Canadian Aboriginal People
LIVING WITH HIV/AIDS
CARE, TREATMENT AND SUPPORT ISSUES

A publication of the Canadian Aboriginal AIDS Network

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BRIEF OVERVIEW OF THE CANADIAN ABORIGINAL AIDS NETWORK (CAAN);

- Established in 1997
- National and not-for-profit organization
- Represents over 200 member organizations and individuals
- Provides a National forum for members to express needs and concerns
- Provides relevant, accurate and up-to-date information on issues facing Aboriginal people living with and affected by HIV/AIDS in Canada
- Is governed by a twelve member National Board of Directors and operated by a four member Executive

MISSION STATEMENT

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

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EXECUTIVE SUMMARY

In the summer of 2004, CAAN conducted a nation-wide survey of 195 Aboriginal people living with HIV/AIDS (APHAs) in Canada. The primary goal of this study is to document the extent to which service needs of APHAs are being met, and to identify deficiencies in the provision of those services. The survey elicited closed and open-ended responses about 38 types of care, treatment and support services used or needed by APHAs. Service utilization and effectiveness are analysed by Aboriginal identity, geographic region, disease stage, gender, age and mode of transmission. Recommendations by APHA participants point directly to ways in which access to and delivery of services can be improved. This summary outlines the main findings and recommendations of the study.

The national survey results provide a sound basis for policy and practice recommendations related to care, treatment and support services for Aboriginal persons with HIV/AIDS in Canada:

- Validity: A participatory action research approach involved members of the Aboriginal HIV/AIDS community who guided the project from inception to completion, assuring the validity of survey questions and interpretations of findings.
- Reliability: The rigour of survey administration resulted in higher than expected responses from 195 APHAs (64% response rate), representing all Aboriginal groups in regions across Canada.
- Integrity: A comprehensive review of the literature, and adherence to social scientific standards of qualitative content analysis and quantitative statistical analysis provide a level of confidence in the study's results about Aboriginal persons living with HIV/AIDS.
- Limitations: The survey sample is, by necessity, purposive (non-random). This means that statistically significant findings must be interpreted as probable, but not conclusive. It is also important to note that the study was confined to APHA clients who currently access services offered by AIDS Service Organizations (ASO) in their region. As such, findings do not capture information about the 'invisible' APHA population who are unable or unwilling to use ASO services.

Traditional Aboriginal Health and Wellness Services: 60.5% of the APHA study group use or need traditional Aboriginal health and wellness services such as Elder counsel, ceremonies, medicines, and sharing/healing circles. This reflects the extent to which cultural values, belief and practices shape individual responses to HIV illness. APHAs offered numerous unsolicited positive comments about their experiences using traditional health and wellness services. For example, APHAs benefited from advice by Elders, and received social support by participating in sharing and healing circles. Other researchers have also concluded that when Aboriginal people are afforded opportunities to learn and re-connect with their culture, they generally build stronger coping mechanisms for negative life experiences associated with the disease:

- Cultural competence emerges as an important design and health system delivery consideration when providing care to Aboriginal people living with HIV/AIDS. In some areas of the country, notably Saskatchewan (83.3%), APHAs report higher levels of satisfaction with traditional health and wellness services. How this province organizes to respond to the traditional health care needs of their APHAs may prove of benefit to others responding to similar needs elsewhere in Canada.

- Dedicated funding and human resources are required to promote existing or establish new traditional Aboriginal health and wellness services. Types of traditional services recommended include: Elders who are knowledgeable about HIV/AIDS available at local health centres and ASOs; access to traditional medicines accompanied by information on the application and effects of these medicines, and; access to ceremonies near APHAs' place of residence.

- Service design and delivery must account for logistical barriers (i.e., transportation, etc.) that compromise access. Lower use of traditional Aboriginal health and wellness services may be partially explained, for example, by APHAs in poorer health who lack viable options to circumvent such logistical barriers. Program design and funding must be made available, beyond public transit, to accommodate those in particularly poor health who wish to access traditional health and wellness supports. Eliminating logistical barriers to access are important considering that APHAs who are less healthy tend to use traditional services at a lower rate (52.8%) than do more healthy individuals (70%).

- Traditional sharing and healing circles need to ensure confidentiality. Clearly, the study population understands the risk/benefits associated with such group activities. However, these programs can be better designed to reassure APHAs, for example by establishing boundaries of participation, and/or penalties if confidentiality and privacy are violated.

