# Voices of Two-Spirited Men

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# Preface

## *A Survey of Aboriginal Two-Spirited Men across Canada*

This study is about knowledge, attitudes, behaviours and social conditions of Aboriginal, two-spirited men across Canada. It was commissioned by *2-Spirited People of the 1st Nations* in Toronto and was distributed by researchers at the Centre for Quality Service Research, Ryerson University. Aboriginal people representing various communities were involved in the development of the survey questions.

The 12-page survey took about 45 minutes to complete. Once the individual answered the questions, the survey was put in the envelope provided, sealed, and returned to the person who provided it. The sealed envelope was mailed to the Centre for Quality Service Research, Ryerson University (Toronto). Questions or concerns about participation in this study were handled on the cross-Canada toll-free line established for this study.

We gratefully acknowledge the participation of our respondents who gave their time to this project. We also appreciate their candour. They provided us with a great deal of information, insight, and advice on some very sensitive issues. Further, they allowed us to appreciate the circumstances of their lives and the challenges they face. Accurate knowledge about HIV transmission is evident in all our respondents. For those who are HIV+, it was heartening to read about the care they take in protecting others from exposure to HIV. For those who do not have HIV, knowledge about HIV transmission is a very real concern.

These two-spirited men face enormous pressures - racism, homophobia, poor housing. Many have experienced homelessness and unemployment. Yet they are very concerned about the threat of HIV in their communities of origin. They express a great deal of worry for Aboriginal people. Almost half of them are HIV+, yet many of them avoid medical treatment due to fear of discrimination because of their status and lack of information about where to go for services.

To those two-spirited men who responded to this survey, we have heard your voices. Thank you for your input.

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# **Literature Review** (as of October, 1999)

To gather relevant information on this needs assessment, a number of search strategies have been employed. Among them are the use of Internet search engines (such as MetaCrawler and Dogpile), Lexis/Nexis (with specific reference to MEDLINE), library journal holdings, and conference proceedings. The key words used in these searches included: Aboriginal, two-spirited, models of intervention, HIV/AIDS high-risk behaviour, and educational initiatives. In addition, a number of researchers familiar with issues surrounding HIV transmission, educational initiatives, and Aboriginal issues were contacted by phone, email or fax (for example, Marcel Dubois, Ted Myers, Albert McLeod, Diane Aubry, Steve Hill, and Bill Greenwood provided reports, made suggestions, and suggested other contacts).

From these searches and contacts we compiled a number of articles, proceedings, monographs, and government reports. In reviewing these, a number of themes emerged and are summarized in separate sections below. Although many of the articles span more than one topic area, they are organized under specific headings.

## Aboriginal HIV/AIDS Issues

### Infection Rates

A main problem in the collection of data on the spread of infection of HIV/AIDS disease among Aboriginal people is that data collection on ethnicity was first initiated in 1988 (Ontario Aboriginal HIV/AIDS Strategy, 1996). What we did find was that infection rates were lower for Aboriginals than for the general population but these have now risen higher than the general population (Rekart et al., 1991). Young Aboriginals seem to be especially at risk (Health Canada, 1998) as well as Aboriginal women mainly due to sexual contact possibly infecting infants during pregnancy (Duff et al., 1993). Infection rates may still be underestimated because of underreporting. Given an increase in seroprevalence rates in Aboriginal communities, Thomas et al. (1998) predict that further economic hardship will fall upon already impoverished communities.

There is evidence in one study that some Aboriginals in British Columbia may be carrying the variant HTLV-I of the virus (normally endemic to the Caribbean and South America). This may have implications for the treatment of this population as well as the different rate of infection in this population (Picard et al., 1993).

The literature also focuses on high-risk behaviour (Rekart et al., 1991), lack of access to services and poverty (Canadian HIV/AIDS Legal Network, 1996). These factors mean that infection rates and progression of the disease may

be more rapid in the Aboriginal population (Goldstone et al, 1998). HIV/AIDS is especially a challenge in rural communities (Canadian AIDS News, 1996) because services and basic infrastructures are limited resulting in: increased threat of opportunistic infections; lack of access to appropriate health care; lack of access to proper diet, lack of access to medications, and; lack of supportive housing/long-term care facilities (Ontario Aboriginal HIV/AIDS Strategy, 1996).

Further, Houston and Reese (1996) report that "Canadian Aboriginal people experience high rates of socioeconomic and behavioural risk factors for HIV infection including poverty, incarceration, IDU, STD, and commercial sex".

Infection rates seem to be exhibiting Pattern II trends in the Aboriginal community as opposed to Pattern I in mainstream Canada. The implication is that prevention programs targeting mainstream Canadians will not be effective for Aboriginals and that prevention should be focused on the prevention of sexually transmitted diseases (Wortman, 1990) as well as encouraging condom use.

Nguyen et al. (1996) report that the proportion of reported AIDS cases among Aboriginals has increased from 1.2% (pre1990) to 2.8% (1993-95). The main exposure categories for Canadian Aboriginal Men are men who have sex with men (72.3%), IDUs (6.5%) and heterosexual contact (4.9%). Aboriginals are infected earlier than non-Aboriginals and IDU is the most important mode of transmission among Aboriginal women.

Environmental Circumstances

A consistent theme in the literature is the lack of adequate housing facilities for Aboriginals both in urban and rural environments. A needs assessment prepared by *the 2-Spirited People of the First Nations* in 1995 "found that 70% of the sample community is unemployed, 30% of the community does not have stable housing, 52% of the community lives in unaffordable housing, and that 58% of the homes presently occupied by Aboriginal PHAs [people living with HIV/AIDS] are not suitable for people living with HIV/AIDS" (Deschamps & Thoms, 1995). This study recommended that there is a "urgent need" for a housing facility in Toronto specifically for Aboriginal people living with HIV/AIDS.

The mobility of the Aboriginal population between urban centres and their communities of origin poses the additional problem of facilitating the spread of HIV/AIDS disease to the rural communities by sexual contact or injection drug use where adequate services are not available (Health Canada, 1998; Deschamps, 1998).

Earlier studies seemed to show that the Aboriginal population is at risk because of lack of basic AIDS information (Myers et al., 1993). However, more recent studies show that the knowledge of HIV/AIDS disease is increasing

(DuBois et al., 1996). Increased knowledge of the disease, however, does not seem to be translated into the reduction of engaging in high-risk behaviour.

Other factors that place Aboriginal people at risk are outlined in the Ontario Aboriginal HIV/AIDS Strategy (1996). They include the high rates of sexually transmitted diseases, non-consensual sex (sexual assault, incest, abuse), lack of self-esteem, intravenous and injection drug use (IDU), the abuse of alcohol especially in conjunction with other drugs, and limited safer sex education. "For two-spirit people, and in particular two-spirit youth, whose identity may be repeatedly assaulted by racism and homophobia, the risk for suicide is dangerously high" (Manitoba Aboriginal AIDS Task Force, 1998).

Also, a high level of homophobia, intolerance and discrimination relating to HIV/AIDS (McLeod, 1998; Vanderhoef, 1998; Canadian HIV/AIDS Legal Network, 1996; Manitoba Aboriginal AIDS Task Force, 1998) has been seen in the community possibly as a result of "a history of oppression, racism and colonization" (Matiation & Jurgensz, 1998; Canadian HIV/AIDS Legal Network, 1996). This has produced a move away from traditional culture taking on the homophobic attitudes associated with established religions (Manitoba Aboriginal AIDS Task Force, 1998). The current trend to return to traditional culture and spirituality may reduce intolerance in Aboriginal communities especially rural ones. Also, traditional healing and spirituality may play an important role in treating Aboriginals who are infected with HIV/AIDS (DuBois, 1996; Lambert, 1993; Manitoba Aboriginal AIDS Task Force, 1998).

Although introduced in 1990, the concept of "two spiritedness" may be a way for the Aboriginal gay community to promote and support itself and become accepted once again as part of mainstream Aboriginal society (Manitoba Aboriginal AIDS Task Force, 1998). Two-spirited people sometimes have special roles that are spiritual or ceremonial in certain cultures as counsellors, healers, seers and visionaries (DuBois, 1996; McLeod, 1998; Deschamps, 1998). However, our focus group interviews seem to show that urban Aboriginal gays do not seem to identify themselves as two-spirited but rather as "gay".

**Complicating Risk Factors for Aboriginal People**

Substance Abuse

Strathdee et al. (1996) report that substance use is associated with high-risk sexual behaviour among young MSM and sexual abuse is independently associated with a two-fold risk of sexual risk-taking.

Injection drug use among Aboriginal peoples is a main concern especially for young people (Mai et al., 1998) with an over-representation of Aboriginal people seen in the injection drug user population specifically in Vancouver and a greater likelihood of HIV transmission in this population (Schechter et al., 1998). Birkel & Golaszewski (1993) found that younger intravenous drug users (IDUs)

were less likely to lower sex risk, and showed lower levels of change overall for both sex and needle risk.

Condom Use

In a survey of 658 Aboriginal men and women (Calzavara, Burchell, Myers, Bullock, Escobar and Cockerill, 1998), of those that had sexual intercourse in the last 12 months (n=400) 61% reported that they never used condoms. However, rates of condom use differed by age and gender. Males, under the age of 30, were most likely to use condoms. Further, condoms were used by for those people who were knowledgeable about HIV/AIDS and had more than one sex partner. Our target population for this study is with young men — the group that is most likely to use condoms.

Encouragement of condom use is an essential strategy in reducing the risk of HIV transmission. "The use of condoms for birth control was the strongest predictor of condom use for STD prevention. This suggests that efforts to increase condom use in this population should address pregnancy concerns and ensure that individuals at risk of STDs or HIV disease do not discontinue using condoms if they switch to another method of birth control" (Calzavara et al., 1996). "In view of the fact that familiarity with the traditional way of life was an important predictor of condom use, a better understanding of the effect of culture on condom use may be useful in developing prevention programs" (Calzavara et al., 1996). "A better understanding of the meanings people ascribe to sex is important to help individuals become more aware of why they choose to participate in particular sexual activities, and will ultimately lead to more culturally sensitive AIDS education strategies" (Bullock et al., 1996).

Street-involved sexual behaviour

In a small study of transsexuals (n=40), half of whom were of Aboriginal ancestry, Rekart et al. (1993) found that this group faced serious social difficulties including homelessness, discrimination, physical abuse, racism and homophobia. HIV risk behaviours were common including unprotected receptive anal intercourse (85%), prostitution (90%), and infection drug use with needle sharing (62%).

HIV-related tuberculosis

In the United States, increases in the numbers of cases of active tuberculosis (TB) are thought to be related to HIV infection (Fitzgerald, 1995). However, this recent increase in Canada is probably not due to HIV infection but it is acknowledged that risk factors, such as HIV, are associated with increased risk of TB. In Canada, the highest rates of TB are seen in Aboriginal people (80/100,000) so it is important for physicians to be aware of this and understand

the management of TB. Unfortunately, one of the common adverse reactions to three of the commonly used first line drugs is hepatitis.

High-risk behaviour

Although the more recent studies show that the knowledge of HIV/AIDS disease is increasing (DuBois et al., 1996) increased knowledge of the disease does not seem to be translated into the reduction of engaging in risk behaviour (Basen, Engquist & Parcel, 1992). As stated earlier, some studies have focused on high risk behaviour (Rekart et al., 1991). In AIDS prevention for the general population, Browne and Barone (1991) suggest certain variables that need to be considered. Specifically, they report that age, gender, and AIDS-related anxiety are significant variables in the AIDS education process. In adults, perceived susceptibility to AIDS is associated with reports of safer behaviour but also more coercive attitudes towards people with AIDS. They also found that improved knowledge is weakly associated with greater tolerance and intention towards safer behaviour. Mill (1997) suggests that HIV risk behaviours such as running away, substance abuse, abusive relationships, are survival techniques for Aboriginal women.

In a study on risk behaviours and HIV prevalence among a cohort of young men who have sex with men in Vancouver, Martindale et al. (1996) found that a sizeable proportion of young men who have sex with men are engaging in unprotected sexual intercourse. Moreover, this study also found that there was a strong association between sexual abuse in childhood and adolescence and subsequent involvement in sex trade. Aboriginal people accounted for 5% of this study.

**Education and Prevention Strategies**

Effective education and prevention programs seem to focus on the oral traditions of Aboriginal culture (Lennie & Daniels, 1996). The use of storytelling, visual aids (McLeod, 1996; Hill & Gillies, 1996), gatherings (Vanderhoef, 1998) and strategies based on the model of the Medicine Wheel (Weiser & Badger, 1996) seem to be effective in education and promotion. The large number of different nations, languages and cultures means that programs are best targeted to specific groups and implemented with the participation of Aboriginal people with the blessing of the elders (Houston & Reese, 1996; Manitoba Aboriginal AIDS Task Force, 1998). Community-level involvement and planning (Myers et al., 1993; 1999; Manitoba Aboriginal AIDS Task Force, 1998) and confidentiality and participatory models (Haour-Knipe & Aggleton, 1998; Nguyen et al., 1998; Health Canada, 1998) are reported as being most effective. "Drop-in programs and outreach can successfully target high risk groups and provide comprehensive care if they are culturally sensitive and include a harm reduction and strong advocacy approach" (Littlejohn et al., 1998). Also, prevention programs should focus on reducing injection drug use and promoting needle exchange programs

(Mai et al., 1998; Schechter et al., 1998). The lack of evaluation protocols in many programs described in the literature means that their effectiveness may not properly assessed. Future initiatives must include an evaluation component (Nguyen et al., 1998).

The literature has also revealed several differences in prevention and education strategies between the general population and the Aboriginal population. For example, in a study conducted by Haour-Knipe & Aggleton (1998), the poorest and most marginal people experience HIV-related vulnerability factors.

To address the needs of Aboriginal people many culturally sensitive teaching tools have been used in HIV/AIDS prevention strategies. Tools used to counter language and literacy barriers are 101 posters (McLeod & Manitoba Aboriginal AIDS Task Force Inc., 1996), puppetry (Hill & Gillies, 1996). However, posters are seen as ineffective for people who are functionally illiterate, have sensory impairment (IDUsers), or live in poverty (a disproportionate number are Aboriginal) (Egan, 1998).

According to Walter & Vaughan (1993), some predictors of AIDS-related risky behaviours are susceptibility, severity, benefits, barriers, self-efficacy, values, and norms. Also, HIV-related risks vary with level of intimacy/commitment, relationship status/phase, different partners, sexual communication, etc.

Freudenberg and Trinidad (1992) point out possible obstacles in AIDS prevention activities such as lack of available social and health services, drug use, fear of stigmatization, and lack of resources. Crown at al (1993) address obstacles to HIV prevention and techniques used to overcome them. These include: confidentiality & anonymity in small communities, language (i.e. 8 official languages in the NWT and some with no comparable vocabulary for HIV/AIDS concepts), and high turnover of staff (lack of professionally trained people).

**Models/Theories in Health Prevention**

One model used frequently in the HIV/AIDS prevention literature is the Health Belief Model (HBM) (Petosa & Wessinger, 1989-90; Petosa & Jackson, 1991; Walter & Vaughan, 1993). HBM focuses on failure of people to participate in programs to prevent/detect disease. Factors include perceived susceptibility, perceived benefits of prevention and treatment as elements in decision-making process (Haour-Knipe & Aggleton, 1998). There have been criticisms of this model: It over-emphasizes individual rationality and rational decision making and fails to move beyond the retrospective accounting for health behaviour in order to offer ways to predict and/or to bring about behaviour change (Haour-Knipe & Aggleton, 1998).

Risk Reduction and Harm Reduction Models

Another model frequently cited involves Social Cognitive Theory, which considers both the person and the environment in determining health risk behaviours (Stiffman, & Dore, 1995; Walter & Vaughan, 1993). In the Theory of Reasoned Action (TRA) (Basen, Engquist & Parcel, 1992), there is emphasis on the role of intentions and beliefs in engaging in certain behaviours. Criticisms of the model include an over-emphasizes individual rationality and rational decision making and a failure to move beyond the retrospective accounting for health behaviour in order to offer ways to predict and/or to bring about behaviour change (Haour-Knipe & Aggleton, 1998).

The AIDS risk reduction model (ARRM) (Catania & Kegeles, 1990) consists of:

1) **labeling** of high risk behaviours as problematic,
2) making a **commitment** to changing high risk behaviours,
3) seeking and **enacting** solutions directed at reducing high risk activities.

The goal of this model is to broaden understanding about why people fail to progress over the change process.

Fisher and Fisher (1992) propose that there are 3 fundamental determinants of AIDS-risk reduction: information regarding the means of AIDS transmission and specific methods of preventing infection; motivation to change AIDS-risk behaviour; and behavioural skills. Two things determine motivation: attitudes towards performance of AIDS-preventive acts and perceptions of personal vulnerability to HIV (Fisher et al., 1996).

Other models that have been used in the study of HIV/AIDS prevention and education are: Information-Motivation-Behavioural Skills (IMB) Model (Fisher, Fisher, Misovich, Kimble & Malloy, 1996); Model of Social Influence (Walter & Vaughan, 1993); Transtheoretical Model of Change (Prochaska & Redding, 1994); and Protection Motivation Theory (Haour-Knipe & Aggleton, 1998). Petosa & Jackson (1991) discuss motivational schema which includes perceptions of normative sexual behaviour; interest in adopting adult roles; and needs for peer support and affection.

Findings from the Reviews of Prevention Strategy Effectiveness

Prochaska and Redding (1994) suggest that an important distinction between main sexual partners and casual sexual partners be made.

Janz and Zimmerman (1996) comment that few published descriptions of the process of *implementing* AIDS prevention interventions are available. In their opinion, the 5 most effective project activities include: small group discussions;

outreach to high-risk populations; train peers/volunteers; provide safer-sex kits; and large-group discussions

Stiffman and Dore (1995) argue that preventive programs should focus on personal problems in mental health and environmental problems in parent-child relations, peer behavours, stressful events, and neighbourhood violence and unemployment.

Strathdee et al. (1996) stress the importance of sexual abuse counseling. They recommend this should be a component of HIV prevention efforts.

Erben (1991) recommends providing information at an early age; involving community action groups; building healthy public policy and creating supportive environments (i.e., theatre, "make the healthier choice the easier choice").

Egan (1998), from his experience, suggests that the people he worked with seek other venues of information: informal discussions, broadcast media, and for those with a low level of literacy, use interpersonal verbal interventions.

McLeod & Manitoba Aboriginal AIDS Task Force (1996) using bingo games, support participation rather than focusing only on information exchange.

Moar (1993) reports that establishing trust on the street using a non-judgemental approach was effective in doing prevention education with IDUs.

Birkel & Golaszewski (1993) used indigenous outreach workers as change agents for IDUs (Hispanic subjects). The Outreach worker profile was a recovering IDU; active in 12-step programs; who lived and used drugs in the area; possessed a desire and commitment to "give back to the community"; was a natural leader; role model to members of the target population; had a knowledge of the IDU network and current use patterns; and an ease in approaching IDUs and other drug users on the streets.

