will only listen to outsiders". There isn't very much exposure to media in some communities but most communities have a radio station, advertise messages on radio – in this area during radio BINGO you'd get the largest audience. (Our winters are long and cold. I'm afraid radio and TV get too much attention in this area.)
3) Where I come from a small reserve on Vancouver Island no one would listen to you unless you involved the elders. Here if you involve the elders they'll pretend to listen. Here it would be the money people you need on your side; chief and counsel.

10.
1) Bring visual presentations.
2) Bring in youth to talk and plan education and intervention.

11.
1) AIDS Fairs.
2) Host positive youth talks.
3) More and better sex ed. in school system.

12.
1) Start with a 'focus group' – what are their needs? – Where do they think the gaps are? – Do they see themselves as being at risk? – Why or why not?
2) Do a workshop or theatre event to get them thinking / talking about the topic if they're not already... make sure it's fun and interactive.
3) Enlist youth from the community you're working with to guide and inform the process – make them the spokespeople for their own prevention messages.

13.
1) Coming of Age ceremonies – incorporate the risks of toady around diseases, drug use and the street. Get community involved in supporting youth.
2) Educate the parents and staff – get the nurse trained in STI testing.
3) Involve leadership.

14.
1) Encourage parents to start at home – help with easier ways to discuss with their children.
2) For workshops with youth, incentives to get them to participate, i.e., free pizza or $20.00 to be there.
3) Start a youth group in each community specifically on way to prevent HIV/AIDS and let the youth come up with strategies for their own community.

15.
1) Find out what youth feel they need to know. Be non-judgmental.
2) Get youth leaders to buy in – other youth will follow. Get support from all levels of the community.
3) Ask youth to do a focus group to find out where to start, topics, feedback on messages and old materials.

16.
1) Gain support of schools. Approach schools with initiatives.
2) Engage youth groups.
3) Be inclusive. We live in a non-Aboriginal world. It is important we don't leave others out of the circle because we all live on a big circle.

19.
1) Go to band council or Métis or Inuit governing bodies as group of parents and demand action – bring your kids and bring the latest epi-update.
2) Survey high school youth about HIV prevention – ask for their help and recommendations – send results to government (FN, Métis, Inuit).
3) Stage a demonstration using youth!

20. 1) Work to gain support of community leadership.
2) Be youth directed.
3) Emphasize respect.

21. 1) Fournir des statistiques significatives sur les jeunes.
2) Informer les professeurs au sujet du VIH afin qu'ils puissent en parler dans leurs cours.
3) Sensibiliser les parents sur la sexualité des jeunes et les comportements à risque afin qu'ils amorcent une conversation avec leurs jeunes.

[1) Provide significant stats about youth.
2) Inform professors/teachers about HIV so they can talk about it during their courses.
3) Sensitize parents about the sexuality of youth and risky behaviour so as to begin conversations with youth.]

22. 1) Start by sharing alarming stats.
2) Relate sex to their own life experience. Everyone needs to be close. It is part of the human experience.
3) Use traditional teachings and legends that talk about relationships.

24. 1) Bring in guests with personal stories – put a humorous face on HIV.

25. 1) Ask what they want.
2) Ask how they want it delivered.

26. 1) Use a medicine wheel concept
2) Sharing circles
3) Incentive programs.

27. 1) Firstly, give them the education and knowledge to get their head thinking.

2) Talk about testing and stress importance.

3) Have a one-on-one with youth who may be interested. Could be youth leaders, youth in homes, youth not in school. Then have an open forum Talking Circle to get things rolling.

28. 1) Be available.

30. 1) Go to elders/grandparents, work your way down to youth. You can't only work with youth, everyone in their lives regardless of age needs to be given the same message. Consistency is important.

31. 1) Go to the Elders first. Respect the community.
2) Not all Aboriginal youth are interested in the medicine wheel or Tree of Creation. So know your audience. Speak with them and find out what they want.
3) Find a hook to draw people in. You need the support of the community. So offer an event or food whatever it takes to draw them in. Move slowly and respectfully.

32. 1) Have community members involved. Keep it familiar.
2) Make it fun. Often this takes time and $$$ money! Interactive art.
3) Incorporate other activities that are known to be enjoyed, ex., basketball, pizza party.