- Community-based AIDS service organizations and local primary health care centres are best able to determine how traditional health and wellness services can effectively be incorporated into existing programs to best meet the needs of APHAs they serve. Community organizations must take the lead in designing features of traditional health and wellness that can be incorporated into their overall care models.

Primary Medical Services: Not surprisingly, a high proportion (88%) of APHAs in the study use or need primary medical services such as a doctor, hospital emergency centre, pharmacy, and drug plan. Consistent with what others report in the literature, common barriers to care experienced by the APHA study group include logistical access barriers such as long wait times (52.4%), the perception they receive poor care (46.0%), or experiences of racial prejudice or homophobia (30.2%). It is important to note that although a relatively high proportion of study participants use one or more of these services, approximately 12.0% state they do not use any primary medical services. Addressing barriers to primary health care may prompt individuals to use services they currently avoid. To ignore calls for medical service providers to address these barriers, may lead to continued poor health, reduced access and/or later stage diagnoses among Aboriginal people with HIV/AIDS:

- Hospital emergency room wait-times must be reduced. It is recommended that primary medical care staff, including those in hospital emergency rooms, receive professional development training related to the care needs that are characteristic of Aboriginal people living with HIV/AIDS. It is particularly important for primary medical professionals to be cognizant that persons with HIV/AIDS tend to use such services when they are in particular ill health. A significantly higher proportion of APHAs diagnosed with AIDS (i.e., in poorer health) visit hospital emergency rooms (82.6%), than do APHAs who are HIV-positive but not diagnosed with AIDS (57.8%). Also significant is that female APHAs tend to visit emergency centres at a slightly higher rate (67.6%) than do male APHAs (54.9%). This result is given greater meaning by members of the research/advisory teams who stated that in their experience, women tend to take care of the needs of others (eg., their children) before themselves. Although unforeseen circumstances (i.e., more pressing medical emergencies, etc.) at times interfere with the length of a wait during a visit to a hospital emergency department, it is important that individuals be informed of these circumstances before losing them to care they may urgently require.

- There is a need for family physicians to be more knowledgeable about HIV/AIDS, and for such physicians to be positioned in rural, northern and remote communities. Slightly more than one-quarter (26.6%) of APHA participants in this study perceive the care they receive from physicians to be less than adequate. Another 15.0% of APHAs in the study group do not use physician services at all. In circumstances where local health clinics and nursing stations are the first line of defence against the disease, study participants indicate a rate of dissatisfaction almost double (40.0%) to that of physicians generally. Lack of access to knowledgeable medical service providers continue to be a barrier for APHAs, particularly for those living on Reserves and in isolated communities.

- Professional development and continuing education programs are required to eliminate attitudes associated with HIV/AIDS stigma, racial prejudice and homophobia within the primary medical system. Internalized homophobic and racial attitudes compromise quality of care. Almost one-third (30.2%) of Aboriginal PHAs in this study indicate that these prejudices remain prevalent among primary health care providers. That such prejudices negatively impacts access to services is also documented in the literature. In responses to open-ended questions, for example, APHAs report situations in which a physician or pharmacist assumed a predilection to addiction and drug abuse based on ethnicity. This may lead APHAs to feel they are not welcome and to avoid these services except in extreme circumstances. (This may help explain the almost 15.0% non-use rate of physicians by the APHA study group.) It is important that primary health care providers increase their levels of cultural competence, and reduce their levels of discomfort when providing treatment to APHAs.

- An APHA's perspective should be considered as a factor in drug plan coverage for HIV/AIDS medication and treatment. Drug program officials who are responsible for approving medications/treatments unto or off formularies require additional information beyond assessments of potential risk/benefits associated with any particular medication/treatment under consideration. More than half (52.0%) of the APHAs in this study rely on provincial, territorial and/or federal drug plans to assist with the cost of HIV/AIDS medication and treatment. These participants report high levels of satisfaction (80.2%) with such programs. However, many APHAs (48.0%) are not accessing medication or treatment under such programs. This is a serious concern in light of repeated responses that access is limited by financial barriers, particularly the limited coverage of HIV/AIDS medications/treatments.