Basen-Engquist & Parcel (1992) found that attitudes, norms, and intentions were directly related to the number of sexual partners. Self-efficacy and condom use intentions were directly related to frequency of condom use and knowledge does not determine practice. In addition, there was no difference in knowledge between those who use condoms and those who don't, and social norms are the weakest prediction of intention and behaviour.

Dowsett et al. (1998) outlines 3 concepts as useful framing devices for thinking about young people's sexual interests: **sexual cultures**: systems of sexual behaviour among any group of people; **sexual identities**: provides a psychological place for situating the self in sexual activity; and **sexual meanings**: a way of getting a firmer grip on the significance of sexual activity to young

people; and shift our rethinking from the merely behavioural and descriptive, to the more sociocultural and interactionist.

The mobility of the Aboriginal population between urban centres and their communities of origin poses the additional problem of facilitating the spread of HIV/AIDS disease to the rural communities by sexual contact or injection drug use where adequate services are not available (Health Canada, 1998; Deschamps, 1998; MAATF, 1999). Missing from existing services/ programs for IDUs is: 1-on-1 counselling, elders, methadone program to wean oneself off, programs just for IV (IDU) use, compassion and understanding, follow up programs, and counsellors who have experienced the use of needling (CAAN, p.57). They suggest that programs should provide more specific information about how to link with regional health authorities, acquire needles, establish methadone programs and secure funding for community-based Harm Reduction programs. Also, there should be should be: condom distribution, needle exchange, and methadone maintenance treatment. Attention should not focus on abstinence but should consider cultural and local level needs, be non-judgmental, pragmatic, flexible and allow people to make own informed decisions.

Empowerment Issues

A high level of homophobia, intolerance, and discrimination relating to HIV/AIDS (McLeod, 1998; Vanderhoef, 1998; Canadian HIV/AIDS Legal Network, 1996; Manitoba Aboriginal AIDS Task Force, 1998) has been seen in the community possibly as a result of "a history of oppression, racism and colonization" (Matiation & Jurgensz, 1998; Canadian HIV/AIDS Legal Network, 1996). This has produced a move away from traditional culture taking on the homophobic attitudes associated with established religions (Manitoba Aboriginal AIDS Task Force, 1998). The current trend to return to traditional culture and spirituality may reduce intolerance in Aboriginal communities especially rural ones and also empower those who are perceived as 'different'. However, it is important to empower those that are personally affected by homophobia, intolerance and discrimination (Haour-Knipe & Aggleton, 1998). This can involve the development of participatory programs.

Petosa & Jackson (1991) suggests that educational programs to promote safer sex intentions should focus on health related motivations among younger students. For older adolescents, factors directly relevant to their motivational schema and social environment should be addressed.

Harper et al. (no date) suggest "giving high-risk youth a voice". In their study, young people were invited to join the collaborators in order to incorporate their perspectives in the research. The young people helped by assessing the feasibility and acceptability of certain concepts, translating them into "street youth" language, recruited participants, etc. They also provided access to populations that are typically suspicious of adults, greater ease in tracking

participants, greater acceptability and credibility of the research, the feeling of empowerment in offering feedback

La Fortune (1993) suggests empowering gay, lesbian and bisexual Native persons through historically correct and/or adapted social roles, self-worth and self-preservation. And Rekart (1993) presents a seven step plan for empowering the urban aboriginal community to develop, deliver, manage, and support Aboriginal people themselves. Mill and DesJardins (1996) stress developing culturally-sensitive HIV programs which emphasize empowerment at the individuals and group level but make sure they are congruent with the shift to self-determination by Aboriginal people. Pepper & Henry's Model sets our 4 conditions necessary to the development of self-esteem in Indian children: connectiveness, uniqueness, power, and appropriate role models (Mill, 1997).

Spirituality

Traditional healing and spirituality may also play an important role in treating Aboriginals that are infected with HIV/AIDS (DuBois, 1996; Lambert, 1993; Manitoba Aboriginal AIDS Task Force, 1998). Driedger (1996) found that faith was most commonly expressed through relationships with others rather than through a systematic internalized belief system and that PLWHAs report the need to feel productive and creative, and that they matter to something or someone. Although they generally reject religious institutions, spirituality plays an important role in the lives of PLWHAs, providing a sense of meaning and purpose in life.

Cultural Sensitivity

In research on the Aboriginal Harm Reduction Model, 84% of respondents said they think culture is important when dealing with HIV/AIDS and 80% would find an Elder helpful and 78% would use the services of an Elder. It would seem that effective education and prevention programs should focus on the oral traditions of Aboriginal culture. The use of storytelling, visual aids, gatherings (Vanderhoef, 1998) and strategies based on the model of the Medicine Wheel (Weiser & Badger, 1996) seem to be effective in education and promotion. Other supporters of programs that rely on oral traditions include McLeod and Johnson (1996) who suggest that culturally-appropriate teaching tools are transferable to more than Aboriginal people. They suggest that these types of tools may be appropriate for other hard to reach populations such as prisoners, street-involved people, people with low literacy levels, and non-English speaking populations. Other studies include:

McLeod and Manitoba Aboriginal AIDS Task Force (1996) on HIV/AIDS teaching tools using the medicine wheel to explain how HIV affects all aspects of life and the teaching turtle poster - an animal that is recognized as a spiritual guide

Manitoba Aboriginal AIDS Task Force (1999) on Strategies of Four Doorways Project: which portrays a model for peer education training, outreach and community development through partnerships, research and culture-based services

Lennie and Daniels (1996) use HIV (the Shape Shifter) as a teacher, through the oral and spiritual traditions; hope (Eagle feather) symbol, balance, healing and self-empowerment. Their position is that taking "AIDS 101" for a couple of hours does not work because it only appeals to the mind. Rather, one must examine the causal issues controlling risky behaviour: mind, body, emotions and spirit

La Fortune (1993) suggests disseminating information which incorporates traditional teachings about sexuality, spirituality, and social organization; empowering gay, lesbian and bisexual Native persons through historically correct and/or adapted social roles, self-worth and self-preservation. This allows the broader Native population to access information with more success and less subjectivity

Valverde and Smeja (1993) suggest that increase in self-sufficiency in AIDS education underlines the importance of using a methodology that is *culturally appropriate* and respectful of *traditional customs and ways of learning.*

Adams and Wortman (1990) describe "snapshots" - drama depicting the experiences of a native youth whom discovers he has AIDS. They found this to be effective for AIDS and other sensitive topics to aboriginal audiences where a frank discussion of these issues can be difficult to initiate.

Mill and DesJardins (1996) suggest designing culturally-sensitive HIV programs which emphasize empowerment at the individuals and group level. This is congruent with the shift to self-determination by Aboriginal people. And Crown et al. (1993) described an approach where Band chiefs were informed, and elder support was obtained.

Role of Communities

Community-level involvement and planning (Myers et al., 1993; 1999; Manitoba Aboriginal AIDS Task Force, 1998) and confidentiality and participatory models (Nguyen et al., 1998; Health Canada, 1998) are reported as being most effective. "Drop-in programs and outreach can successfully target high risk groups and provide comprehensive care if they are culturally sensitive and include a harm reduction and strong advocacy approach" (Littlejohn et al., 1998).

Freudenberg and Trinidad (1992) describe the role of community organizations in AIDS prevention in Black and Latino communities. They state that these groups differ from gay communities in important ways: social resources, income, education, etc. The advantage to this approach is that of

community organizations have knowledge of relevant cultural values and beliefs, familiarity of relevant channels of communication, and a commitment to safeguard the well being of their neighbourhoods.

The MAATF (1999) uses a Four Doorways Project that involves the development of a model for peer education training, outreach and community development through partnerships, research and culture-based services. Valverde & Smeja (1993) emphasize training support of Native AIDS educators towards community-based activities and policy development. Wortman (1992) uses a dual approach that involves support of community-based initiatives.

As mentioned earlier, Crown et al. (1993), feel it is important to inform Band chiefs and gain elder support. Also, use door to door campaign and community visits by PLWAs giving the message about healthy lifestyle choices. Further, they suggest that Community Health Representatives (CHRs) play a vital role in health promotion and HIV/AIDS awareness.

Also, prevention programs should focus on reducing injection drug use (Mai et al., 1998) and promoting needle exchange programs. The lack of evaluation protocols in many programs described in the literature means that their effectiveness may not properly assessed. Future initiatives must include an evaluation component (Nguyen et al., 1998).

Myers et al. (1999) have shown that "most prevention initiatives in response to HIV/AIDS have been introduced with a public health paradigm, a paradigm of modern medicine". In addition, concepts about the discussion of sex between partners and following the medical advice of experts with regard to condom use may not coincide with Aboriginal cultural traditions. Therefore, "cultural conflict between traditional ways, knowledge and responses and public health imperatives is a primary issue" (Myers et al., 1999). Using culturally appropriate and specific tools that integrate with or complement the holistic approach to health used in Aboriginal communities will achieve better results while keeping in mind that the Aboriginal community is a complex mix of cultures, languages and traditions: "with differences within and between communities and individuals" (Myers et al., 1999). This is supported by LeMaster & Connell, (1994) who discuss a major barrier to successful interventions: a mistrust of interventions implemented by individuals with a different cultural background; language barriers; and geographic location. Other barriers outlined in the work on the Aboriginal Harm Reduction Model include:

-focus of drug treatment centers on quitting/abstinence
-centers' lack of understanding of IDU addictions
-centers' lack of cross-culturally trained staff
-structural/institutional barriers
-abstinence expectations
-issues of labels and stigma
-internalized shame and personal obstacles

-the attitude of service providers
-lack of cultural awareness among service providers, and
-internal community and cultural barriers confidentiality

Factors that facilitate intervention effectiveness are outlined by Janz and Zimmerman (1996). They include: culturally relevant and language appropriate; AIDS information embedded into broader contexts; creative rewards and enticements; opportunities for program flexibility; promoting integration into and acceptance by the community; repeat essential AIDS prevention messages; create a forum for open discussion; solicit participant involvement. Additionally, Freudenberg and Trinidad (1992) describe characteristics of groups that successfully reached populations at risk of HIV infection. These include: hire staff of similar ethnicity, class, and gender; engage clients in discussions on issues such as drug abuse and sex roles; control and lead by a community resident rather than by professionals who live outside the community; and an established planning mechanisms in which staff and constituents provide ongoing feedback on program to agency directors. Hill and Gillies (1996) recommend promoting community discussion around common values and respect for diversity. Also, they suggest that puppetry can reach audiences who are uncomfortable with traditional methods of learning; bridges language and literacy barriers.

**HIV Testing**

"Anonymous HIV testing may play a role in the effective HIV prevention in the Canadian Aboriginal population [since] HIV infection could spread quickly through the relatively young Aboriginal population, with potentially devastating consequences" (Tseng, 1996). A survey conducted by Watershed Writing and the 2-Spirited People of the 1st Nations found that "HIV surveillance data should not be collected by Health Canada without personal consent, that chief and councils or Provincial Testing Organizations (PTOs) can not authorize Health Canada to undertake blind HIV testing of an Aboriginal population area, and that individuals and the community are the best persons to authorize this form of HIV surveillance" (2-Spirited People of the 1st Nations, 1996).

In their work on the effects of HIV testing patterns on reactions of HIV+ diagnosis, authors Calzavara, Brabazon, Myers, Millson, Major, Logue, and Rachlis (1998) found that although HIV anti-body testing can be a difficult ordeal, qualitative interviews conducted on individuals who underwent HIV anti-body testing revealed that individuals who were tested and counselled often and repeatedly were able to adapt better and more quickly to the news a positive test result.

In a surveillance of AIDS in Canada, Farley et al (1998) showed that of the reported AIDS cases in Canada there were changing trends in the number of reported cases and the shifts in the affected risk categories. The number of reported AIDS cases are declining and although men who have sex with men still

represent a large proportion of reported cases, current findings indicated new trends in those who are infected. It is speculated that new drug treatments and prevention programs may account for the decline in reported cases. "Recent trends are however showing increases in the heterosexual, women, intravenous drug use and aboriginal [sic] categories."

McGee and Cerre (1996) report that multi-government co-operation and communication facilitated the identification and development of community projects that enhanced collaborative efforts. "The creation of close working relationships between government community ensures productive and effective programs."

## References


2-Spirited People of the 1st Nations (1996). *A community-based discussion paper on: The social, moral, ethical and legal implications of conducting blind HIV seroprevalence studies in Aboriginal communities*. Vancouver: Watershed Writing and Research.

Aboriginal AIDS strategy (1989). *Dimens Health Service, 66(5),* 7.

Adams, E., & Wortman, J. A. (1990, June 20-23). The use of live theatre to raise awareness about AIDS and related issues among aboriginal people. *International Conference on AIDS, 6(2).* 454.

Albert, D., Deschamps, G., & Thoms, M. (1996, July 7-12). Mino-Waakaa'igun: A needs assessment regarding supportive housing for Aboriginal people living with HIV/AIDS. *International Conference on AIDS. 11(1)*, 207.

Allman, D., Myers, T., & Cockerill, R. (1997). *Concepts, definitions and models for community-based HIV prevention research in Canada*. Toronto: University of Toronto.

Arvanitakis, Z., Long, R. L., Hershfield, E. S., Manfreda, J., Kabani, A., Kunimoto, D., & Power, C. (1998). M. tuberculosis molecular variation in CNS infection: Evidence for strain-dependent neurovirulence. *Neurology, 50(6),* 1827-32.

Barker, D. (1995). New video on Canadian AIDS & development activist. *Canadian AIDS News, VII(Supplement),* 11.

Basen-Engquist, K., & Parcel, G. S. (1992). Attitudes, norms, and self-efficacy: A model of adolescents' HIV-related sexual risk behavior. *Health Education Quarterly, 19(2).* 263-277.

Birkel, R. C., & Golaszewski, T. (1993). Findings from the Horizontes Acquired Immune Deficiency Syndrome education project: The impact of indigenous outreach workers as change agents for injection drug users. *Health Education Quarterly, 20(4).* 523-538.

Blenkush, M. F., Korzeniewska-Kozela, M., Elwood, R. K., Black, W., & FitzGerald, J. M. (1996). HIV-related tuberculosis in British Columbia: Indications of a rise in prevalence and a change in risk groups. *Clinical & Investigative Medicine, 19(4),* 271-8.

Brown, L. K., & Barone, V. J. (1991). AIDS education: The Rhode Island experience. *Health Education Quarterly, 18(2).* 195-206.

Bullock, S. L., Myers, T., Calzavara, L. M., Cockerill, R., Marshall, V. W., & Burchell, A. (1996, July 7-12). Unprotected intercourse and the meanings ascribed to sex by aboriginal people living on-reserve in Ontario, Canada. *International Conference on AIDS, 11(1).* 50.

Calzavara, L., Burchell, A., Myers, T., Bullock, S., Cockerill, R., & Marshall, V. (1996, July 7-12). Condom use among Aboriginal people with multiple partners living in reserve communities in Ontario, Canada. *International Conference on AIDS, 11(2).* 327.

Calzavara, L., Brabazon, C., Myers, T., Millson, M., Major, C., Logue, K. J., & Rachlis, A. (1998a). The effects of HIV testing patterns on reactions to HIV+ diagnosis. *International Conference on AIDS, 12.* 492.

Calzavara, L. M., Burchell, A. N., Myers, T., Bullock, S. L., Escobar, M., & Cockerill, R. (1998b). Condom use among Aboriginal people in Ontario, Canada. *International Journal of STD & AIDS, 9(5),* 272-9.

The Canadian Aboriginal AIDS Network (1998). *Joining the circle: An aboriginal harm reduction model*. Vancouver: Watershed Writing and Research.

Canadian HIV/AIDS Legal Network (1996). HIV/AIDS and Aboriginal communities: Problems of jurisdiction and discrimination: A review. *Canadian HIV/AIDS Policy & Law Newsletter, 3(1).*

Canadian Thoracic Society (1994). Essentials of tuberculosis control for the practicing physician. *Canadian Medical Association Journal, 150(10),* 1561-71.

Catania, J. A., & Kegeles, S. M. (1990). Towards an understanding of risk behavior: An AIDS risk reduction model (ARRM). *Health Education Quarterly, 17(1).* 53-72.

Crown, M., Duncan, K., Hurrell, M., Ootoova, R., Tremblay, R., & Yazdanmehr, S. (1993). Making HIV prevention work in the north. *Canadian Journal of Public Health, 84(Supplement 1),* S55-8.

de Bruyn, T. (1998). Discrimination, HIV/AIDS and Aboriginal people: A discussion paper. *Canadian HIV/AIDS Legal Network and Canadian AIDS Society.* http://www.aidslaw.ca/elements/06TEXTDe.html

de Burger, R. (1995). AIDS prevention programming in Aboriginal communities is still in start-up phase. *Canadian AIDS News, VII(Supplement),* 1-2.

Deschamps, G., & Thoms, M. (1995). *Mino-Waakaa'igun: A proposal to provide a supportive housing facility for aboriginal people living with HIV/AIDS.* Toronto: 2-Spirited People of the 1st Nations.

Dowsett, G. W., Aggleton, P., Abega, S., Jenkins, C., Marshall, T. M., Runganga, A., Schifter, J., Tan, M. L., & Tarr, C. M. (1998). Changing gender relations among young people: The global challenge for HIV/AIDS prevention. *Critical Public Health, 8(4),* 291-309.

Drieger, S. M. (1996, July 7-12). What is the meaning of life with HIV/AIDS?: A survey of values, beliefs, faith, and spirituality. *International Conference on AIDS, 11(1).* 403.

DuBois, M. J. (1994a). *Survey of urban Aboriginals' knowledge, attitudes and behaviour regarding HIV/AIDS and related issues.* Montreal: Urban Aboriginal AIDS Awareness Project.

DuBois, M. J. (1994b). *The environment in Aboriginal communities and its impact on people infected with HIV/AIDS.* Montreal: The Native Women's Shelter of Montreal.

DuBois, M. J. (1995). Raising awareness of AIDS among Montreal's Aboriginal communities. *Canadian AIDS News, VII(Supplement),* 4.

DuBois, M. J. (1996a). All my relations and AIDS epidemiology. *Canadian AIDS News, VIII(4).*

DuBois, M. J. (1996b, July 7-12). Examining the pros and cons of spirituality on Canada's aboriginal people living with HIV/AIDS. *International Conference on AIDS, 11(1).* 205.

DuBois, M. J., Brassard, P., & Smeja, C. (1996). Survey of Montreal's Aboriginal population's knowledge, attitudes and behaviour regarding HIV/AIDS. *Canadian Journal of Public Health, 87(1),* 37-9.

Duff, F. P., King, S. M., Baird, T., & Read, S. E. (1993, June 6-11). Canadian National Survey of Perinatal HIV Infections: 1991 and 1992. The Canadian Paediatric HIV Research Group. *International Conference on AIDS, 9(2).* 666.

Dunbrack, J. (1995). Street-involved people meet to "share energy" about HIV/AIDS. *Canadian AIDS News, VIII(1),* 21.