34. 1) We need to get leaders to hear and participate in the message.
2) Youth also need to be an active part of the work.

35. 1) Be consistent.
2) Use their language.
3) Meet them where they're at.

APPENDIX D.18

Q23. Do you have any other comments?

1. Make some more videos! I always receive the comment that presentations should include videos. "A Long Walk" and "Through A Blue Lens" are awesome, but I need shorter videos (10 minutes, 20 minutes) specific for youth, and affordable videos. As a non-profit NGO, I don't want to pay $300 for a video produced in Seattle (or wherever). Or lame videos that show 5 youth sitting in a circle talking. WANT GOOD VIDEOS!

5. First Nations Health Branch do not seem to have the message. There is a real lack of credence when it comes to point of service. They hoard funding and really don't allow groups like us to do anything in fact they ridicule any program application.

8. Last year I did a 500 km bike ride with an Aboriginal man who is 2-spirited and HIV+. We rode from his community of Janvier to the pilgrimage at Lac St. Anne- we camped along the way. His family and friends were grateful to our organization- as well it fostered positive relations between a white woman and the Aboriginal community.

9. Thank you so much for allowing me to fill out this survey. You have given me the opportunity to express some of my frustrations. We live in an area where STI's, sexual abuse, incest, addictions are extremely high. I am not proud of the fact that we are #1 in many things considered to be social diseases.

14. I hope you get the response that you hope in this questionnaire. HIV/AIDS is too serious of a disease to let our Aboriginal youth be unaware of.

16. If you have a good idea make sure you review all foreseeable scenarios to avoid exclusion. People judge a book by its cover so make sure you have the correct title (i.e. see answer 22). Not my organization but it's the only Inuit one around doing HIV/AIDS work.

17. We do not often have Aboriginal people using our services. Any street outreach encounters are with people coming through the region on the way to Toronto. We do have contact numbers for Toronto services that specialize in Aboriginal services.

20. We do not specialize in serving Aboriginal people, however, we are committed to promoting universal access to comprehensive, reliable information and services on sexuality and related health services to diverse communities, including urban Aboriginal communities (First Nations, Métis, Non-Status) (people of Turtle Island). We work with professionals who work with the urban Aboriginal community as well as First Nations.

27. Looks Good!!

29. Sorry, I don't have enough time to spend completing this survey well (re-check this).

31. We are a rural based program. We try to adjust our program to meet the needs of our clients. We are very flexible and open to suggestions. We have nothing designed specifically for Aboriginal youth. Our harm reduction coordinator has a background in Aboriginal studies.

32. Next time perhaps we could have the option of doing this electronically. Email or online???

34. The most important way to get a message to any group is to include them in forming the message and be active in carrying the message. I suggest a group of youth from different communities be hired to travel to all the small communities and take the message to their home communities as a group.

APPENDIX E
SURVEY DESIGN AND ANALYSIS

The HIV/AIDS Prevention Messages for Canadian Aboriginal Youth Survey was designed and developed by the youth project coordinator, in collaboration with the National Steering Committee (NSC). Members of the NSC provided over-all guidance on the project, and had direct input into the design and layout of the questionnaire, the themes it explored, and the wording of individual questions. Once the project coordinator and the NSC were satisfied with the survey questions, it was sent through a plain language review process to ensure that the language used was appropriate and easy to understand.

The survey was mailed to 157 AIDS Service Organizations (ASO's), Aboriginal AIDS Service Organizations (AASO's) and community health organizations across Canada from the Canadian Aboriginal AIDS Network (CAAN) and Canadian AIDS Society (CAS) membership lists. Six (6) of the surveys were returned unopened and 2 were incomplete. Therefore, from a possible sample of 149 surveys, 35 completed surveys were returned, for a 23.5% return rate[9].

Responses to the survey items were then entered into a computer data base and analyzed using SPSS® (Statistical Package for the Social Sciences). Frequencies (the number of times an answer was chosen) were calculated for all single and multiple response questions, and cross-tabs (how answers are related) were performed for significant variables. All answers to open-ended questions were entered into a Word document, and scanned for similarities and differences.

[9]This is considered to be a fairly high response rate given that response rates for mail-in surveys are often only 5-10% and rarely reach more than 30% (Alreck and Settle 1995: 35).

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