Secondary Health Services: A high proportion of APHAs in this study (about 75%) report they need or use one or more secondary health services, such as a dentist, optician, chiropractor, physiotherapist, home nurse and home care professional. However, when considering actual reported usage, the services of chiropractors, physiotherapists, and home nursing/care are low (between 7.0% and 14%). In almost all cases, lower than expected use was most strongly correlated with financial barriers (30.8%) and by logistical access barriers (30.8%). Addressing these barriers to care may prompt APHAs to more readily use these types of health care services where such may significantly improve their quality of life:

- Provincial, territorial and federal health insurance programs need to consider ways to expand coverage for Aboriginal persons with HIV/AIDS who require secondary health services. This is a quality of life issue, particularly as it relates to the burden of a serious health condition such as HIV/AIDS. In the Aboriginal context, extreme poverty may prevent APHAs from using such services. This is true particularly for youth who generally possess less financial power to access services not covered under health insurance programs. The national survey indicates, for example, that use/need increases incrementally with age (for the under 30 age group use/need rates were 74.7% compared to those 40 years and older (83.0%).
- Hours of operation as a logistical barrier to secondary health services also require consideration. Secondary health care providers who know they serve Aboriginal HIV/AIDS patients, may need to be flexible in their

hours of service, taking into account APHAs' different health statuses and transportation needs.

Alternative and Complementary Therapies: Access and use of alternative and complementary therapies are equally important when considering quality of life in the context of HIV/AIDS. Almost half (45.6%) of APHA study participants indicate they use or need massage, homeopathy, and/or medical marijuana. While use/need of marijuana for medical purposes was high (35.9%), access differed by region (the North, Manitoba, Ontario, British Columbia reporting the highest rates), and by health status (those in poor health reported more common use/need). Again, financial and logistical barriers were most common for those whose needs are not being met:

- Continued attention to ways of improving access to marijuana for medical purposes for those APHAs who require this alternative form of therapy, is recommended. More than one-third of APHAs in the study group rely on medical marijuana to alleviate symptoms associated with HIV/AIDS or the side effects of treatment regimes. However, the legal and financial issues surrounding purchase, possession and growing of marijuana continue to limit access by APHAs.
- It is recommended that provincial, territory and federal medical plans find ways to expand coverage for APHAs to access the health benefits of massage therapists and homeopathic physicians. For the APHA study group, cost was the main barrier to both of these types of therapy.

Social and Family Services: A majority (62.1%) of APHAs access social and family services in relation to their HIV/AIDS care. Of importance is that this was mainly confined to the services of social workers (58.5%). Child care, family planning and parenting skills programs were needed far less (7.2 - 9.2%). Rates of use vary significantly by region and to some extent by health status. APHAs in Manitoba, the North and British Columbia report the most frequent usage of social and family services (76.1 - 83.3%) . Those with more serious health problems (77.4%) report greater use than those were health problems are not serious (61.3%). This category of service received the highest dissatisfaction rate (40%). APHAs are dissatisfied mainly because they do not trust that confidentiality/privacy is respected (37.5%), and they experience and/or perceive stigma and discrimination (30.0%):

- Policies within Social Service organizations which have Aboriginal PHA clientele must address the vital importance of assuring confidentiality and privacy.
- Social Work curricula and professional development and continuing education within social service institutions must address attitudes associated with HIV/AIDS stigma, homophobia and racial prejudice.

Substance Use Programs: A high proportion (60.5%) of APHAs in our study indicate they use or need one or more substance use programs. Not surprisingly, use/need rates were highest among APHAs who indicated injection drug use (sharing needles) and tattoos as a dominant mode of HIV transmission (82.7%). However, use of addiction treatment, harm reduction and/or needle exchange programs is compromised by lack of availability, inadequate care or objections to an abstinence-based approach. More specifically, particularly in connection with either addiction treatment and harm reduction programs, commonly cited barriers included long waits, closed facilitates, or lack of transportation. Additionally, confidentiality and privacy were also cited as concerns of the APHA study population. It is important to note that use/need generally increased (40.0%) with serious to very serious health status compared to those who reported better health (19.0%):

- Where substance use programs exist, there is a need to address barriers such as objections to an abstinence-based approach, long wait-times to enter facilities, transportation needs, as well as issues of confidentiality and privacy. The overall use/need rates demonstrate that when afforded opportunities to access substance use programs, APHAs will do so.