Egan, J. P. (1998). Functional illiteracy and AIDS education: The marginalisation of the marginalised in Vancouver, Canada. *International Conference on AIDS, 12.* 1096.

Erben, R. (1991). Health challenges for the year 2000: Health promotion and AIDS. *Health Education Quarterly, 18(1).* 28-36.

Farley, J., Sutherland, D. W., Yan, P., & Sutherland, J. (1998). Surveillance of AIDS in Canada - change to surveillance of HIV infections. *International Conference on AIDS, 12.* 129.

Fisher, J. D., & Fisher, W. A. (1992). Changing AIDS-Risk behavior. *Psychological Bulletin, 111(3).* 455-474.

Fisher, J. D., Fisher, W. A., Misovich, S. J., Kimble, D. L., & Malloy, T. E. (1996). Changing AIDS risk behavior: Effects of an intervention emphasizing AIDS risk reduction information, motivation, and behavioral skills in a college student population. *Health Psychology, 15(2).* 114-123.

Fitzgerald, J. M. (1995). Tuberculosis in the 1990s. Issues for primary care physicians. *Canadian Family Physician, 41,* 1030-6.

Freudenberg, N., & Trinidad, U. (1992). The role of community organizations in AIDS prevention in two Latino communities in New York City. *Health Education Quarterly, 19(2).* 221-232.

Gardiner, L. (1995). And the winner is_bingo and AIDS education. *Canadian AIDS News, VII(Supplement),* 8-9.

Goldstone, I. L., Demerais, L., Hogg, R. S., Perry, T., Albert, R., Markowski, S., & McLeod, A. (1998). Dual epidemics of HIV and injection drug use lead to shorter survival for first nations in Vancouver, Canada. *International Conference on AIDS, 12.* 863.

Hankins, C., Hum, L., Tran, T., Laberge, C., Lapointe, N., O'Shaughnessy, M., Lepine, D., Malloch, L., Rud, E., & Robinson, E. (1997). Low HIV prevalence among childbearing women of aboriginal origin [letter]. *AIDS, 11(7),* 945-7.

Haour-Knipe, M., & Aggleton, P. (1998). Social enquiry and HIV/AIDS. *Critical Public Health, 8(4).* 257-271.

Hays, M. (1996). Queer spirits. *Montreal Mirror.*

Health Canada (1998). *Research on HIV/AIDS in Aboriginal people: A background paper*. Ottawa, ON: Minister of Public Works and Government Services Canada.

Hill, S., & Gillies, P. (1996, July 7-12). Puppets against AIDS: An innovative tool for AIDS education. *International Conference on AIDS, 11(2).* 33.

Houston, S., & Reese, H. (1996, July 7-12). HIV infection among First Nations people in Northern Alberta. *International Conference on AIDS, 11(1).* 128.

Imrie, R. A. (1990, June 20-23). Development of a national strategy to address AIDS among aboriginal people in Canada. *International Conference on AIDS, 6(2).* 303.

Imrie, R. A. (1991). Establishing the Joint National Committee on Aboriginal AIDS Education and Prevention. *Arctic Medical Research, Supplement,* 363-367.

Imrie, R. A. (1995). James Bay Cree maintain the line with AIDS education. *Canadian AIDS News, VII(Supplement),* 5.

Jamieson, M. E. (1991). *Needs assessment: AIDS/HIV education and prevention. Aboriginal community of Toronto*. Toronto: The Gays and Lesbians of the First Nations.

Janz, N. K., & Zimmerman, M. A. (1996). Evaluation of 37 AIDS prevention projects: Successful approaches and barriers to program effectiveness. *Health Education Quarterly, 23(1).* 80-97.

Jinich, S., Stall, R., Acree, M., Paul, J., Kegeles, S., Hoff, C., & Coates, T.J. (1996). Childhood sexual abuse predicts HIV risk behavior in adult gay and bisexual men. *International Conference on AIDS, 11*.

Kippax, S., & Van De Ven, P. (1998). An epidemic of orthodoxy? Design and methodology in the evaluation of the effectiveness of HIV health promotion. *Critical Public Health, 8(4),* 371-86.

La Fortune, R. (1993, June 6-11). Access to Native American communities in the context of traditional social/spiritual roles for gay/lesbian/bisexual persons and their partners and families. *International Conference on AIDS, 9(2).* 812.

Lambert, D. T. (1993). AIDS and the aboriginal community. *Canadian Journal of Public Health, 84(Supplement 1),* S46-7.

Lambert, D. (1995). Kiskinowmakew (learning and teaching) AIDS conference in Edmonton a big success. *Canadian AIDS News, VII(Supplement),* 10.

Lea, A., & Price, D. (1998). Challenges in being a non-profit, community organisation for children infected with/affected by HIV/AIDS. *International Conference on AIDS, 12.* 972.

Lee, R. M. (1993). *Doing research on sensitive topics*. Newbury Park, CA: Sage Publications.

LeMaster, P. L., & Connell, C. M. (1994). Health education interventions among native americans: A review and analysis. *Health Education Quarterly, 21(4),* 521-538.

Lennie, E. H., & Daniels, J. A. (1996, July 7-12). Feather of hope aboriginal AIDS prevention society (FOHAAPS): An oral tradition of "cultural sensitivity" and spiritually based process. *International Conference on AIDS, 11(1).* 50.

Littlejohn, D., Antoine, V., & Rockthunder, R. (1998). Challenges of providing AIDS care to multi-diagnosed aboriginal people in the downtown eastside of Vancouver. *International Conference on AIDS, 12.* 492.

Logue, K., Brabazon, C., Millson, M., Galli, R., & Leeb, K. (1998). Two methods to identify potential long-term non-progressors using observational databases. *International Conference on AIDS, 12.* 158-9.

Mai, N., Patrick, D., Houston, S., Romanowski, B., Hudson, S., Roy, E., & Archibald, C. P. (1998). HIV among aboriginal people in Canada: Injection drug use is a main concern. *International Conference on AIDS, 12.* 444.

Malcolm, A., Aggleton, P., Bronfman, M., Galvao, J., Mane, P., & Verrall, J. (1998). HIV-related stigmatization and discrimination: Its forms and contexts. *Critical Public Health, 8(4),* 347-369.

Manitoba Aboriginal AIDS Task Force (1998). 11th Annual Two Spirit Gathering. Winnipeg, MB: Manitoba Aboriginal AIDS Task Force.

Marin, G., & Burhansstipanov, L. (1995). A research agenda for health education among underserved populations. *Health Education Quarterly, 22(3),* 364-63.

Martindale, S. L., Strathdee, S. A., Hogg, R. S., Craib, K. J., Pitchford, W., Montaner, J. S., O'Shaughnessy, M. V., & Schechter, M. T. (1996, July 7-12). Risk behaviours and HIV prevalence among a cohort of young men who have sex with men in Vancouver. *International Conference on AIDS, 11(2).* 42.

Matiation, S., & Jurgensz, R. E. (1998). Legal issues relating to aboriginal people and HIV/AIDS: Discrimination, jurisdictional divisions, testing and confidentiality. *International Conference on AIDS, 12.* 970.

McGee, F., & Cerre, M. (1996, July 7-12). "Your place or mine": Community development and multi-government cooperation. *International Conference on AIDS, 11(2).* 196.

McLeod, A. (1996). Effective visual teaching tools developed for Aboriginal people in Canada. *Canadian AIDS News, IX(2),* 4.

McLeod, A. W., Johnson, L., Gardiner, L., & Kakeway, G. (1996, July 7-12). Culturally-appropriate visual teaching tools developed for Aboriginal people in Canada. *International Conference on AIDS, 11(2).* 52.

McLeod, A. (1998). North American aboriginal two-spirited sexual identity and HIV/AIDS. *International Conference on AIDS, 12.* 725.

McLeroy, K. R., & Clark, N. M. (1995). Creating capacity: Establishing a health education research agenda for special populations. *Health Education Quarterly, 22(3),* 390-405.

McLuhan, T.C. (1971). *Touch the earth*. New York: Outerbridge & Dienstfrey.

Miedzinski, L., Reese, H., Houston, S., Romanowski, B., Shafran, S., & Taylor, G. (1996, July 7-12). Hepatitis B and C infection in HIV-infected Albertans. *International Conference on AIDS, 11(1).* 170.

Mill, J. E., & DesJardins, D. A. (1996). The Feather of Hope Aboriginal AIDS Prevention Society: A community approach to HIV/AIDS prevention. *Canadian Journal of Public Health, 87(4).* 268-271.

Mill, J. E. (1997). HIV risk behaviors become survival techniques for aboriginal women. *Western Journal of Nursing Research, 19(4),* 466-489.

Moar, W. (1993, June 6-11). AIDS/HIV prevention education with IDUs in shooting galleries. *International Conference on AIDS, 9(2).* 873.

Myers, T, Calzavara, L. M., Cockerill, R., Marshall, V. W., & Bullock, S. L. (1993a, June 6-11). A participatory model for HIV research in culturally

diverse communities: Ontario First Nations AIDS Survey. First Nations Steering Committee. *International Conference on AIDS. 9(2),* 953.

Myers, T., Calzavara, L. M., Cockerill, R., Marshall, V. W., & Bullock, S. L. (1993b). *Ontario First Nations AIDS and healthy lifestyle survey*. Ottawa, ON: National AIDS Clearinghouse.

Myers, T., Calzavara, L. M., Cockerill, R., Marshall, V. W., & Bullock, S. L. (1993c, June 6-11). Major socio-cultural factors and HIV-among First Nations people: Results of the Ontario AIDS and Healthy Lifestyle Survey. First Nations Steering Committee. *International Conference on AIDS, 9(2).* 934.

Myers, T., Calzavara, L., Bullock, S., Cockerill, R., & Marshall, V. (1994, August 7-12). Gender differences in the use and influence of alcohol and drugs upon sexual behaviour in an aboriginal population. *International Conference on AIDS, 10(1).* 59.

Myers, T., Bullock, S. L., Calzavara, L. M., Cockerill, R., & Marshall, V. W. (1997). Differences in sexual-risk taking behavior with state of inebriation in an aboriginal population in Ontario, Canada. *Journal of Studies on Alcohol,58(3),* 312-22.

Myers, T., Bullock, S. L., Calzavara, L. M., Cockerill, R., Marshall, V. W., & George-Mandora, C. (1999). Culture and sexual practices in response to HIV among Aboriginal people living on-reserve. *Culture, Health & Sexuality, 1(1),* 19-37.

Nguyen, M. (1996). First surveillance meeting focusing on HIV/AIDS and Aboriginal communities in Canada. *Canadian AIDS News, IX(1),* 18-19.

Nguyen, M., Archibald, C. P., Yan, P., & Sutherland, D. (1996, July 7-12). Aboriginal HIV/AIDS in Canada. *International Conference on AIDS, 11(1).* 373.

Nguyen, M., Barlow, K., Laframboise, S., Albert, D., Andersen, F., & Etienne, D. (1998). Involving aboriginal communities in HIV/AIDS surveillance and research. *International Conference on AIDS, 12.* 989.

Ontario Aboriginal HIV/AIDS Strategy (1996). *Ontario Aboriginal HIV/AIDS Strategy*. Toronto: Ontario Aboriginal HIV/AIDS Strategy.

Parker, R., Khan, S., & Aggleton, P. (1998). Conspicuous by their absence? Men who have sex with men (MSM) in developing countries: Implications for HIV prevention. *Critical Public Health, 8(4),* 329-345.

Petosa, R., & Wessinger, J. (1990). Using the health belief model to assess the HIV education needs of junior and senior high school students. *International Quarterly of Community Health Education, 10(2).* 135-143.

Petosa, R., & Jackson, K. (1991). Using the health belief model to predict safer sex intentions among adolescents. *Health Education Quarterly, 18(4).* 462-476.

Picard, F. J., King, E. E., Oger, J. J., Rice, G. P., & Dekaban, G. A. (1993, December 12-16). Molecular epidemiology of HTLV-I infection in native Indians from British Columbia. *National Conference on Human Retroviruses & Related Infections,*150.

Prescott, D. A. (1995). Video focuses on gay and lesbian youth in Canada. *Canadian AIDS News, VII(Supplement),* 24.

Prochaska, J. O., & Redding, C. A. (1994). The transtheoretical model of change and HIV prevention: A review. *Health Education Quarterly, 21(4).* 471-486.

Procyk, R. (1995). Aboriginal PHA network faces an uncertain future. *Canadian AIDS News, VII(Supplement),* 6-7.

Pulley, L. V., & McAlister, A. L. (1996). Prevention campaigns for hard-to-reach populations at risk for HIV infection: Theory and implementation. *Health Education Quarterly, 23(4),* 488-97.

Purvis, A. (1999, February 15). Whose home and native land? *Time Magazine, 153(6),* 16- 26.

Rekart, M. L., Chan, S., Barnett, J., Lawrence, C., & Manzon, L. (1991, June 16-21). HIV and North American aboriginal peoples. *International Conference on AIDS, 7(1).* 357.

Rekart, M. L. (1993, June 6-11). Developing a strategy for urban aboriginal AIDS education prevention. *International Conference on AIDS, 9(1).* 109.

Rekart, M. L., Manzon, L. M., & Tucker, P. (1993, June 6-11). Transsexuals and AIDS. *International Conference on AIDS, 9(2).* 734.

Rivers, K., Aggleton, P., Elizondo, J., Hernandez, G., Herrera, G., Mane, P., Ibrahima Niang, C., Scott, S., & Setiadi, B. (1998). Gender relations, sexual communication and the female condom. *Critical Public Health, 8(4),* 273-289.

Schechter, M. T., Heath, K., Strathdee, S.A., Palepu, A., & O'Shaughnessy, M. V. (1998). Determinants of HIV infection in a cohort of native Canadian injection drug users. *International Conference on AIDS, 12.* 444.

Schilder, A. J., Braitstien, P., Hogg, R. S., Goldstone, I., Schechter, M. T., & O'Shaughnessy, M. V. (1998a). Treatment information dissemination and decision-making among HIV-positive persons is a regional and local phenomenon. *International Conference on AIDS, 12.* 820-1.

Schilder, A. J., Buchner, C., Hogg, R. S., Goldstone, I., Trussler, T., Schechter, M. T., & O'Shaughnessy, M. V. (1998b). Poor experiences of health care leads to avoidance by HIV-positive gay men in youth, ages 18 to 27, and can influence access and adherence. *International Conference on AIDS, 12.* 1055-6.

Schilder, A. J., Hogg, R. S., Goldstone, I., Strathdee, S., Schechter, M. T., & O'Shaughnessy, M. V. (1998c). Adult social identity is part of culturally competent HIV care for sexual minorities and affects care-seeking behaviors and therapeutic adherence. *International Conference on AIDS, 12.* 592.

Schilder, A. J., Laframboise, S., Strathdee, S., Goldstone, I., Trussler, T., Schechter, M. T., & O'Shaughnessy, M. V. (1998d). The social identity and self-concept of HIV-positive transgendered persons intervenes in HIV care. *International Conference on AIDS, 12.* 1056.

Schilder, A. J., Strathdee, S., Goldstone, I., Trussler, T., Schechter, M. T., & O'Shaughnessy, M. V. (1998e). Disclosure in health care experiences of HIV-positive bisexual men can influence access to antiretroviral therapy. *International Conference on AIDS, 12.* 607.

Srimshaw, S. C. M., & Carballo, M. (1991). The AIDS rapid anthropological assessment procedures: A tool for health education planning and evaluation. *Health Education Quarterly, 18(1).* 111-123.

Stiffman, A. R., & Dore, P. (1995). Person and environment in HIV risk behavior change between adolescence and young adulthood. *Health Education Quarterly, 22(2).* 211-225.

Strathdee, S. A., Hogg, R. S., Martindale, S. L., Cornelisse, P. G. A., Craib, K. J. P., Schilder, A., Montaner, J. S. G., O'Shaughnessy, M. V., & Schechter, M. T. (1996, July 7-12). Sexual abuse is an independent predictor of sexual risk-taking among young HIV-negative gay men: Results from a prospective study at baseline. *International Conference on AIDS, 11*.

Thomas, B. L., Hanvelt, R., Schneider, D., Meagher, N., Copley, T. T., Nowgesic, E., & DuBois, M. J. (1998). The economic impact of HIV on aboriginal people in Canada. *International Conference on AIDS, 12.* 604.

Tseng, A. L. (1996). Anonymous HIV testing in the Canadian aboriginal population. *Canadian Family Physician, 42,* 1734-40.

Valverde, C., & Smeja, C. (1993, June 6-11). Reflections on an aboriginal AIDS awareness programme in the U. N. year of the indigenous person. *International Conference on AIDS, 9(2).* 811.

Vanderhoef, S. (1998). Aboriginal palliative care. *International Conference on AIDS, 12.* 489.

Walter, H. J., & Vaughan, R. D. (1993). Factors associated with AIDS-related behavioral intentions among high school students in an AIDS epicenter. *Health Education Quarterly, 20(3).* 409-420.

Weiser, J., & Badger, D. (1996, July 7-12). Taking the medicine wheel to the street - educating and counselling Aboriginal street youth about HIV/AIDS. *International Conference on AIDS, 11(2).* 392.

Wortman, J. A. (1990, June 20-23). The AIDS pattern among Canadian Aboriginals. *International Conference on AIDS, 6(1).* 302.

Wortman, J. (1992, July 19-24). AIDS prevention programs for Canadian aboriginal people. *International Conference on AIDS, 8(2).* D445.

Young, H. (1995). AIDS education among the First Nations in Manitoba takes off. *Canadian AIDS News, VII(Supplement),* 3.

## Methodology

### The Survey Development Process

A focus group was organized drawing on clients of the *2-Spirited People of the 1st Nations*. The focus group consisted of seven young Aboriginal gay men and was conducted on March 25, 1999 by Dennis Haubrich and Judith Waalen (Centre for Quality Service Research). Two of the participants identified themselves as transgendered and reported that they obtained their income through work in the sex trade and one individual mentioned he was involved in the drug trade. A third participant reported deriving his income by selling drugs and sex trade work. None of the other participants reported employment. The focus group lasted approximately two hours. Each participant was reimbursed with fifty dollars for their participation in the study. The focus group discussion questions are listed below. The staff of the *2-Spirited People of the First Nations* organized this event which was held at Ryerson University.

### Focus Group Discussion Questions

1. What does it mean to you to be a two-spirited person?
   Probe: · to your family
   · to your community
   · to your culture

2. What were the circumstances in your life when you came out as a two-spirited person?

3. What were the circumstances in your life at the time you left your community of origin?

4. What were the issues that you had to face when you first came to Toronto? Have these changed? How did these change?

5. What impact has HIV disease/AIDS disease had on your life?

   Probe: · If you are HIV-, is becoming HIV+ a concern for you?
   · Have you been tested for HIV? When? How many times?
   · If you are HIV+, when do you think you were infected?
   · What has changed in your life since you became infected with HIV?
   · What are the ways in which you manage your infection?