Community-based and AIDS Service Organizations Services: APHAs in this study indicate a high need/use of community-based AIDS service organizations (80.5%). This in not an entirely unexpected result given our chosen recruitment method: participants were approached within the context of their existing connection with ASOs. Drop-in programs and treatment information are the most widely used services, followed by buddy support programs and health education programs. Comparatively few APHAs used crisis help-lines or hospice care. It appears that community organizations generally rise to the challenge of meeting the needs of APHAs (75.0%). However, APHAs did express concerns related to privacy/confidentiality issues and a lack of services such as hospice programs:

- Community programs need to address privacy/confidentiality concerns, particularly as they arise though participation in group programs such as buddies and drop-in support.

- Treatment information was highlighted as an important area of concern for APHA in this study. Specifically, written information is needed at various literacy levels. As well, given the complexity of treatment information and the desire to be active participants in the care process, APHAs may require face-to-face counselling by knowledgeable HIV/AIDS care providers.

- Buddy systems and hospice care programs should be considered as a component of a comprehensive approach to providing care to APHAs, particularly to those experiencing serious health problems.

Mental Health and Counselling Services: Slightly more than half (54.4%) of the APHA study group need or use one or more mental health or counselling (spiritual, grief, financial, legal) services. Mental health care and spiritual care are the most commonly accessed types of service within this category. Where needs are not being met, APHAs indicate they do not know if or where such services exist (26.3%), they feel the care or service they receive is inadequate (18.4%), or they feel that confidentiality is compromised:

- Given mental health challenges associated with living with HIV/AIDS, and in some cases with a traumatic personal and cultural history (eg., residential school legacy), there is a clear need to establish programs and/or promote existing mental health services to APHAs that require care. Of significance is that mental health care issues are increasingly important to APHAs whose health is declining, or who are experiencing grief associated with the loss of a loved-one due to the disease.

- There is a need to address privacy/confidentiality issues, particularly in relation to the spiritual care needs of APHAs. Findings indicate there is a lack of trust of spiritual care providers, possibly the result of historical circumstances.

The Voices of APHA Participants: Best Approaches to Improve Services: As a group with a tremendous amount of experience in accessing care and treatment for HIV/AIDS, 85.0% of APHA participants provided comments and/or recommendations on how best to adapt services to meet support needs.

Although there is some agreement that services are doing the best possible work under extraordinary circumstances (30.7%), APHAs in this study also recognize the need for better approaches to improve services. APHAs recommend the following best practice approaches to improving care, treatment and support services:

- First and foremost, APHAs express the need for cultural competence in their care, treatment and support. Recommendations pertaining to Aboriginal - specific and traditional services constitute the greatest number of open-ended comments. APHAs advocate for more Aboriginal service providers and front-line workers, more traditional support programs, and more attention to issues of diversity.

- There an equally strong call by APHAs not only for new support services (eg., logistical access support such as transportation assistance), but also that existing services be sustainable. Under the new Federal Initiative on HIV/AIDS, and as funding allocations are finalized, APHAs recommend that community agencies that provide HIV-related services be allowed to access funding and develop programs under core funding arrangements. Time-limited project funding does not adequately address the issue of sustainable service provision. Clearly, programs are developed based on needs which do not disappear when project funds terminate.

- APHA's emphasize their need for up-to-date HIV/AIDS treatment information. The complexity of HIV-related information is such that attention to literacy levels of written documents are an important concern. Written information should be supplemented with optional verbal and one-on-one information services.

- APHAs emphasize the importance of tolerance and respect as a fundamental component of effective care, treatment and support. APHAs advocate for the continuation and enhancement of public education and awareness initiatives.

- Income security, family and housing matters are concerns common to many APHAs. In terms of housing, for example, approximately one third of the study group are homeless or live in institutional/subsidized type settings. In the context of health generally, and for HIV/AIDS specifically, APHAs recommend that safe and healthy housing assistance be added as a component of program funding arrangements.

- Finally, APHAs speak eloquently of their emotional, mental and spiritual needs that, together with the need for treatment of their physical condition, call for holistic support programs and services that aim toward overall health and wellness in the context of living daily with HIV/AIDS.