6. What is your current relationship with your family and your community of origin?

7. How do you see your future?

**Focus Group Themes**

The focus group interview was audiotaped and transcribed verbatim. Four members of the research team independently reviewed the transcript in order to identify issues and generate questions for the survey.

There were several themes that emerged from the focus group participants. They were:

self-identification;

the process of coming out;

relationships (with partners, families and friends);

discrimination (race, culture, sexual orientation, welfare and HIV status);

poverty; mobility and changes in residence;

relationship and history with various social services and systems (i.e., education, legal, social services, CAS, child welfare);

abuse (i.e., physical, mental, emotional, sexual, spousal or partner, alcohol and drug);

involvement in activities which could bring them into conflict with the law (i.e., sex and drug trade); and

coping and adaptation skills.

<u>Self Identification</u>

Most of the participants in the focus group did not refer to themselves as two-spirited but as gay men, although one participant mentioned that it would depend on the situation. They further elucidated their identity by describing their coming out process.

<u>Coming out process</u>

For some participants, disclosure of sexual orientation and HIV positive status was a difficult process. Many of the participants expressed an early realization and rejection of the (gay) "party scene." The participants also

described many of the difficulties of coming out on the reserve and within the Aboriginal community.

Family

Most of the participants had several or different notions of family (i.e., adoptive, foster, biological and chosen). Participants described the difficulties of coming out to families and development of relationships with families. The participants' families had varying degrees of acceptance and tolerance. Some were more understanding than others were.

Reservation/community/nations

Perceptions and attitudes of their home communities/nations regarding sexual orientation have changed over time. Participants identified how historically the Berdache or two-spirited people were considered important members of the community. However, the participants also described how present day attitudes, namely the lack of acceptance of gay identified individuals and people living with HIV/AIDS have manifested into ostracizing and discrimination from within the Aboriginal community and even from band leaders and Aboriginal governments. These circumstances have forced some of the participants off of their reserves.

History of "being in care"

A number of participants described their circumstances and involvement with Children's Aid Society, child welfare and other social services. While in care some of them experienced and/or witnessed discrimination and abuse.

Housing

Many of the participants came from and lived in a variety of foster homes, shelters, and rooming houses and/or were involved with Children's Aid Society. They also described their current crisis in lack of housing. Several of the participants have lived on the streets surviving through drug trafficking and/or the sex trade.

Abuse

The participants described how they experienced or witnessed a variety of abuse (i.e., physical, mental, sexual and emotional abuse) from friends and relatives. Some participants also described experiences with spousal abuse.

Survival and adaptation on the streets

Practically all of the participants survived by working in the sex trade and/or the drug trade. One participant described his alleged involvement in other criminal activity such as break and enters.

Discrimination

All participants described experiencing discrimination of some form. One participant described his experiences of racism (within the gay community). Other participants elucidated their experiences of homophobia within their respective families and Aboriginal communities. Moreover, a few of the participants described their experiences of gay bashing. One HIV+ participant described his experiences of discrimination based on his HIV status and negative attitudes in his reserve community. A common assumption or stereotype placed upon them is that all gay people have or will get HIV/AIDS. The participants also described discrimination because of welfare status as a common experience.

Positive Experiences

Despite many of difficulties that the participants described it seems all of them have found some way to cope and survive. Most notably many of the focus group participants used humour to deal with their circumstances. Most of the participants appeared highly independent and one participant described it as "taking care of oneself."

Spirituality

One participant described his belief and practice of traditional Aboriginal medicines. Although, he mentioned that he later switched to Western medical treatment.

**Development of Research Strategy**

At the end of the focus group discussion, we asked what would be the best way to get information on the topics we asked about from the broader two-spirited community.

1. Individual self-administered surveys were the suggested data collection method. "You would get more truthful answers".

3. Ensure that the survey is confidential and that people could write down their answers without showing it to anyone.

4. Face to face interviews were reported as too invasive for some but others felt the group setting was safe also because of the nature of the questions.

From these themes and suggestions, a number of questions were developed for use in the survey. Questions that arose from the focus group included:

- What is the level of education/literacy?
- If and when did they leave school? Have or did they return to school?
- How does mobility (i.e., moving from city to city) affect their circumstances and life chances?
- How frequently have they moved?
- How do their different notions of family (i.e., adoptive, foster, biological, etc.) and their relationship to those families affect them?
- What are the available supports? How accessible are they?
- What is their level of knowledge with regards to services that are available?
- What is their perception of the services that are available to them?
- Have they had any involvement with the law?
- Have they had any involvement with the psychiatric system?
- How do they perceive and practice their spirituality?
- Are they taking responsibility for safer sex and/or disclosure of HIV status?
- Have they been tested for the HIV anti-body?
- How does HIV/AIDS affect them personally?
- What were the circumstances that were involved in their coming out?
- When did they come out?
- What are the different circumstances that would cause individuals to willingly leave or be forced off of their reserve community?
- How do they deal with their issues (need to specify which issues)?

From our review of the literature, additional survey questions were developed. These include:

<u>Demographic Information (Questions 1-8)</u>

- Age
- How many months have you lived in the city you now live?
- How many other cities have you lived in?
- Aboriginal identification
- Highest level of education
- First language

These questions are generic in nature but questions on Aboriginal identification and highest level of education were adapted from the Primary Source Questionnaire which was part of the Gay and Lesbian of the First Nations (GLFN) Native HIV/AIDS Awareness Project survey (Jamieson, 1991) used in

Toronto. The question on language was taken from the Urban Aboriginal AIDS Awareness Survey (UAAAS) (Dubois, 1996) used in Montreal.

We developed a question with six options to determine the self-identified sexual orientation of the respondent. Specifically, the question reads, "How do you identify yourself presently? Check all that apply to you." "Two-spirited" was one of the choices. Supporting literature for inclusion of two-spirited response comes from McLeod (1998), Deschamps (1998), Manitoba Aboriginal AIDS Task Force (1998), and Parker et al. (1998).

Four remaining demographic questions related to housing, employment and source of income are:

- What is your current housing situation?
- What is your usual occupation?
- What is your primary source of income?
- What is your current weekly income?

Questions on housing and primary source of income were modified from the UAAAS (Dubois, 1996) and the question on occupation was taken from the GLFN Primary Source Questionnaire (Jamieson, 1991). In addition, supporting literature for these four questions comes from Deschamps & Thoms (1995), Deschamps (1998).

Background Information and Relationships (Questions 9-14)

This section consists of seven questions. Among them are:

- Did you ever live in various housing facilities?
- When you arrived in this city, how easy was it to make contact with Aboriginal people, Aboriginal gay men, and non-Aboriginal gay men?
- Have you ever considered moving back to your home community?
- If you wanted to move home, is there anything that would prevent it?

The above questions were modified from the GLFN Primary Resource Questionnaire (Jamieson, 1991). Supporting literature came from Canadian AIDS News (1996), Deschamps (1998), and Thomas et al. (1998).

Another type of question was developed specifically for this survey as a result of the focus group discussion to allow for the development of an importance-satisfaction analysis. Fifteen (15) items were listed (e.g., the amount of control you have over your life, the emotional support you get from others) and the respondent was asked to rate their levels of satisfaction and importance for each item. One set of questions asked how satisfied the respondent is with various elements of his life (i.e., spirituality, relationship with friends) and the second set asked how important these areas of his life are to him. Graphical

representation of the responses on a grid identifies four quadrants representing high and low importance as well as high and low satisfaction on each of the fifteen areas.

Hope (Questions 15-17)

In two open- and one closed-ended questions, we asked for what hopes the respondent has in his life and how likely he feels that he will achieve this.

Health Concerns (Questions 18-22)

The section on "Health Concerns" is comprised of five questions.

- What do you consider to be your health risks with regard to sexually transmitted diseases? Check all that apply (9 options are listed).
- From the following list, what do you consider to be your health risks? Check all that apply (8 options are listed).

Supporting literature for health risks relating to tuberculosis includes Canadian Thoracic Society (1994), Fitzgerald (1995), Blenkusk et al. (1996), Miedzinski et al. (1996), Arvanitakis et al. (1998).

- What do you consider to be your lifestyle risks with regard to injection drug use? Check all that apply (6 options are listed including 'other').
- What to you consider to be your lifestyle risks? Check all that apply (15 options are listed including 'other').

Supporting literature includes Steffani et al. (1996), Deschamps (1998), Farley et al. (1998), Goldsone et al. (1998), Mai et al. (1998), Schechter et al. (1998).

Social Factors (Questions 22-23)

- Have any of the following social factors affected your life? Check all that apply or have applied to you (20 options are listed including 'other').
- Who do you consider to be your family? Check all that apply (6 options are listed including 'other').

Supporting literature includes Freudenberg & Trinidad (1992), Dubois (1994), Deschamps & Thoms (1995), Canadian HIV/AIDS Legal Network (1996), Steffani et al. (1996), Deschamps (1998), Haour-Knipe & Aggleton (1998), Malcolm et al. (1998), Schilder et al. (1998b, 1998c), Stiffman & Dore (1998), Thomas et al. (1998), Vanderhoef (1998), Jinich et al. (1996) and Dubois (1996). In addition, the 'family' question was developed as a result of feedback

from the focus group discussion, which indicated there are various notions for the term "family".

Sexual activity (Question 24)

This question is modified from the UAAAS (Dubois, 1996).

- Do you have one steady sex partner at the moment?

The three follow-up questions (if the respondent answered 'yes') were structured to determine the length of the current steady relationship as well as the number of sex partners of the respondent and his steady partner. Supporting references include Basen-Engquist & Parcel (1992), Prochaska & Redding (1994).

Attitudes about Sexual Activity (Questions 27-39)

Thirteen questions are included in this section.

- According to your community of origin, is it okay for men to have sex with men?
- According to your family, is it okay for men to have sex with men?
- According to you, is it okay for men to have sex with men?
- In the last 12 months, have you received money, gifts or favours in return for sex?
- In the last 12 months, have you been forced into sex with a person against your will?
- In the last 12 months, have you had sex with a person you didn't want to have sex with?

Supporting literature for these questions includes Freudenberg & Trinidad (1992), Deschamps (1998), Steffani et al. (1996), Stiffman & Dore (1998) and Dubois (1996).

Samples of the remaining questions in this section are:

- Do you ever use protection during a "*blow job*" (oral-genital sex) or "*bum fuck*" (anal-genital sex)?
- Have you had sex without a condom in the last 12 months? If yes, are any of the following reasons why you have not used a condom ("rubber" or "safe") on one or more occasions in the past 12 months?

Supporting literature includes Basen-Engquist & Parcel (1992), Bullock et al. (1996), Calzavara et al. (1996), Martindale et al. (1996), Deschamps (1998), Calzavara et al. (1998) and Dubois (1996).

Alcohol Consumption (Questions 40-45)

This section is made up of questions adapted from the UAAAS (Dubois, 1996).

- How often do you usually have drinks containing alcohol?
- If you do drink, where do you normally go to drink?
- Do you usually have sex [with people other than your steady sex partner] when you have been drinking?
- Do you usually have sex when steady sex partner has been drinking?
- Do you think drinking helps you meet people sexually?

Supporting literature includes Steffani et al. (1996), Myers et al. (1997), Deschamps (1998), and Ontario Aboriginal HIV/AIDS Strategy (1996).

Concerns about Access to Services (Questions 46-47)

- Have any of the following reasons kept you from using the health services available to you? Check all that apply (11 options are listed).
- Have any of the following reasons kept you from using the social services available to you? Check all that apply (11 options are listed).

Supporting literature: Canadian HIV/AIDS Legal Network (1996), Deschamps (1998), Schilder et al (1998d, 1998e), Hays (1996). These two questions were modified from the GLFN Primary Resource Questionnaire (Jamieson, 1991).

Knowledge & Attitudes about HIV/AIDS (Questions 48-67)

- Have you personally ever known anyone with HIV/AIDS disease?
- In your opinion, how great is the risk of getting AIDS or the HIV virus from any of the following activities?
- How many times would you say you have discussed AIDS with various people?
- How much of an immediate threat do you think AIDS is to the health of Aboriginal people?
- What are the chances that you yourself might get AIDS?
- How worried are you about getting AIDS?
- Do you think that you need to change any of your behaviours to protect yourself from getting AIDS?
- Have there been situations in which you felt that you should protect yourself from getting AIDS but were not able to?
- If one of your friends were to be diagnosed with AIDS, would you still continue to visit him/her?
- Who do you think should care for a person with AIDS?

- What do you think should be done to make sure that the virus is not passed from one person to another?
- How many times have you been tested for AIDS or HIV?
- If you had or thought you had AIDS, who would you feel most comfortable speaking about it besides your family?
- If you had or thought you had AIDS, would you seek support from any of the following?
- How common do you think AIDS is among First Nations, Native or Inuit people?

The above questions are all taken or adapted from the UAAAS (Dubois, 1996).

- What HIV/AIDS prevention programs do you think are most effective for Aboriginal people? (5 options are listed).
- Do you believe AIDS transmission among Aboriginals is mainly through? (4 options are listed).

These questions were developed as a result of the focus group discussions and additional supporting literature including: Wortman (1990), Rekart et al. (1991), Lambert (1993), Bullock et al. (1996), Canadian HIV/AIDS Legal Network (1996), Dubois (1996), McLeod et al. (1996), Mill & Desjardins (1996), Weiser & Badger (1996), Baker (1998), Calzavara et al. (1998a), Deschamps (1998), Goldstone et al. (1998), Health Canada (1998), Lea & Price (1998), Littlejohn et al. (1998), Schilder et al. (1998a, 1998d, 1998e), Vanderhoef (1998), Myers et al. (1999), and The Canadian Aboriginal AIDS Network (1998).

<u>Aboriginal Identification (Question 68)</u>

- Do you identify yourself as native, native Canadian, First Nations, Indian, Aboriginal, Inuit, Status, Non-Status, Treaty, Non-treaty, C-31, Metis, Mixed Heritage? Check all that apply to you.

At the end of the survey, space was left for respondents to include something that we might have missed or that they would like to tell us. A copy of the survey is located in the Appendix.

## Survey Results

The results are based on the surveys from 189 respondents returned during the period April 2000 through February 2001. The respondents are from British Columbia (n=69), Saskatchewan (n=2), Manitoba (n=62), Ontario (n=41), Quebec (n=9), and Eastern Canada (n=6).

### Demographic Information

The age of the participants ranged from 17 to 62 years (average=34 years, SD=8). The length of time respondents reported residing in their current town or city ranged from 1 week to 49 years (average=12 years, SD=10).

Sexual identification. When asked, "How do you presently identify yourself?" respondents could check as many descriptors as applied. Most reported they were two-spirited (58%) or gay (48%), some using both terms. Sixteen percent identified themselves as bisexual and 11% as transgendered.

Aboriginal identification. "How do you identify yourself?". Again, respondents could check as many descriptors as applied. About half of our respondents chose to identify themselves as 'native' (53%), 'First Nations' (50%), "Aboriginal' (50%) or 'Status' (41%). Less frequently used descriptors were 'Native Canadian' (41%), 'Treaty' (36%), and 'Indian' (27%). Very few respondents chose the remaining categories: 'Métis' (15%), 'Mixed heritage' (10%), 'C-31' (8%), 'Non-status' (6%), 'Inuit' (5%) or 'non-treaty' (3%).

Family identification. We asked participants, "Who do you consider to be your family?" and they checked as many descriptors as applied. Over two-thirds (69%) defined 'family' as friends and over half (57%) considered their biological family to be their family. Respondents also identified their family to be their chosen family (20%), adoptive family (12%), and foster family (5%).

Opinions about sexual orientation. When asked "According to your **community of origin**, is it okay for men to have sex with men?", 51% replied "no", 26% said "yes" and 23% said "don't know".

**"**According to your **family**, is it okay for men to have sex with men?", 42% replied "no", 32% said "yes" and 26% answered "don't know".

"According to **you**, is it okay for men to have sex with men?", 86% said "yes", only 9% replied "no" and 5% answered "don't know".

***"HIV/AIDS and its spread is inextricably tied to intolerance of diversity. Having the self-esteem to protect yourself from diseases is dependent on living in a society that honours and respects all people."***

Sources and level of income. Sources of income are primarily from social assistance (45%), disability (31%) and wages (29%). Note that respondents were asked to check all the categories that applied and some reported having more than one source of income. Their reported weekly income ranged from $0 to $2,500 (average=$304, SD=327).

Educational level. Over two thirds of the respondents reported either completing secondary school (41%) or primary school (17%). In terms of post-secondary education, 16% had completed community college, 13% had completed university, 11% had completed technical/vocational college, and 2% of respondents reported some other educational level such as Aboriginal literacy or adult education.

Housing situation. Almost half of the respondents reported living in a rental apartment (49%) and others reported living in subsidized housing (12%), in a rooming house (12%), in a rental house (7%), with friends (7%), in a house or condo (3%) or in a shelter or halfway house (2%). Three percent of the respondents said they are homeless and 5% reported living elsewhere (i.e., with family, in a hotel, etc.).

Occupation. "What is your occupation?" The respondents' written answers were classified into the following categories:

| ***Category*** | ***frequency*** | ***percentage*** |
|---|---|---|
| **Manual labour** (e.g. construction, carpentry, cleaning) | **(24)** | **21%** |
| **Food service industry** (e.g. waiter, cook, restaurant manager) | **(15)** | **13%** |
| **Student** | **(14)** | **12%** |
| **Retail services** (e.g. hairdresser, sales, cashier, customer service) | **(13)** | **11%** |
| **Social services** (e.g. counsellor, social service or youth worker) | **(10)** | **8%** |
| **Health services** (e.g. HIV/AIDS educator, nurse, health care aide) | **(9)** | **8%** |
| **Administration** (e.g. secretary, board member, director, clerk) | **(7)** | **6%** |
| **Arts** (e.g. artist, writer, soapstone carver, designer) | **(7)** | **6%** |
| **Sex trade** (e.g. prostitution, hustling) | **(5)** | **4%** |
| **Education/Research** (e.g. teacher, researcher) | **(4)** | **3%** |
| **Technical/Computers** (e.g. computer support, technician) | **(3)** | **2%** |
| **Other** (e.g., native guide, security guard, cycle messenger) | **(10)** | **8%** |

The occupation categories are diverse. About one-fifth have occupations that involve construction, carpentry and cleaning. Food service industry occupations account for 13% of the sample. Social and health services combined account for 16%. About one-tenth are students or have retail-related occupations. Occupations associated with the arts are represented (6%). A few are teachers, tutors, or computer technicians.

**Background**

Stability. To the multi-item question "Did you ever live…?", the following "**yes**" responses were received. Note that the respondents could check more than one answer.

| *Past history* | *frequency* | *percentage* |
|---|---|---|
| **on a reserve** | **(121)** | **72%** |
| **on the street** (homeless) | **(83)** | **49%** |
| **in a foster home** | **(58)** | **34%** |
| **in a group home** | **(43)** | **26%** |
| **in a detention facility** | **(31)** | **18%** |
| **at a residential school** | **(24)** | **14%** |

Over 70% have lived on a reserve and half have experienced homelessness. One third have lived in a foster home. A small percentage (14%) report that they have lived at a residential school.

Negative social influences. When asked "Have any of the following social factors affected your life?", the following responses were received. Only 8 respondents (5%) did not check at least one of these factors.

| *Sociological Factors* | *frequency* | *percentage* |
|---|---|---|
| **Unemployment** | **(141)** | **76%** |
| **Poor housing** | **(83)** | **45%** |
| **Racism** | **(82)** | **44%** |
| **Poverty** | **(75)** | **40%** |
| **Homophobia** | **(71)** | **38%** |
| **Suicide** | **(60)** | **32%** |
| **HIV discrimination** | **(59)** | **32%** |
| **Physical abuse** | **(59)** | **32%** |
| **Sexual abuse** | **(58)** | **31%** |
| **Gay bashing** | **(58)** | **31%** |
| **Partner/spousal abuse** | **(52)** | **28%** |
| **Problems with the law** | **(52)** | **28%** |
| **Mental abuse** | **(52)** | **28%** |
| **Poor health services** | **(49)** | **26%** |
| **Lack of access to education** | **(46)** | **25%** |
| **Psychological issues** | **(42)** | **23%** |
| **Learning disabilities** | **(32)** | **17%** |
| **Pollution** | **(23)** | **12%** |
| **Rehabilitation** | **(15)** | **8%** |
| **Other factor(s)** (e.g., native politics, sexual assault) | **(5)** | **3%** |

***"Two-spirited men experience an enormous amount of grief, much of it intergenerational -- passed on, so to speak. It usually goes unaddressed and is the major reason for the high degree of depression"***

Three-quarters of our respondents have been affected by unemployment and almost half have lived in poor housing, been exposed to racism, and experienced poverty. About one-third have been affected by homophobia, suicide, HIV discrimination, physical and sexual abuse, and gay bashing.

**Relationships**

Home community relationships. When we asked the question "Have you ever considered moving back to your home community?", 57% reported that they did not consider it. Only 7% said that they live in their home community. To the follow-up question "If you wanted to go home, is there anything that would prevent this?", 52% replied "yes". The following reasons were selected:

| ***Reasons for not going home*** | ***frequency*** | ***percentage*** |
|---|---|---|
| **The town I am presently living in has become my home** | **(43)** | **49%** |
| **No services that I need are available at home** | **(40)** | **46%** |
| **My community would not accept me** | **(38)** | **43%** |
| **There is no work/employment for me at home** | **(38)** | **43%** |
| **I have the support of people where I live** | **(29)** | **33%** |
| **Other reason** (e.g., homophobia, HIV status) | **(25)** | **28%** |
| **I can't afford to get there** | **(25)** | **28%** |
| **My family would not accept me** | **(19)** | **22%** |
| **I have been banished from my community** | **(8)** | **9%** |
| **Difficulties with the law prevent me from going home** | **(7)** | **8%** |
| **Probation/parole restrictions** | **(5)** | **6%** |

For half of the respondents, home is where they live now. About half of the respondents report that are no services, no acceptance and no work at home.

Urban relationships. We asked "When you arrived in the town or city in which you now live, how easy was it to make contact with other **Aboriginal people**?" Most (72%) reported that it was relatively easy although 13% said it was relatively difficult. The remainder (15%) reported no interest in making contact with other Aboriginal people.

***"Having an HIV/ AIDS lover made my reserve react badly towards this. I am forced to live away from those who care because I was told I couldn't be protected 24 hours/day."***

"How easy was it to make contact with other **Aboriginal gay men**?". Two-thirds (63%) reported that it was relatively easy, while 17% said it was relatively difficult. The remainder (20%) reported they were not interested in making contact with other Aboriginal gay men.

And we also asked "How easy was it to make contact with **non-Aboriginal gay men**?" Over two-thirds (68%) said it was relatively easy, 17% said it was relatively difficult while 15% reported that they were uninterested in making contact with this group.

Urban relationships were reported as being relatively easy to establish by two-thirds of our respondents. The ease of making contact did not vary depending on whether it was other Aboriginal people, Aboriginal gay men, or non-Aboriginal gay men.

**Importance and Satisfaction in Life**

Importance. We asked participants to rate the importance of 15 areas of life on a 4-point Likert scale. For ease of reading, we combined the 'very important' and 'important' responses into one category. Similarly, the 'very unimportant' and 'unimportant' responses were combined.

| ***How important to you is……..…*** | **Unimportant or Very Unimportant** | **Important or Very Important** |
|---|---|---|
| **The amount of control you have over your life?** | **2%** | **98%** |
| **Feeling pride in your cultural background?** | **10%** | **90%** |
| **The emotional support you get from others?** | **8%** | **92%** |
| **Yourself?** | **6%** | **94%** |
| **Your sex life?** | **22%** | **78%** |
| **Your usefulness to others?** | **8%** | **92%** |
| **Where you are now living?** | **18%** | **82%** |
| **Your leisure time activities?** | **16%** | **84%** |
| **Your peace of mind?** | **8%** | **92%** |
| **Your spirituality?** | **7%** | **93%** |
| **Your ability to protect yourself from abuse?** | **10%** | **90%** |
| **Your sexual identity?** | **11%** | **89%** |
| **Your financial situation?** | **13%** | **87%** |
| **Your relationship with your friends?** | **5%** | **95%** |
| **Your relationship with other gay people?** | **17%** | **83%** |

Satisfaction. We then asked participants to rate their level of satisfaction for these areas of their life.

| *Areas of satisfaction/dissatisfaction* | Dissatisfied or Very Dissatisfied | Satisfied or Very Satisfied |
|---|---|---|
| **The amount of control you have over your life?** | **24%** | **76%** |
| **Feeling pride in your cultural background?** | **21%** | **79%** |
| **The emotional support you get from others?** | **25%** | **75%** |
| **Yourself?** | **26%** | **74%** |
| **Your sex life?** | **31%** | **69%** |
| **Your usefulness to others?** | **21%** | **79%** |
| **Where you are now living?** | **37%** | **63%** |
| **Your leisure time activities?** | **34%** | **66%** |
| **Your peace of mind?** | **28%** | **72%** |
| **Your spirituality?** | **26%** | **74%** |
| **Your ability to protect yourself from abuse?** | **25%** | **75%** |
| **Your sexual identity?** | **17%** | **83%** |
| **Your financial situation?** | **58%** | **42%** |
| **Your relationship with your friends?** | **20%** | **80%** |
| **Your relationship with other gay people?** | **18%** | **82%** |

The greatest difference in the ratings of importance and satisfaction is “financial situation.” Most (88%) rated it as important or very important but rated their level of satisfaction as dissatisfied or very dissatisfied (58%). Almost everyone (98%) rated the “amount of control you have over your life” as important or very important but fewer (76%) reported being satisfied or very satisfied with their locus of control. Cultural pride was important or very important (90%) and 79% reported being satisfied or very satisfied with their cultural pride.

Themes regarding importance and satisfaction. We also asked respondents, "In order to better understand your personal situation, are there any comments or explanations that you would like to give us about your answers to the areas of life in the previous two questions?' Interestingly, their responses highlighted the importance of good or bad relationships, self-actualization and spirituality, as well as the impact of the availability of basic financial resources in day-to-day living. Most of the comments were positive and characterized by words such as ‘fighting, ‘survival’, ‘one day at a time’, ‘spiritual connection’, ‘love’, ‘loving relationship’, ‘holistic’, ‘life is a gift’, etc. These comments seemed to be tied to spiritual and relationship themes. Negative comments, however, were flagged with words such as ‘unhappy’, withdrawn’, ‘lost’, ‘isolated’, ‘dissatisfied’, ‘fear’, or ‘not a lot of control’. In all, thirteen themes emerged from the responses. Those themes and examples of them are outlined below.

*Satisfaction with amount of control over own life*

- I am very much in Control of my life and very contented.

- I am in a very stressful relationship, my partner is in custody and is in a lot of trouble. He owes a lot of money & cigarettes to people on his range and he relies on me to do unusual tasks.
- I'm Aboriginal transsexual prostitute living with disease of addiction & HIV…in my unhealthy relationship but too scared to leave him.
- I am a sex trade worker ONLY to support my crack addiction, alcohol addiction. I do have a boyfriend who is trying to help me help myself.

*Satisfaction with feeling pride in cultural background*

- So for myself my cultural background is very important to me as a person! Knowing who you are in life helps to deal with everyday, one day at a time.
- In general, I am still feeling withdrawn from the rest of society. As an Aboriginal Youth, I find people asking me about my culture. It is something that I lost and I feel that on a daily basis. People tell me that it was probably for the best. I feel that I have lost out on what seems so right.
- No access to Dene cultural activities.
- I was fortunate enough to be adopted by a family with strong ties to their culture.
- When I do go out with other men, I don't go out with other aboriginal men, I feel that I'm disrespecting my aboriginal brothers.

*Satisfaction with emotional support from others*

- Having looked after my dying partner I am mentally emotionally & physically exhausted as I was in an isolated situation with no support.

*Satisfaction with self*

- I am old; before my time. But my age has not benefited me with much wisdom, just sore bruises, and achy joints and some grey hair. I sometimes wonder about how I came to this, it should not be like this, but I see it could be no other way. I was a child once, who did not know the hand in front of his face, at least then. I knew more than my parents were allowed to know. I saw my hand.

*Satisfaction with sex life*

- Not sexually active. Widower, partner passed away.
- As for the sex thing, it was more important when I was younger.

*Satisfaction with usefulness to others*

- Due to my past life history and all the situations I was involved in, I dedicate my time in helping others so they don't endure or make the same mistakes I have. I've always been very strong mentally, spiritually, emotionally, and physically.

*Satisfaction with current living situation*

- At this point in my life, I wish to go back to living alone to get back to my roots and sanity back.
- My homeless situation is by my own choice and ought not be regarded in a negative light. I won't be homeless for long and right now I feel I need to experience life on the street. It makes for good wisdom.

*Satisfaction with spirituality*

- At times I'm very dissatisfied with life in general. I need more spirituality in my life.
- God + homosexuality?? Only he knows.
- I don't believe in homosexual sex I am a Christian and God does not approve. I don't have sex.

*Satisfaction with ability to protect yourself from abuse*

- I moved to get away from the abuse and ridicule from the Reserve. I'd like to participate in the future healing circles, or anything to do with the natural way of life.

*Satisfaction with sexual identity*

- I am ashamed to admit to being gay.
- I was raised in the Catholic church which instilled a lot of shame about sexuality in general and self-hatred because of my homosexuality.
- To be transgendered and waiting for the sex change operation makes me sometimes mad and impatient.

*Satisfaction with financial situation*

- Financial situation bad due to returning to school for last 5 years.
- I am unhappy at my age being untrained and finding it difficult to find resources or monies for "realistic job training."
- My financial situation is the one factor in my life that does create the most amount of stress, other than that I'm able to take life as it comes.
- I am unhappy at my age being untrained and finding it difficult to find resources or monies for "realistic job training".

*Satisfaction with relationship with friends*

- I feel that trust and understanding comes first in every relationship and life in general.
- I do have a few close friends, but mostly I keep people an arms length away.
- I have spent a great deal of time working on my career and establishing some kind of professional security but have neglected to take time to develop rewarding recreation and intimate personal relationships. I don't seem to have "fun" too often.

*Satisfaction with relationship with other gay people*

- I am totally unaware of my background I just try to live day to day trying to be happy but I find it almost impossible due to the gay scene being so mistrustful chaotic and promiscuous it's hard to have a decent relationship.

***"Due to my past life history and all the situations I was involved in, I dedicate my time in helping others so they don't endure or make the same mistakes I have. I've always been very strong mentally, spiritually, emotionally and physically."***

Hope. In an open-ended format, we asked "What do you hope for in your life?" The dominant themes that emerged were hopes regarding healthy and loving relationships, security, acceptance and peace of mind, better education or employment, improved physical health, enhanced self-esteem, fulfillment, and helping others. The following are examples from the 171 (96%) participants who provided answers organized into eight themes.

*Healthy and loving relationships*

- A stable, equal same sex relationship.
- To meet a good friend for life.
- A fulfilling relationship.
- To remarry.
- To find the love of my life.
- To find someone who will be with me for me so that we may have a full and long happy life together.
- It is important for me and my partner to have a better future being gay.
- To settle down, slow down, develop a loving long term relationship with another stable First Nations or other man.
- I hope for a sense of belonging to my family, community and to myself.

*Security*

- To become financially secure for myself & my family.
- Full-time job, better apartment, new bed, clean water, independence.
- To be financially secure with my partner.
- I hope to first develop my stability and structure in order to plan ahead how well I would like to live.
- Financial independence, and freedom of choice, to do as I please and not what I'm told.
- To find a place to live, a job, and a boyfriend who won't beat me.

*Acceptance and peace of mind*

- To be a good person.
- I hope that I can live a long, happy, and fulfilling life, free of negativity and blame, animosity and bitterness.
- Spiritual fulfillment.
- Peace of mind.
- To be happy and accepted as I am.
- I hope for a better understanding from other native peoples who are not two spirited.
- To live in Peace and Harmony.
- A peaceful life and death.
- My spiritual life is not what it is supposed to be, but I think about it a lot.
- Le bonheur, la paix de l'espris, et d'etre considere comme un etre humain simplement!

***Le bonheur, la paix de l'espris et d'être consideré comme un être humain simplement!***

(Happiness, peace of mind, and to simply be treated like a human!)

*Better education or employment*

- To finish my education.
- To find a better life and get a good job.
- Own my own business.
- To go back to school (now that I'm well enough).
- To get a very good paying job in the future, after I get a pardon.

*Improved physical health*

- That they find a cure for AIDS so I can live longer.
- I especially hope for a cure for HIV/AIDS!!
- To stay alive and healthy.
- A cure.
- Quit drugs, alcohol I hope to lead an HIV positive life in 10 years without Protease Inhibitors.
- A cure.
- Right now I am just trying to survive my addiction.
- Disease free.
- Limit my intake of alcohol. Exercise, quit smoking.
- To be in good health for the rest of my life and so on.
- That they find a cure, and someday I would like to be truly happy again!
- I hope to be still living in 15 to 20 years and hope they find a cure to prevent this from happening to other Natives.

*Enhanced self-esteem*

- To be recognized for the work I do.
- Self-esteem.
- Sober way of life is what I strive for.
- To become something that my family and friends will be proud of.
- To be with my partner and be happy with my self and accept myself.
- I hope to see more 2 spirited people come out and be more open.

*Fulfillment*

- To live my life to the fullest, and do all the required tasks honourably in the eyes of the creator.
- To make something out of my life.
- To know my potential as being fulfilled.
- To be successful and overcome any barriers that may stand in my way.
- Health, wealth, and usefulness to others.
- To live happy fruitful life filled with high spirits.
- Happiness and also the fulfillment of short-term and long-term goals.
- That some day I will find a partner who will accept me for myself and settle down and build a life together.

*Helping others*

- I'm pretty well with my life now, speaking publicly to people about HIV/AIDS. Try to do my best to help other to learn more and to protect myself.
- Contribute to society in a meaningful way.
- To help other native youth that get kicked out of their home for being two-spirited.
- To bring good to others and all of mankind.
- To establish a healing centre for people who have experienced residential school abuse in a sound cultural environment.
- Political changes that benefit all people.
- Just to be happy and treat everyone with respect and bring enough joy for them if they feel down.
- To help others in need.
- I hope to be able to support my mother in her time of need.
- To learn as much about our culture and traditions, teach others to respect one another, and to inform society the injustices that have gone on and still go on today.
- To share my artistic skills.
- I hope to leave some positive inspiration to those who are important to me.
- Wealth to share w/family & friends & less fortunate people.

The comments show that many respondents expressed hope that showed internal locus of control, spirituality, finishing school, and other personal goals. To the follow-up question "How likely do you feel it is that you will achieve this?", 40% said "very likely", 33% said "likely", 6% said "unlikely", 6% said "very unlikely", and 16% said "don't know".

**Accessing Health and Social Services**

Reluctance to use health services. To the question "Have any of the following reasons kept you from using **health** services?", the following responses were received:

| ***Accessing Health Services*** | ***frequency*** | ***percentage*** |
|---|---|---|
| **No transportation** | **(54)** | **40%** |
| **I didn't know where to go for services** | **(50)** | **37%** |
| **Fear of discrimination because of my sexual orientation** | **(49)** | **37%** |
| **Fear of discrimination because I'm HIV positive** | **(45)** | **34%** |
| **Fear of doctors/hospitals** | **(39)** | **29%** |
| **Fear of discrimination because I'm Native** | **(38)** | **28%** |
| **I don't feel welcome where services are offered** | **(35)** | **26%** |
| **Services are too far away or inconvenient** | **(33)** | **25%** |
| **Fear of discrimination because they think I'm in the sex trade** | **(20)** | **15%** |
| **Fear of discrimination because I am an injection drug user** | **(14)** | **10%** |
| **Services aren't available in my language** | **(9)** | **7%** |

Lack of transportation was reported by 40% of the respondents. Lack of information on where to go for services and fear of discrimination because of sexual orientation were chosen by 37% of the respondents.

Reluctance to use social services. When asked "Have any of the following reasons kept you from using **social** services?", the following responses were reported:

| ***Service Use Reluctance*** | ***frequency*** | ***percentage*** |
|---|---|---|
| **I don't feel welcome where services are offered** | **(37)** | **36%** |
| **Fear of social workers/social service organizations** | **(33)** | **32%** |
| **Fear of discrimination because of my sexual orientation** | **(29)** | **29%** |
| **No transportation** | **(30)** | **29%** |
| **Fear of discrimination because I'm HIV positive** | **(26)** | **25%** |
| **Fear of discrimination because I'm Native** | **(26)** | **25%** |
| **I didn't know where to go for services** | **(24)** | **23%** |
| **Services are too far away or inconvenient** | **(19)** | **18%** |
| **Fear of discrimination because I'm in the sex trade** | **(9)** | **9%** |
| **Services aren't available in my language** | **(7)** | **7%** |
| **Fear of discrimination because I am an injection drug user** | **(7)** | **7%** |

**Health Concerns**

Sexually transmitted disease. When asked, "From the following list, what do you consider to be your health risks with regard to sexually transmitted diseases?", the following responses were received. Please note that 33 (18%) of the respondents said that they did not consider any of the following to be a health risk.

| ***STDs*** | ***frequency*** | ***percentage*** |
|---|---|---|
| **HIV/AIDS** | **(129)** | **71%** |
| **Hepatitis** | **(78)** | **43%** |
| **Herpes** | **(51)** | **28%** |
| **Genital warts** | **(42)** | **23%** |
| **Crabs** | **(38)** | **21%** |
| **Gonorrhoea** | **(38)** | **21%** |
| **Syphilis** | **(36)** | **20%** |
| **Chlamydia** | **(27)** | **15%** |
| **NSU** (nonspecific urethritis) | **(11)** | **6%** |
| **Other disease** | **(8)** | **4%** |

General health risks. When asked "From the following list, what do you consider to be your health risks?", the following responses were received. Twenty-eight (16%) of the respondents reported having none of these health risks.

| *General Health Risks* | *frequency* | *percentage* |
|---|---|---|
| **Hepatitis** | **(68)** | **38%** |
| **Cancer** | **(59)** | **33%** |
| **Diabetes** | **(56)** | **31%** |
| **Heart disease** | **(48)** | **27%** |
| **Mental illness** | **(45)** | **25%** |
| **Pneumonia** | **(43)** | **24%** |
| **Tuberculosis** (TB) | **(43)** | **24%** |
| **Asthma** | **(36)** | **20%** |
| **Other disease** (e.g., Arthritis, alcohol) | **(24)** | **13%** |

**Lifestyle Risks**

Injection drug use risks. When asked "From the list below, what do you consider to be your lifestyle risks with regard to injection drug use?", the following responses were received. Of note is the fact that 101 participants (57%), reported that none of the lifestyle risks applied to them. Of those options checked, Cocaine was selected by 32% (56).

| *IDU Risks* | *frequency* | *percentage* |
|---|---|---|
| **Cocaine** | **(56)** | **32%** |
| **Crack** | **(37)** | **21%** |
| **Heroin** | **(20)** | **11%** |
| **T and R** | **(14)** | **8%** |

Other lifestyle risks. When asked "From the list below, what do you consider to be your lifestyle risks?", the following responses were received. Only 5 (3%) respondents said that none of the risks (in the list below) applied to them. Of those options selected, smoking, alcohol, poor diet, and lack of exercise were the most frequently selected risks.