CHAPTER I

INTRODUCTION

It is widely acknowledged that HIV/AIDS has and will continue to have a profound impact on the health and well-being of Aboriginal (Inuit, Métis, and First Nations) people in Canada. Collectively, Aboriginal groups comprise 3.3% of the Canadian population. However, "Aboriginal peoples make up a growing percentage of positive HIV test reports and reported AIDS cases" (CIDPC, May 2004: 46). For example, in provinces that report HIV surveillance data along with ethnic identifiers, of 711 HIV-positive test reports in 2002, 169 or 23.8% were Aboriginal (CIDPC, May 2004). This disproportional representation is the result of a myriad of social, economic and behavioural factors (eg., high rates of povesssssssrty, substance use, sexually transmitted diseases, and limited access to or use of health care services) compounded by historical and cultural factors.

It was against this backdrop that the fundamental goals of this study were first defined. CAAN set out to ascertain utilization of HIV-related services, to assess the extent to which needs are met, to explore reasons why needs are not met, and to formulate practice and policy recommendations. There exists very little evidence in the literature that systematically documents service needs of Aboriginal persons living with HIV/AIDS (APHAs) or of barriers that they may encounter in accessing needed services. To date, published studies tend to focus on other marginalised groups, particularly in the United States. Although this research is important towards increasing knowledge of HIV/AIDS generally, it cannot be assumed that these studies adequately address the issues encountered by the Canadian Aboriginal population. As such, it was important to draw on the experience of APHAs obtaining health services in Canada. Such knowledge can benefit Aboriginal people as they seek care, treatment and support for HIV infection, particularly where such knowledge may stimulate the development of sensitive, relevant and culturally competent health care services.

STUDY OBJECTIVES

The primary goal of the study is to determine which services and programs currently address and fulfill the needs of Canadian Aboriginal people living with HIV/AIDS. Secondary research goals include: to identify barriers that prevent or limit access to needed services, and; to develop policy/practice recommendations for the design of relevant programs. In brief, the study objectives include:

- To document the extent to which service needs are being met by Aboriginal identity, geographic region, disease stage, gender, age and transmission category
- To identify deficiencies in the provision of services
- To develop policy and/or practice recommendations based on the findings
- To review and summarize the literature placing the findings into context
- To equitably involve Aboriginal community stakeholders in the research process
- To disseminate the findings by report distribution, conference presentations and publication
- To evaluate the process and outcome of the research project

RATIONALE

The three main reasons for undertaking a project to explore the service needs and barriers encountered by Aboriginal people living with HIV/AIDS, are:

- First, the need to gain a more complete and comprehensive understanding of the needs of Aboriginal people living with HIV/AIDS and of the barriers they encounter in accessing services. Such an understanding, it is hoped, will benefit Aboriginal people as they seek care, treatment and support for HIV infection. Knowledge of the particular needs of this group may stimulate the development of sensitive, relevant and culturally appropriate/competent health care.
- Second, consideration of indicators that the number of Canadian Aboriginal people living with HIV/AIDS is increasing. As rates of infection continue to climb, it is increasingly important for service agencies to draw on evidence-based research that justifies funding allocation and the need for services that target and address issues Aboriginal people must deal with concerning HIV/AIDS.
- Third, to address the relative absence of any other such analysis in the scientific literature. No other study has documented service utilization

and barriers faced by Aboriginal people living with HIV/AIDS across Canada. Although smaller studies have addressed the lack of access, and have outlined possible consequences of lower than expected utilization, these do not propose comprehensive recommendations that will promote changes in policy and practice at a national level.

Our hope is that this study is the first in a series of attempts to document the needs and concerns of Canadian Aboriginal people living with HIV/AIDS.

METHODOLOGY

Using a participatory action research (PAR) design, between March 24th and September 15th 2004, with assistance from 31 recruitment agencies, a purposive sample of APHAs from across Canada where supplied with a self-administered survey. Agency staff provided survey packages to potential participants. Respondents and recruitment agencies were provided with a small honorarium for their participation. When completed, agencies returned consent forms to the consulting firm (Praxis Research Associates) and the surveys to the Canadian Aboriginal AIDS Network (CAAN). All identifying information is stored in a locked safe and separate from completed surveys. The study design was approved by the Carleton University Ethics Committee.