***"I think an important subject is a person's mental health"***

| *Other Lifestyle Risks* | *frequency* | *percentage* |
|---|---|---|
| **Smoking** | **(142)** | **78%** |
| **Alcohol** | **(125)** | **69%** |
| **Poor diet** | **(101)** | **56%** |
| **Lack of exercise** | **(82)** | **45%** |
| **Undereating** | **(59)** | **33%** |
| **Marijuana/Hashish** | **(58)** | **32%** |
| **Cocaine** | **(57)** | **31%** |
| **Overeating** | **(38)** | **21%** |
| **Poppers** | **(36)** | **20%** |
| **Street drugs** (E, X, GBH, K) | **(35)** | **19%** |
| **Exposure to weather** | **(27)** | **15%** |
| **Gambling** | **(25)** | **14%** |
| **Tranquilizers** (downers) | **(19)** | **10%** |
| **Pep Pills** (uppers) | **(10)** | **6%** |
| **Solvents/glue/mouthwash** | **(10)** | **6%** |

**Sexual Activity**

Sex partner. "Do you have one steady sex partner at this time?", 58% replied "no" and 42% replied "yes". Of those that replied "yes", 35% indicated that they had been together for over 5 years, 27% between 1 and 5 years, 23% between 7 months and 1 year, and 15% for 6 months or less.

Again, for those who replied "yes", 53% stated that their steady partner had no other sex partners at that time, 18% stated that their partner did have another sex partner and 30% said that they did not know. When asked, "Do you have other sex partners?", 42% replied that they did.

When asked, "How old were you when you had your first sexual experience?", the answers ranged from 2 and ½ years to 25 years (average=12 years, SD=4.2).

When asked "In the past year, have you received money, gifts, drugs or favours in return for sex?", 35% replied "yes". "In the past year, have you been forced into having sex

with a person against your will?", 16% replied "yes". "In the past year, have you had sex with a person you didn't want to have sex with?", 35% replied "yes".

Condom use. The answers to questions on condom use for various sexual activities are summarized in the following table (reported as percentages):

| **Do you use a condom for:** | **Always** | **Often** | **Sometimes** | **Never** |
|---|---|---|---|---|
| Giving oral-genital sex | 21% | 10% | 36% | 34% |
| Receiving oral-genital sex | 23% | 7% | 28% | 42% |
| Insertive anal-genital sex | 55% | 6% | 25% | 14% |
| Receptive anal-genital sex | 57% | 6% | 25% | 12% |

Over half of the respondents always use a condom when engaging in insertive anal-genital sex and when engaging in receptive anal-genital sex. Further, in a sub-analysis of this information, 11% of the respondents said they "always" use a condom in all 4 situations and 6% said they "never" use a condom in any of the 4 situations.

When asked "Have you had sex without a condom in the past year?", 61% said "yes" and 39% replied "no". Of those that said "yes", there were a number of reasons checked for why they did not use a condom when you had sex in the past year. The most frequent reason was when the respondent was using alcohol or drugs. Over half of the respondents selected this reason. The second reason was that 'my partner did not want to use one'. Almost half (49%) of the respondents checked this option. The other reasons are outlined below.

| ***Reasons for not using a condom*** | ***frequency*** | ***percentage*** |
|---|---|---|
| **I was using alcohol or drugs** | **(59)** | **57%** |
| **My partner did not want to use one** | **(51)** | **49%** |
| **The sex was so exciting that I didn't use one** | **(42)** | **40%** |
| **I did not want to use one** | **(39)** | **38%** |
| **I was with my steady partner** | **(37)** | **36%** |
| **I thought I was in a safe situation** | **(34)** | **33%** |
| **I did not have a condom at the time** | **(30)** | **29%** |
| **I find condoms uncomfortable** | **(21)** | **20%** |
| **I did not think of using a condom** | **(20)** | **19%** |
| **I could not talk about using a condom** | **(12)** | **12%** |
| **The condom broke** | **(9)** | **9%** |
| **I was forced to have sex against my will** | **(8)** | **8%** |
| **I could not afford to buy any condoms** | **(4)** | **4%** |
| **I was too embarrassed to get condoms** | **(4)** | **4%** |
| **She wanted to get pregnant** | **(1)** | **1%** |

Unsafe sex situations. We asked "Are there situations when you have unsafe sex?" Half (52%) of our respondents said "yes". For those that said "yes", we asked them to describe those situations (in an open-ended question). Eighty-seven respondents provided descriptions. In summary, twenty-four of the situations involved being under the influence of alcohol or drugs ('too much booze', 'drunk or high', 'when I am really inebriated'). Seven respondents reported bathhouses, parks, and pick-up bars as the places they engage in unsafe sex. Five respondents reported that 'johns' often request sex without a condom. Six reported practising unsafe sex with their partners who are HIV+. Two respondents were the victims of rape or sexual assault. In general, the responses appear to demonstrate that situations of unsafe sex occurred when control and conscious decision were compromised by the influence of drugs or alcohol, or by other people. The exception to this was those few who practised unsafe sex with similarly HIV+ partners.

Safe sex situations. To the question, "Are their situations when you only have safe sex?" 64% responded "yes". For those who said "yes", we asked them to describe those situations. Ninety-two individuals gave examples. In summary, a concern about passing on or getting HIV was expressed by 27 of the respondents. Being sober was a reason expressed by nine of the respondents. Twelve practiced safe sex if anal intercourse was involved. The remainder of the comments referred to long term relationships, protection of the other person, complying with partners' requests, or uncertainty with respect to knowing about the other partner's history. In contrast with the previous question involving unsafe sex, the respondents' choices for safe sex seemed to involve rational and conscious choice and/or consideration for their partners. The qualitative responses to both questions seem to suggest that the lack of knowledge is not necessarily the dominant factor involved in decisions regarding safe/unsafe sex.

**Alcohol Consumption**

When asked "How often do you usually have drinks containing alcohol?", 10% said "Daily", 16% said "More than twice a week", 20% said "Once or twice a week", 25% said "Once or twice a month", 15% said "Less often than once or twice a month", and 14% said "Never".

Of the 86% of respondents who do drink alcohol, we asked where they normally go to drink. They could check as many options as applied. The locations chosen were a bar/nightclub (81%), at home (65%), a friend's or relative's place (58%), and a restaurant or hotel (30%).

**Knowledge and Attitudes about HIV/AIDS**

Prevalence. When asked the question "Do you know or have you ever known anyone with HIV/AIDS disease?", 94% of the respondents said "yes", 5% said "no" and 1% said "Don't know".

When asked "How common do you think HIV/AIDS is among First Nations, Native or Inuit people?", 47% said "Very common", 38% said "Moderately common", 5% said "Not common", 2% said "Very rare" and 8% said "Do not know/not sure".

> ***"I find that due to the lack of knowledge with HIV/ AIDS, people don't really take it seriously until that day it hits home"***

HIV transmission. To the question "In your opinion, how great is the risk of getting HIV/AIDS from any of the following activities?" the following responses were received.

| *Activity* | *Very great risk* | *Great risk* | *Moderate risk* | *Small risk* | *No risk* |
|---|---|---|---|---|---|
| **Deep kissing with someone who has HIV** | **6%** | **7%** | **11%** | **28%** | **48%** |
| **Using a syringe or needle used by other people without cleaning it** | **88%** | **4%** | **2%** | **1%** | **4%** |
| **Unprotected oral sex** (without a condom) | **37%** | **15%** | **22%** | **18%** | **9%** |

About three quarters of the respondents see no risk or a small risk from deep kissing with someone who has HIV. Almost everyone (92%) reported needle sharing is very risky. Over half (52%) reported that unprotected oral sex is risky.

| *"Do you believe HIV/AIDS transmission among Aboriginal people is mainly by…* | *frequency* | *percentage* |
|---|---|---|
| **Injection drug users sharing needles?"** | **(135)** | **75%** |
| **Sex between men?"** | **(111)** | **62%** |
| **Sex between men and women?"** | **(108)** | **60%** |
| **Mother to newborn?"** | **(37)** | **21%** |

Sharing needles as a mode of HIV transmission among Aboriginal people was the most frequently chosen option (75%). However, sex between men and sex between men and women were also seen as modes of transmission. Interestingly, very few respondents (21%) felt that mother to newborn transmission was common among Aboriginal people.

Sharing information. We asked our respondents who they discussed HIV/AIDS with in four separate questions.

| *"How many times would you say …* | *Never* | *Once or twice* | *More often* |
|---|---|---|---|
| **You have discussed AIDS with your family or relatives?"** | **24%** | **26%** | **50%** |
| **You have discussed AIDS with your friends?"** | **8%** | **22%** | **70%** |
| **You have discussed AIDS with a health professional?"** | **15%** | **20%** | **65%** |
| **You have discussed sexual orientation with your family?"** | **26%** | **32%** | **41%** |

About one quarter of respondents have not discussed sexual orientation or the topic of AIDS with their family. Few (15%) have never discussed AIDS with a health professional. Most (92%) report discussing AIDS with their friends.

Support. To the hypothetical question "If you had or thought you had HIV/AIDS, would you be comfortable speaking to your family (i.e., spouse, parents or children) about it?", 60% said that they would be comfortable speaking to their family. 26% replied that they would not be comfortable speaking to their family. 14% reported that they "don't know".

When asked, "If you had or thought you had HIV/AIDS, who would you feel most comfortable speaking about it? From the options below, respondents were asked to check all that apply.

| *Comfortable with:* | *frequency* | *percentage* |
|---|---|---|
| **Friends** | **(134)** | **74%** |
| **Other family member** (sibling, relative) | **(91)** | **50%** |
| **Praying to the Creator** | **(85)** | **47%** |
| **Spiritual advisor** | **(70)** | **39%** |
| **Community health representative** | **(70)** | **39%** |
| **Traditional Aboriginal healer** | **(65)** | **36%** |
| **Elders** | **(63)** | **35%** |
| **Telephone hotline** | **(45)** | **25%** |
| **Keep it to myself** | **(22)** | **12%** |
| **Don't have anybody to talk to** | **(10)** | **6%** |
| **Other** (i.e. partner, therapist) | **(10)** | **6%** |

"If you had or thought you had HIV/AIDS, **would** you seek support from any of the following?"

| *Seek Support from:* | *frequency* | *percentage* |
|---|---|---|
| **Friends** | **(151)** | **81%** |
| **Family** | **(128)** | **68%** |
| **Aboriginal AIDS Organizations** | **(124)** | **66%** |
| **Doctor** | **(119)** | **64%** |
| **AIDS support group** | **(108)** | **58%** |

| | | |
|---|---|---|
| **Other Aboriginal people with HIV/AIDS** | **(92)** | **49%** |
| **Community Health Representative** | **(91)** | **49%** |
| **Nurse** | **(87)** | **46%** |
| **Spiritual advisor** | **(76)** | **41%** |
| **Traditional Aboriginal healer** | **(76)** | **41%** |
| **Elder(s)** | **(74)** | **40%** |
| **Sweet grass** | **(74)** | **40%** |
| **Talking circle** | **(74)** | **40%** |
| **Sweat lodge** | **(72)** | **38%** |
| **Non-Aboriginal AIDS Organizations** | **(66)** | **35%** |
| **Power of healing circle** | **(63)** | **34%** |
| **Holistic practitioner** | **(33)** | **18%** |
| **Homeopathic practitioner** | **(32)** | **17%** |
| **Acupuncturist** | **(25)** | **13%** |
| **Other** (i.e. self, natural remedies, self) | **(12)** | **6%** |

Perceived risk. When asked "How much of an immediate threat do you think HIV/AIDS is to the health of Aboriginal people?", 3% said "No threat at all", 9% said "Some threat", 77% said "Serious threat" and 11% responded with "Do not know/not sure".

When asked "What are the chances that you yourself might get HIV/AIDS?", 12% said "None", 20% said "Very small", 16% said "Moderate", 17% said "High", 26% said "Very high" and 9% responded with "Do not know/not sure".

When asked "How worried are you about getting HIV/AIDS?", 40% said "Very worried", 15% said "Moderately worried", 17% said "Slightly worried", 20% said "Not worried" and 8% responded with "Do not know/not sure".

***"Try not to be swayed by another when it could be just a one-night stand and no condom is in sight"***

**Behaviour Change and High Risk Situations surrounding HIV/AIDS**

Behaviour change. To the question "Do you think that you need to change any of your behaviours to protect yourself from getting HIV/AIDS?", 50% replied "yes", 36% replied "no" and 14% responded with "Don't know/not sure". Eighty-nine percent (76 people) of the respondents who said "yes" commented on the behaviours that need changing.

*Avoiding drugs, alcohol or related situations*

- Picking up after going out to the bar.

- Alcohol & drugs.
- Stop hustling, stop drinking!!
- Drinking too much.
- The way I think when I drink.
- Limiting myself on drinking, because I feel I am more sexual when I'm drunk.
- Stop sticking needles in my veins.
- Too much partying, over consumption of alcohol.
- Drinking (alcohol) and the way in which meet people if I'm drinking too much.
- When drinking no sex.
- Alcohol abuse -- going out and getting too loaded and not remembering.
- I use alcohol to lower inhibitions, which may cloud judgement.
- Don't share my syringes with anybody, don't use anybody else's syringe.

*Condom use*

- If sleeping with someone; protect yourself & partner.
- Use condoms more often.
- Use condoms while having sex with my dates.
- Never have sex without a condom. I don't do injection drugs.
- Start using condoms and requesting one if need be.
- I don't want to re-infect myself so using condoms with my partner is a must
- Always use protection -- no matter the situation.

*Limited number of partners*

- Finding one sex partner.
- Sleeping around with different partners.
- Abstain from multiple partners.
- Multiple partners and risky sexual behaviors.
- Sticking with the same partner in a monogamous relationship.
- I have to stay with one person.

*Avoiding men or sexual situations*

- Quit selling my body and get better boyfriend in my life… or just be alone like every other trannie.
- Meet fewer gay men.
- Not being with other people.
- Try to stop soliciting, because I don't know if the person I am with has some other disease that he can pass on to me.
- Stop being a hooker.
- Stop drugs and working on streets.

*Relationship or interpersonal issues*

- Start asking my partner if he ever cheated on me because he doesn't use condoms.
- I drink too much but my partner and I have been able to stay faithful nonetheless.
- Try not to be swayed by another when it could be just a one-night stand and no condom is in sight.

- Know who you are with and not take people at face value.

*Self-Esteem*
- I respect myself and hope others do.
- Need to feel better emotionally about being native + gay. Sex is just a tool for immediate satisfaction of that!

*Abstinence from sex*
- Abstain/celibacy.
- I may have to stop having sex all together.

*Why change?*
- I am positive have been for 11 years
- I'm already HIV+

In summary, a number of the respondents referred to avoiding drugs and alcohol, or situations where they normally might use these substances. Others referred to relationship and interpersonal issues, making comments such as 'try not to be swayed', 'get a better boyfriend', 'limit my partners', or 'requesting [condom] if need be'. The other behaviours that respondents identified were to use condoms always or to abstain. In general, the responses reveal recognition on the respondents' part that they may often be coerced for one reason or another to engage in risky behaviour despite being knowledgeable about the risks.

High risk situations. To the question "Have there been situations in which you felt that you should protect yourself from getting HIV/AIDS but were not able to?", 64% replied "no" and 36% replied "yes". Of those who said "yes", 79% (50 people) commented on these situations.

*Alcohol and drug use*
- When I'm drunk or under the influence or something.
- Sharing needles knowing they may be infected.
- More than 5 years ago, I would have sex with someone when I was drunk or high. We usually had oral sex. Twice I had sex with someone who was HIV+
- Not getting drunk.
- Shared needles.
- Back when I used needles I didn't use clean ones when getting high.
- Drinking and sex don't mix.
- Whenever I "black out" due to drinking, then I know that I don't care what happens to me.

*Partner pressure*
- Partner unwilling.
- Partner drunk wanting sex.
- Aggressive partner.

- Johns don't want to use condoms.
- Partners promiscuity.

*Inconvenience*
- When picked up or engaged in a sexual manner and it was late or no services around.
- No condom.
- No condoms available.

*Spontaneous or anonymous sex*
- Anonymous sex.
- Having safe sex then getting caught up in the heat of the moment & not really knowing the other person sexual history.
- Parks & cruising areas.

*Lack of communication*
- Meeting people who are not open.
- My partner and I had unprotected sex... I didn't know that he may have been infected.
- Partner removed condom during intercourse without informing me.

*Assume partner is HIV negative*
- To think he or she is not HIV or aids.
- Sex with male partner trusted no discussion of HIV/STD risk.

*Prostitution*
- Being raped.
- Hooking.
- When I am working the streets.

Situations that were cited were those that involved prostitution, spontaneous sex, the partner's desires/wishes/urges/habits, their partner's failure to disclose his HIV+/AIDS status, or being the victim of rape or assault. Other situations that were identified were those that involved alcohol or drug use. What emerges is that those situations where people felt that they should protect themselves seem to be those that involve a lack or loss of an internal locus of control. Empowerment seems to be an important theme.

Supportive relationships. Ninety-seven percent of the respondents said that if one of their friends were to be diagnosed with HIV/AIDS, they would still continue to visit him/her. Only 2% said they would not continue to visit their friend and 1% said "Don't know/not sure".

When asked "Who do you think should care for a person with HIV/AIDS?", the following responses were reported.

| ***Should care for a person with HIV/AIDS:*** | ***frequency*** | ***percentage*** |
|---|---|---|

| | | |
|---|---|---|
| **Friends** | **(141)** | **76%** |
| **His/her own family** | **(140)** | **76%** |
| **AIDS service organizations** | **(131)** | **71%** |
| **Doctors/nurses specially trained** | **(130)** | **70%** |
| **Other people with HIV/AIDS** | **(113)** | **61%** |
| **Home community** | **(84)** | **45%** |
| **Ordinary doctors/nurses** | **(54)** | **29%** |
| **Religious or charitable groups** | **(48)** | **26%** |
| **Do not know/not sure** | **(8)** | **4%** |
| **Other** (i.e. partner, everyone) | **(15)** | **8%** |

What can be done? We asked the following open-ended question, "Some people may have HIV and pass it on to others. What do you think should be done to make sure that the virus is not passed from one person to another?", and received 156 comments. We have grouped them into eight themes and provide examples for each.

*Education*

- Educate people to protect themselves.
- Educate on HIV/AIDS transmission in schools and religious entities.
- Teach it in school to kids at an early age.
- Make sure everyone knows the consequences.
- Educate yourself on HIV with others all the time.
- Education, stress abstinence!
- Educate them more and make them more aware.
- Educate people about transmission and prevention.
- Educate people in condom use.
- Sex education.
- More education on HIV/AIDS.
- More education on safe sex.
- Additional information/sessions on top of the current awareness that is out there but geared towards two-sprited men in terms of education and prevention.
- There is no way to control other people's behaviour so education is the best.
- Make it very known that one time you have sex without protection is like putting a gun to your head 5 or 10 years from now.
- Education – prevention programs.
- You cannot do anything to prevent that person from spreading it. Just more education.
- Get the word out that HIV doesn't come from gays.
- Keep on educating facts on HIV and AIDS.
- Teaching the importance of being safe with any situation with AIDS/HIV at a young age.
- I know that it should not be made known to the public the person's name who is infecting others, other than that, educate other people about the disease.

*Safe sex*

- Safe sex.
- They should use a condom every time they have sex.
- Make sure that people use condoms and have some respect for others.
- People are going to have sex no matter what, and I believe the only appropriate way to make it safe is to use protection or become celibate until people with AIDS die out (and that will never happen).
- Wear a condom at all times.
- Protected sex.
- Stop having unsafe sex.

*Honesty (by infected partner) and Asking (by non-infected partner)*

- Always be honest about your HIV+ status and always ask.
- See a doctor first, and be honest about sexual issues.
- People who are HIV+ should tell the truth always when asked, then the negative partner can decide, do it as safe as possible – always.
- The person should ask that person if they have HIV/AIDS.
- Honest communication. Openness re: health re: HIV/AIDS.
- Always tell your new partner that you are HIV+ and have safe sex.
- The person that is infected with AIDS should tell people that he is or she is HIV infected.
- Let the person know about the situation.
- Talk about being positive.
- I think those people should tell others about their condition.
- Get to know the person.
- Truth + honesty. Shared communication.

*Penalties and responsibility*

- Stiffer penalties should be implemented in the Criminal Code never the precedents of case law.
- People who knowingly pass the virus to others should be charged and quarantined.
- If intentionally spreading the virus they should be institutionalized.
- Make it a criminal offense punishable by long-term imprisonment, if they are knowingly passing it on.
- They should be fined. It is wrong!
- Everybody is responsible for themselves. Everybody is responsible.
- Certain cases may require quarantine.
- They should be made to tell you. Face jail time for passing on a life threatening illness death slowly.
- Those people should be charged for giving other people a death sentence.
- Invoke criminality.
- In the extreme – perhaps some form of legislation if that person is knowingly passing it on.
- Tattoos on buttcheeks.

***"People who knowingly pass the virus to others should be charged and quarantined."***

*Protect yourself*

- People should protect themselves! If someone is going to have sex with someone else? They should think in their mind that the person may have HIV/AIDS.
- No cuts or blood between you and your friends.
- Assume everyone is HIV + and take the safety precaution.
- People should be aware about HIV/AIDS and not trust anyone!
- Protection, condoms, etc.
- Universal precaution gloves personal hygiene.
- Always use protection, never share needles.
- Take all precautions that are needed.

*Make it easier for HIV positive people to be open and honest*

- Have more awareness workshops for both gay and straight comm. So stigmatization is reduced or eliminated.
- Make him/her aware that they have the virus, without damaging their friendships.
- Education – assist in losing the stigma and ignorance.
- Strict conscious counselling to let people know that they may be killing each other.
- More counselling and support, outreach and traditional healing services, addictions treatment.
- Social acceptance of people with HIV.
- More involvement with others, and hope the other person is aware and not vindictive.
- I think people with HIV should get help and to get help from the people who say that care about them.

*Testing*

- Continuous testing
- Make sure people get tested.
- Go for bloodwork.
- Go get yourself checked often.
- Regular blood tests.
- Encourage people to be tested and make healthier lifestyle choices.

For the most part, respondents identified safe sex methods and education as an important part of the prevention of HIV/AIDS. Comments also referred to a need for culturally sensitive/peer support interventions. Two other interesting themes were that of anger towards those who knowingly spread the disease, as well as a sense of personal responsibility in the matter in the form of knowledge ("Always tell your partner…"), self-esteem ("love yourself…"), or interpersonal assertiveness ("Confront the person with HIV…").

**HIV/AIDS Testing and Prevention**

Testing. When asked "Have you ever been tested for HIV/AIDS?", almost everyone (91%) stated that they had been tested. Of those that said they had been tested, the year of their last HIV test ranged from 1982 to 2001. Those who have been tested reported having the tests done by/at places such as a clinic (44 people), hospital (16 people), doctor/nurse (11 people), health/community centre (7), etc. Forty-eight respondents gave a specific address, city, or province where they were tested but did not indicate the type of place it was.

Of those that had been tested, 54% stated that the test was anonymous, 30% responded that it was not anonymous and 16% said "Can't remember/not sure". And again, of those that had been tested for HIV, 45% said that they received "guidance/counselling", 42% reported they had not, and 13% were not sure or couldn't remember.

For the 161 respondents that had been tested for HIV, 48% said they "did not have the virus", 3% did not know the result, and 49% responded that "they have the virus".

For those respondents that are HIV positive, 65% said it was "5 years or more" since they found out. 24% reported they found out "1 to 4 years ago", 2% stated it was "7 to 11 months ago", 4% said it was "4 to 6 months ago", and 2% responded it was "less than 3 months ago". 2% were unsure of when it was that they found out they were HIV+.

For those respondents who are HIV+, 49% reported they were not taking any drug therapy, while 42% said they were on some drug therapy. 9% of HIV+ respondents reported they were "thinking about it".

Two-thirds of the respondents who are HIV+ said they "know how they were infected", 17% reported that they did not know and 15% replied "don't know/not sure". Of those who know how they were infected, 59 people made a comment about how they were infected. The most common themes were unsafe sex (22), sharing needles (15) and partner (13).

The testing experience. Of those that had been tested for HIV in the past, 32% said that they had been tested "more than six times" while 32% stated that they had been tested "three to six times". 16% reported that they had been tested "twice" and another 15% replied that they had been tested "once".

Prevention programs. When asked, "Which HIV/AIDS prevention programs do you think are most effective for Aboriginal people?" respondents answered as follows.

| ***Prevention Programs*** | ***frequency*** | ***percentage*** |
|---|---|---|
| **Promoting condom use** | **(146)** | **79%** |
| **Talking/Healing Circles** | **(119)** | **64%** |
| **Needle exchange program** | **(115)** | **62%** |
| **Elder counselling** | **(79)** | **43%** |
| **Medicine Wheel** | **(74)** | **40%** |

## General Comments

Seventy-eight respondents chose to make a comment at the end of the survey. Many of them wrote about the acute need to have more support and education with respect to risky lifestyles and behavior before it is too late. Others referred to the discrimination they suffered. Quite a few respondents chose to offer comments on being part of the survey, and most felt positively about it either as a chance to reflect, or as a chance to pass on their experience and knowledge to others. Several chose to make specific comments about the questionnaire. The responses are grouped under five headings.

*Need for/importance of specific support/education/strategies for First Nations*

- I believe the biggest problem is that our people are coming to the cities not knowing anything about HIV/AIDS! Not having the education about this problem, coming from their community they could get HIV/AIDS and go from the city to back home not knowing that he or she has HIV/AIDS pass it on to others in the First Nation's Communities. I believe that Health Canada should have done something about this long ago. Now I feel that a lot of my people are at risk because of this problem and also back in the 1980s! People as a whole believe that this disease was a GAY PEOPLE PROBLEM.
- I am a firm believer that preventing the spread of HIV/AIDS will come through educating the people that this horrible disease is not just a 'gay' thing. I also believe that the people who are doing the educating had better be walking the talk
- I am a status Indian and we should put all our heads and power and money and education together and address the problem not the end result our people need help.
- There should be more people in the support system who have been affected by street life styles.
- There should be way more institutions or places like Healing Our Spirits because there are many many Gay people in the reserve both boy/girl and these "boy/girl" come to the big Metropolitan and party with new people they meet and don't always know their past history about especially the younger people
- Education in schools talking about HIV/AIDS in reserve schools is very important.

*Stigma*

- In some instances, family is both a strength and barrier for me, because some of my siblings are very homophobic. The extended family (i.e. aunts and uncles) are homophobic as well. However I do have a sister who is supportive and non-judgmental. My father regularly prays to have me cured of my "lifestyle". I am suspicious of most people and tend to avoid them wherever I can. I also believe that most people are homophobic.
- I was adopted at a young age, lived with adopted family who were ministers. Grew up well, missed out on my heritage, and got kicked out when I came out of the closet at age 15. Been on my own since I know how to survive, but that's about it. Lost my

culture due to adoption. I consider myself fortunate to be two-spirited and proud to be First Nations.
- Traditional healers from my experience aren't open minded to Gay issues.
- I hate going to a clinic & the clinic is full of gay men. Oh, there's another faggot with AIDS.

*Telling their stories*

- Yes, the term two spirited has been commercialized. You can talk the walk but don't walk the talk. Two-spirited people are dedicated to their culture. Now-a-days two-spirited people are just gay. I find this offensive as a true two-spirited man.
- I believe the greatest prevention against HIV/AIDS, other STDs and unhealthy lifestyles is sobriety. Abstinence from all drugs including "legal" drugs makes a tremendous difference not only in the individual, but all around that person. I'm living proof that addiction can be overcome. I imagine you will look for correlations of alcohol/drugs and HIV infection. Prevention starts with sobriety. The road to recovery for myself started there and it only gets better. I hope that in the future sobriety is listed as a prevention and healthier lifestyle choice for all 2 spirits who choose life. The good life! Believe me, it's way more fun remembering the fun.
- Stay off the street. It will kill you.
- I think mental illness is a serious problem among gays. There are so many people out there who are alone.
- Although I am very aware of the issues around HIV/AIDS and Aboriginal Two Spirited men I struggle with my own risk behaviors. It is about self-esteem and a sense of belonging sometimes when I engage in high risk behaviors. I really do not care if I become sick.
- I find that due to the lack of knowledge about HIV, AIDS people don't really take it seriously, until that day it hits home. Also the amount of people who do have the virus are not even aware. Sex used to be something we enjoy.. and still do. It's sad to know the very act that brings life (to some) also brings death. Only in my wildest dreams will I be able to enjoy a loving sexual encounter with another man, and not have to worry about the reaction to my actions.
- HIV is very common in First Nations people, we are a people with very low self-esteem. Alcohol and drugs are the real problem. We use substances to get away and hide, we get drunk and high, we may have unsafe sex, or we may have safe sex. Sometimes we just do not care. Alcohol and drugs gives us courage sometimes. It is not even the sex it is the affection. That we really want.
- We need to address homophobia at the national level i.e., National Aboriginal organizations. There is a lot of historical information about traditional roles for two spirit people.

*Observations on the survey process and purpose of results*

- I feel that survey is well structured and is long overdue. It is important that studies should be done in order to facilitate proper care for ALL persons including Aboriginals.
- Thanks for the opportunity to participate. Good luck with your results.

- Thanks and good luck in all your endeavors to keep our brothers and sisters healthy.
- I hope this survey does help our people, and not to condemn them. Natives have a hard time with "white society" and living among them. With time & love, I believe that circle will heal itself.
- I've truly enjoyed this survey I'm please with the questions that were presented to me thank you for this survey
- I sure hope we learned from this
- I think this is good asking us all of these questions to answer. So we could give you comments about your questions we have to answer
- I wish I completed a survey like this prior to becoming HIV positive. Unfortunately, I did not know too much about HIV/AIDS before. Due in large part, to my own lack of interest in researching what HIV is, how it is spread and what happens once becoming HIV positive. To be blunt, I was ignorant.
- It took me a long time to accept that I am HIV/AIDS and feel now I have to embrace all components of my life, physically & mentally. Including the HIV virus is now a part of me
- Some of the questions did not apply. But I hope at the end if you do decide to write up something one the outcome of your research I hope that you will write something positive, even if it is a negative response. I'm not telling you to lie, I'm just hoping you use a positive manner in which you use your new information.
- I hope I've been a help to you and maybe one day there will be a care and we as Aboriginal People will be at peace of mind.

*Feedback on the survey questions (omissions and suggestions)*

- The questionnaire was targeted for two-spirited people. More questions that link to or evolve around two-spiritedness should be implemented. Some questions should follow around the percentage of Aboriginal people actually know what it is meant by two-spirited or just say they are because of being gay. I was born and raised a traditional two-spirited person and I'm interested in how many people actually know what that really means.
- I would like to see more ask about IV drug users who are affected and are two spirited and about alcohol related HIV
- Could be more expanded for those already with HIV. But very good.
- Please make some sections more clearly printed. See questions 13, 14, 49, 50.
- I would like to thank you for giving me this questionnaire, in a confidential matter, whereas I think I wouldn't have been as truthful, if it were an oral questionnaire
- This is a good survey hope to participate in the future.
- Wonderful questions and an eye opener for me. Question 67 needs to be more clarified, and in my mind it could be all depending on living lifestyle. Thanks for having me in your survey. Meegwetch!
- I feel this questionnaire could be biased in the fact it assumes all native people drink. Question 40. None of the questions deal with a native person (who drinks/who quits) in relation to sexual practices when he was a user/to when he was an abstainer.
- More info/questions regarding emotional needs while filling out the survey.

- My question is the terminology used. Two-Spirited. I like the fact a survey has been done.
- Thank -you for letting me participate. I hope the results help Native peoples
- I really appreciate the fact someone is concerned for the 2 spirited community.
- This should be taught in school, so they don't discriminate later on when they do meet someone like myself who is positive in the reserves. Education is the best medicine.
- You missed out I think is an important subject is about a person's mental health. And also about a person's personal diet and access to food services.
- Privacy plays a big part of people's lives, especially when healing of mind and body, more intimate counselling and workshops on aboriginal towns to let them know this is important to us all not only homosexuals. With all of this training and talking circles we all can "talk" and take time to listen to our bodies and mind to help in the fight to heal and keep healthy mentally, physically, and spiritually. Meeguiittch.
- The questionnaire seems to focus on the negative. I think you might have asked whether or not you come from a stable, supportive family -- I do. One area, which was not mentioned, was the issue of grief. Two-spirited men experience an enormous amount of grief, much of it intergenerational -- passed on, so to speak. It usually goes unaddressed and it is the major reason for the high degree of depression in the aboriginal community. Question 68 should have included a category asking which nation the respondent belongs to, i.e. Cree, Beaver, Dene - most of the categories listed are terms applied to Indigenous Canadians by their colonizers.
- It's about time something like this is done. This is for everyone white, yellow red and black. Only good can come from this.
- I think I learned more about AIDS than I ever did thank you so much.
- Put in some SEX TRADE WORKER questions. A lot of aboriginal are working the streets, that's probably how the virus is passed a lot of the time, too.
- This was a good survey, as it allowed me to share anonymously and to purge myself to help others with this survey. Ekosani!!

## Major Findings

From this analysis, we found that our respondents represent a broad age spectrum (17 to 62 years). Approximately two-thirds have lived on a reserve. Their level of education ranges from primary school completion to university degrees. Most currently live in rental accommodations. Less than one-third are currently employed. Sources of income are primarily from social assistance, disability, and wages. For those who are waged, their occupations include manual labour, artistic or writing occupation, counsellor, director, native guide, or office clerk. Almost half have experienced homelessness. Most report they are two-spirited or gay, some using both terms. Most identify themselves as either native, First Nations, Aboriginal or Status.

Less than half would consider moving back to their home community citing a lack of services, a lack of acceptance, and a lack of employment as the major reasons.

Almost all respondents have been tested for HIV disease (often repeatedly). Half of the respondents are HIV+. Of those who are HIV+, only 50% are receiving drug therapy. The most frequently chosen reasons given for a reluctance to use health services involve fear of discrimination because of HIV status, lack of transportation, and lack of knowledge about where to go for services.

The most important sociological factors negatively affecting their lives are unemployment, poor housing, racism, poverty, homophobia, physical abuse and gay bashing. Their reluctance to access social services to deal with these issues is primarily associated with feeling unwelcome, fear of social worker/social service organizations, fear of discrimination because of sexual orientation, and lack of transportation.

In general, their greatest lifestyle risks are associated with activities that expose them to HIV/AIDS or hepatitis or that result from their use of tobacco, alcohol, or cocaine. They also report that poor diet and lack of exercise put them at greater risk.

With regard to sexual activity almost half have a steady sex partner. Two thirds of these relationships have been in existence for over one year. However, over half of those respondents with a steady sex partner have other sex partners.

Over half report always using a condom for anal-genital sex. Several respondents expressed concern about passing on or being

***"We should put all our heads and power and money and education together and address the problem not the end result. Our people need help"***

infected by HIV disease as the reason for this practice. They report that if they engage in unsafe sexual practices, the events are usually associated with alcohol, bathhouse environments, or prostitution.

Their knowledge of HIV transmission is accurate. Most understand the risks of using a syringe or needle used by other people without cleaning it. Two-thirds see little or no risk associated with deep kissing someone who has HIV disease. Unprotected oral sex (without a condom) was deemed a very great or great risk by over half of the respondents. Half reported a need to change behaviours to protect themselves from getting HIV/AIDS. Personal behaviours that needed changing included using condoms, avoiding drugs and alcohol, and limiting the number of partners.

The prevention programs seen as effective were those that promote condom use (79%), the Talking/Healing Circles (64%), needle exchange programs (62%), Elder counselling (43%) and the Medicine Wheel (40%).

Friends are very important to our respondents. Over two-thirds regard them as 'family'. Three-quarters felt they could share information about their HIV status with them or have shared this information. Almost all (81%) would seek support from their friends, family (68%), Aboriginal AIDS Organizations (66%), and a doctor (64%).

Their hopes are for healthy and loving relationships, security, acceptance and peace of mind, better education, better employment, improved physical health, and enhanced self-esteem. Most felt it was likely or very likely that they would achieve their goals. However, most felt that HIV/AIDS is a serious threat to the health of Aboriginal people.


## *A Survey of Aboriginal Two-spirited Men across Canada*

October, 1999

Dear Study Participant,

This study is about knowledge, attitudes, behaviours and social conditions of Aboriginal, two-spirited men across Canada. The study has been commissioned by *2-Spirited People of the 1st Nations* in Toronto and is being conducted by researchers at the Centre for Quality Service Research, Ryerson Polytechnic University, in Toronto. Drs. Dennis J. Haubrich and Judith K. Waalen are the principal investigators of this study. Aboriginal people representing various communities were involved in the development of the survey questions. The information gathered from this survey will be used to further understanding of Aboriginal, two-spirited men in Canada. You will be able to obtain a copy of the survey report from *2-Spirited People of the 1st Nations*, Toronto in April, 2000.

The survey that we are asking you to complete is anonymous. The questions we ask you are personal. However, your answers to these questions do not allow us to identify you by name. If you do not want to answer a question, put an "R" beside it. If a question does not apply to you, put an "N" beside it. The questionnaire should take 45 minutes to complete.

Once you have answered the questions, put the survey in the envelope provided, seal it, and return it to the person who gave it to you. You will be given $ 25.00 for your participation. The sealed envelope will be mailed to the Centre for Quality Service Research, Ryerson Polytechnic University, Toronto.

If you have any questions or concerns about your participation in this study, please call us on our toll-free line (1-877-282-0222), or in Toronto at (416) 593-7162. Your call will be treated confidentially. Please keep this letter for further reference.

Thank you for your participation. We value your input.

Yours sincerely,

Dennis J. Haubrich, Ph.D. Judith K. Waalen, Ph.D.

Before you complete this survey, the study investigators, Dennis Haubrich and Judith Waalen, need to know that you have read the enclosed information letter, that you understand the purpose of the study, and that you have decided to participate in the study.

Please indicate your consent to participate in this study by checking ( ) this box: .

## *A Survey of Aboriginal Two-spirited Men across Canada*

Please enter the appropriate response in the space provided or circle or check the response that most accurately reflects your situation or the way you feel. Circle or check **ONLY ONE** response unless you are asked to circle or check **ALL THAT APPLY TO YOU**.

Please record today's date: _____

**Demographic questions:** The following set of questions concerns basic information about yourself.

1. How old are you? _____ years

2. How many years have you lived in the town or city where you live? _____ # of years

3. How do you presently identify yourself? (**Check all that apply to you**.)

| | |
|---|---|
| Two-spirited | Gay |
| Bisexual | Transgendered |
| As a man who has sex with men | Unsure |
| As a man who has sex with women | |

4. What are your sources of income? (**Check all that apply to you**.)

| | |
|---|---|
| Wage/salary | Social service benefits |
| Employment insurance | Band council |
| Private insurance | Other (please specify_____) |
| Disability | |

5. What is your current weekly income? $_____per week

6. What is the highest level of school that you have completed?

| | |
|---|---|
| No school | Community college |
| Primary | University |
| Secondary | Other (please specify_____) |
| Technical/Vocational college | |

7. What is your current housing situation?

| | |
|---|---|
| Rental apartment | Rooming house |
| Subsidized housing | Own house/condo |
| Shelter or halfway house | I stay with friends |
| Homeless | Other (please specify_____) |
| Rental house | |

8. What is your occupation? _____

**Background Information and Relationships**

9. Did you ever live (**Check all that apply to you**.)

| | Yes | | Yes |
|---|---|---|---|
| on a reserve? | | in a group home? | |
| at a residential school? | | in a detention facility? | |
| in a foster home? | | on the street? (homeless) | |

10. When you arrived in the town or city in which you now live, how easy was it to make contact with other Aboriginal people?

I was not interested in making contact with Aboriginal people
It was relatively easy
It was relatively difficult

how easy was it to make contact with other Aboriginal gay men?

I was not interested in making contact with other Aboriginal gay men
It was relatively easy
It was relatively difficult

how easy was it to make contact with non-Aboriginal gay men?

I was not interested in making contact with non-Aboriginal gay men
It was relatively easy
It was relatively difficult

11. Have you ever considered moving back to your home community?

I live in my home community **(Go to question 13)**
Yes
No
Not sure

12. If you wanted to go home, is there anything that would prevent this?

Yes No **(Go to Question 13)**

If yes, what are the reasons? **(Check as many as apply to you.)**

I can't afford to get there
No services that I need are available at home
There is no work/employment for me at home
My family would not accept me
My community would not accept me
I have the support of people where I live

The town or city I am presently living in has become my home
Probation/parole restrictions
Difficulties with the law prevent me from going home
I have been banished from my community
Other reason (please specify_____)

13. In this section, please circle the number below the alternative that best describes your opinion about how SATISFIED you are.

| **How satisfied are you with.....** | Very Dissatisfied | Dissatisfied | Satisfied | Very Satisfied |
|---|---|---|---|---|
| the amount of control you have over your life? | 1 | 2 | 3 | 4 |
| feeling pride in your cultural background? | 1 | 2 | 3 | 4 |
| the emotional support you get from others? | 1 | 2 | 3 | 4 |
| yourself? | 1 | 2 | 3 | 4 |
| your sex life? | 1 | 2 | 3 | 4 |
| your usefulness to others? | 1 | 2 | 3 | 4 |
| where you are now living? | 1 | 2 | 3 | 4 |
| your leisure time activities? | 1 | 2 | 3 | 4 |
| your peace of mind? | 1 | 2 | 3 | 4 |
| your spirituality? | 1 | 2 | 3 | 4 |
| your ability to protect yourself from abuse? | 1 | 2 | 3 | 4 |
| your sexual identity? | 1 | 2 | 3 | 4 |
| your financial situation? | 1 | 2 | 3 | 4 |
| your relationship with your friends? | 1 | 2 | 3 | 4 |
| your relationship with other gay people? | 1 | 2 | 3 | 4 |

14. In this section, please circle the number below the alternative that best describes how IMPORTANT each area of life is to you.

| **How important to you is.....** | Very Unimportant | Unimportant | Important | Very Important |
|---|---|---|---|---|
| the amount of control you have over your life? | 1 | 2 | 3 | 4 |
| feeling pride in your cultural background? | 1 | 2 | 3 | 4 |
| the emotional support you get from others? | 1 | 2 | 3 | 4 |
| yourself? | 1 | 2 | 3 | 4 |
| your sex life? | 1 | 2 | 3 | 4 |
| your usefulness to others? | 1 | 2 | 3 | 4 |
| where you are now living? | 1 | 2 | 3 | 4 |
| your leisure time activities? | 1 | 2 | 3 | 4 |
| your peace of mind? | 1 | 2 | 3 | 4 |
| your spirituality? | 1 | 2 | 3 | 4 |
| your ability to protect yourself from abuse? | 1 | 2 | 3 | 4 |
| your sexual identity? | 1 | 2 | 3 | 4 |
| your financial situation? | 1 | 2 | 3 | 4 |
| your relationship with your friends? | 1 | 2 | 3 | 4 |
| your relationship with other gay people? | 1 | 2 | 3 | 4 |

15. In order to better understand your personal situation, are there any comments or explanations that you would like to give us about your answers to the areas of life in Questions 13 and 14. If so, please write them below.

_____

_____

_____

_____

_____

_____

16. What do you hope for in your life?

_____

_____

_____

17. How likely do you feel it is that you will achieve this?

| | |
|---|---|
| Very likely | 1 |
| Likely | 2 |
| Unlikely | 3 |
| Very unlikely | 4 |
| Don't know | 5 |

**Health Concerns**

18. From the following list, what do you consider to be your health risks with regard to sexually transmitted diseases? (**Check all that apply to you**.)

HIV/AIDS
Gonorrhoea
Genital warts
NSU (nonspecific urethritis)
Crabs
Syphilis
Chlamydia
Herpes
Hepatitis
Other disease (please specify_____)
None of the above

19. From the following list, what do you consider to be your health risks? (**Check all that apply to you**.)

Tuberculosis (TB)
Mental illness
Hepatitis
Heart disease
Asthma
Diabetes
Pneumonia
Cancer
Other disease (please specify_____)
None of the above

20. From the list below, what do you consider to be your lifestyle risks with regard to injection drug use? (**Check all that apply to you**.)

| | |
|---|---|
| T and R | Heroin |
| Cocaine | Crack |
| Other substance(s) (please specify_____) | |
| None of the above | |

21. From the list below, what do you consider to be your lifestyle risks? (**Check all that apply to you**.)

| | |
|---|---|
| Smoking | Alcohol |
| Overeating | Undereating |
| Poor diet | Lack of exercise |
| Cocaine | Gambling |
| Marijuana/Hashish | Street drugs (E, X, GBH, K) |
| Tranquilizers (downers) | Pep Pills (uppers) |
| Poppers | Solvents/glue/mouthwash |
| Exposure to weather | |
| Other behaviour(s) (please specify_____) | |
| None of the above | |

22. From the list below, have any of the following social factors affected your life? (**Check all that apply or have applied to you**.)

| | |
|---|---|
| Unemployment | Poor housing |
| Poor health services | Pollution |
| Physical abuse | Sexual abuse |
| Suicide | Poverty |
| Gay bashing | Racism |
| Homophobia | HIV discrimination |
| Problems with the law | Partner/spousal abuse |
| Mental abuse | Rehabilitation |
| Learning disabilities | Psychological issues |
| Lack of access to education | |
| Other factor(s) (please specify_____) | |
| None of the above | |

23. From the list below, who do you consider to be your family? (**Check all that apply**.)

Foster family
Adoptive family
Chosen family
Biological family
Friends
Other (please specify_____)

**Sexual activity**

24. Do you have one steady sex partner at this time?

Yes No **(Go to Question 25)**

If YES, how long how you have been together?
6 months or less
Between 7 months and 1 year
Between 1 and 5 years
Over 5 years

If YES, does your steady partner have any other sex partners at this time?
Yes No Don't know

25. Do you have other sex partners? Yes No

26. How old were you when you had your first sexual experience? _____ years old

**Attitudes about Sexual Activity**

27. According to your community of origin, is it okay for men to have sex with men?
Yes No Don't know

28. According to your family, is it okay for men to have sex with men?
Yes No Don't know

29. According to you, is it okay for men to have sex with men?
Yes No Don't know

30. In the past year, have you received money, gifts, drugs or favours in return for sex?
Yes No

31. In the past year, have you been forced into having sex with a person against your will? Yes No

32. In the past year, have you had sex with a person you didn't want to have sex with?
Yes No

33. Do you use a condom while **giving** a "*blow job*" (oral-genital sex)?
Always Often Sometimes Never

34. Do you use a condom while **receiving** a "*blow job*" (oral-genital sex)?
Always Often Sometimes Never

35. Do you use a condom while "*bum fucking*" as a **top** (insertive anal-genital sex)?
Always Often Sometimes Never

36. Do you use a condom while "*bum fucking*" as a **bottom** (receptive anal-genital sex)?

Always Often Sometimes Never

37. Have you had sex without a condom in the past year?

Yes No **(Go to Question 38)**

If yes, are any of the following reasons why you did not use a condom when you had sex in the past year? **Check as many as apply.**

My partner did not want to use one
I did not want to use one
I was using alcohol or drugs
The sex was so exciting that I didn't use one
I was with my steady partner
I did not have a condom at the time
I could not afford to buy any condoms
I was too embarrassed to get condoms
I did not think of using a condom
She wanted to get pregnant
I could not talk about using a condom
I find condoms uncomfortable
I thought I was in a safe situation
I was forced to have sex against my will
The condom broke



38. Are there situations when you have unsafe sex? Yes No

If YES, please describe:

_____

_____

39. Are there situations when you only have safe sex? Yes No

If YES, please describe:

_____

_____

**Alcohol Consumption**

40. How often do you usually have drinks containing alcohol? Would you say:

Daily
More than twice a week
Once or twice a week
Once or twice a month
Less often than once or twice a month

Never (**Go to question 45**)

If you do drink, where do you normally go to drink? **Check all that apply**:

At home
A friend's or relative's place
A restaurant/hotel
A bar
Other (please specify) _____

41. Do you usually have unsafe sex when you have been drinking?
Yes No

42. Do you usually drink before you go out?
Yes No

43. Do you feel you need to drink before you go out?
Yes No

44. Do you think drinking helps you meet people sexually?
Yes No

45. Do you usually have unsafe sex when your sex partner has been drinking?
Yes No

**Concerns about Access to Services**

46. Have any of the following reasons kept you from using health services? (**Check all that apply**.)

I didn't know where to go for services
Services are too far away or inconvenient
No transportation
Fear of discrimination because I'm Native
Fear of discrimination because of my sexual orientation
Fear of discrimination because they think I'm in the sex trade
Fear of discrimination because I am an injection drug user
Fear of doctors/hospitals
I don't feel welcome where services are offered
Services aren't available in my language
Fear of discrimination because I'm HIV positive

47. Have any of the following reasons kept you from using social services? (**Check all that apply**.)

I didn't know where to go for services
Services are too far away or inconvenient
No transportation
Fear of discrimination because I'm Native
Fear of discrimination because of my sexual orientation
Fear of discrimination because I'm in the sex trade
Fear of discrimination because I am an injection drug user
Fear of social workers/social service organizations
I don't feel welcome where services are offered
Services aren't available in my language
Fear of discrimination because I'm HIV positive

**Knowledge and Attitudes about HIV/AIDS**

48. Do you know or have you ever known anyone with HIV/AIDS disease?

Yes No Do not know/not sure

49. In your opinion, how great is the risk of getting HIV/AIDS from any of the following activities? Use the following codes: VG=Very great risk, G=Great risk, M=Moderate risk, S=Small risk, and N=No risk at all.

| | VG | G | M | S | N |
|---|---|---|---|---|---|
| Deep kissing with someone who has HIV | 1 | 2 | 3 | 4 | 5 |
| Using a syringe or needle used by other people without cleaning it | 1 | 2 | 3 | 4 | 5 |
| Unprotected oral sex (without a condom) | 1 | 2 | 3 | 4 | 5 |

50. How many times would you say ...

| | Never | Once or twice | More often |
|---|---|---|---|
| You have discussed AIDS with your family or relatives? | 1 | 2 | 3 |
| You have discussed AIDS with your friends? | 1 | 2 | 3 |
| You have discussed AIDS with a health professional? | 1 | 2 | 3 |
| You have discussed sexual orientation with your family? | 1 | 2 | 3 |

51. How much of an immediate threat do you think HIV/AIDS is to the health of Aboriginal people? Would you say that it is:

No threat at all
Some threat
Serious threat
Do not know/not sure

52. What are the chances that you yourself might get HIV/AIDS? Would you say that it is:

None
Very small
Moderate
High

Very high
Do not know/not sure

53. How worried are you about getting HIV/AIDS? Would you say that you are:
    Very worried
    Moderately worried
    Slightly worried
    Not worried
    Do not know/not sure

54. Do you think that you need to change any of your behaviours to protect yourself from getting HIV/AIDS?
    Yes No Do not know/not sure

    If yes, what behaviour(s)?

_____

_____

_____

55. Have there been situations in which you felt that you should protect yourself from getting HIV/AIDS but were not able to?
    Yes No

    If yes, what kinds of situations?

_____

_____

_____

56. If one of your friends were to be diagnosed with HIV/AIDS, would you still continue to visit him/her?
    Yes No Do not know/not sure

57. Who do you think should care for a person with HIV/AIDS? (**Check all that apply**.)

| | |
|---|---|
| His/her own family | Other people with HIV/AIDS |
| Doctors/nurses specially trained | AIDS service organizations |
| Ordinary doctors/nurses | Home community |
| Friends | Other (please specify_____) |
| Religious or charitable groups | Do not know/not sure |

58. Some people may have HIV and pass it on to others. What do you think should be done to make sure that the virus is not passed from one person to another?

_____

_____

_____

59. Have you ever been tested for HIV/AIDS?

Yes
No (**Go to question 62**)
Can't remember/not sure (**Go to question 62**)

If yes,
How long ago was your last test? Month _____ Year _____

Where were you tested? _____

Was it an anonymous test? Yes No Can't remember/not sure

Did you receive guidance/counselling? Yes No Can't remember/not sure

The result of my last test was:
I do not have the virus (**Go to question 61**)
I do not know the results (**Go to question 61**)
I have the virus (**Go to question 60**)

60. If you are HIV positive,

how long ago was it since you found out you were positive?

| | |
|---|---|
| Less than 3 months ago | 1 to 4 years ago |
| 4 to 6 months ago | 5 years or more |
| 7 to 11 months ago | unsure |

Are you taking any drug therapy?
Yes No Not yet but thinking about it

Do you think you know how you were infected?
Yes No Don't know/not sure

If yes, how do you think you were infected?

_____

_____

If yes, when do you think you were infected? Date: _____

61. How many times have you been tested for HIV/AIDS?

Once
Twice
Three to six times
More than six times
Do not know/not sure

62. If you had or thought you had HIV/AIDS, would you be comfortable speaking to your family (i.e spouse, parents or children) about it?

Yes No Don't know/not sure

63. If you had or thought you had HIV/AIDS, who would you feel most comfortable speaking about it? (**Check all that apply**)

Other family member (sibling, relative)
Friends
Elders
Community health representative
Traditional Aboriginal healer
Spiritual advisor
Telephone hotline
Keep it to myself
Don't have anybody to talk to
Praying to the Creator
Other (please specify_____)

64. If you had or thought you had HIV/AIDS, would you seek support from any of the following?

Family
Friends
Community Health Representative
Doctor
Nurse
Aboriginal AIDS Service Organizations (ASOs)
Other APHA (Aboriginal people with HIV/AIDS)
Non-Aboriginal AIDS Service Organizations (ASOs)
AIDS support group
Traditional Aboriginal healer
Spiritual advisor
Elder(s)
Sweat lodge
Sweet grass
Talking circle
Power of healing circle
Holistic practitioner
Homeopathic practitioner
Acupuncturist
Other, (please specify_____)

65. How common do you think HIV/AIDS is among First Nations, Native or Inuit people? Would you say that it is:

Very common
Moderately common
Not common
Very rare
Do not know/not sure

66. Which HIV/AIDS prevention programs do you think are most effective for Aboriginal people?

Promoting condom use
Needle exchange program
Medicine Wheel
Elder counselling
Talking/Healing Circles

67. Do you believe HIV/AIDS transmission among Aboriginal people is mainly by…

Sex between men and women?
Sex between men?
Injection drug users sharing needles?
Mother to newborn?

68. Do you identify yourself as (**Check all that apply to you**.)

| | Yes | | Yes |
|---|---|---|---|
| Native? | | Non-Status? | |
| Native Canadian? | | Treaty? | |
| First Nations? | | Non-treaty? | |
| Indian? | | C-31? | |
| Aboriginal? | | Métis? | |
| Inuit? | | Mixed heritage? | |
| Status? | | | |

Thank you for your participation in this study. What comments, if any, do you have about completing this questionnaire? Did we miss something that you would like to tell us? Please write legibly.

Please return your completed survey in the envelope provided to the person who gave it to you. You will receive $25.00 for your participation. Please make sure the envelope is sealed.