Participatory Action Research (PAR)

Participatory action research (PAR) resists much of the structure of conventional research practices (Kemmis and McTaggart, 2000). Where research questions have conventionally been designed, implemented and analysed by researchers from outside a community, PAR allows for more active involvement of community members in all phases of the research process. In allowing more active engagement, knowledge is not produced merely for knowledge sake, but also stimulates action toward the improvement of conditions that affects the lives of members in the study-community. Characteristic of a PAR design are several common themes or approaches: "(a) the problem originates in the community; (b) the goal of the research is political or social change; (c) community investigators control problem definition, information gathering, and resulting actions, and; (d) community researchers and professional investigators are partners in the research process" (Wuest and Merritt-Gray, 1997: 286).

As noted above, the paradigm of participatory action research guided the design and implementation of this project. Questions were originally conceived by community members. The study was further refined under the guidance of a Research Team and National Research Advisory Committee representing APHA stakeholders, formed under the auspices of the Canadian Aboriginal AIDS Network (CAAN). The survey was then implemented by Praxis Research Associates (Ottawa) who were contracted for this purpose.

The Research Team and National Research Advisory Committee is comprised of representatives with expertise in HIV/AIDS and experience in Aboriginal community-based research. They provided the local and regional knowledge on AIDS Service Organizations (ASOs) who serve APHAs, as well as expertise in culturally-based knowledge. The Praxis consultants – who are also adjunct research professors in the Department of Sociology and Anthropology at Carleton University – were closely involved in the more technical aspects of research implementation. "The appeal of such a [design] is that research and practice are brought closer together. Action and change occur during the research process, not just as a final outcome" (Wuest and Merritt-Gray, 1997: 286).

A separate and external process is being implemented to evaluate the impact of Aboriginal HIV/AIDS community-based research approaches and of the benefits/challenges associated with participatory action research.

The Survey Instrument and Data Collection

The study instrument is a self-administered questionnaire composed of both closed and open-ended questions (Appendix A). The questionnaire was designed to collect information on the basic characteristics of participants, APHAs' use of services and opinions of the extent to which their needs are met, and APHAs' thoughts and opinions on how services can be improved.

The survey was pretested in the autumn of 2003: twenty pre-test surveys were distributed to three locations in Canada. All 20 pre-test surveys were completed and returned, providing an excellent base for evaluating both the distribution process and the survey itself. The instrument and process were subsequently revised, under the direction of the research team and advisory committee.

Survey distribution was achieved through the participation of 31 ASOs that agreed to act as recruitment agencies. A primary concern was that APHAs across Canada be represented in the study, and that this representation should reflect the reality of APHAs' Aboriginal identity and geographic residence. As no reliable demographic data was available to guide representative survey distribution, CAAN undertook to poll as many ASOs in Canada as possible, to determine which agencies served Aboriginal clients, and to gain a sense of where surveys should be distributed in order to capture the full range of Canadian Aboriginal people living with HIV/AIDS.

Approximately 150 HIV/AIDS organizations were telephoned in March 2004. Of these it was learned that over 60 ASOs served approximately 2,550 Aboriginal clients. This number is vastly higher than the 509 known Aboriginal AIDS cases as reported by Health Canada (CIDPC 2004: 53).

A general lack of record-keeping with respect to ethnicity by the ASOs we contacted, did not allow for a representative sample based on Aboriginal identity. Sampling therefore focussed on regional representation. Chart 1 shows the residence of APHA clients by province and territory, as of March 2004.

Chart 1

Estimated Number of Aboriginal Persons Living with HIV/AIDS and Accessing Community-Based Services in Canada, 2004

Province/Territory	Estimate (No.)	Proportion (%)
Northern Territories (YK, NWT, and NU)	25	1.0
British Columbia	1100	43.0
Alberta	450	18.0
Saskatchewan	120	4.5
Manitoba	370	14.5
Ontario	425	17.0
Quebec	45	1.5
Atlantic (NB, NS, PEI, and NL)	15	0.5
TOTAL	**2550**	**100**

Using the above regional proportions as a guide for the survey sample, a total of 305 surveys were distributed nation-wide beginning in May 2004. In August, a second round of survey distribution was conducted in an attempt to gain better representation from those regions where few or no surveys had been completed. Although 203 completed surveys were returned to CAAN, 8 were duplicates (same individuals), resulting in 195 valid surveys (64% completion rate).

When calculated according to Health Canada statistics, this study represents almost 40% of Aboriginal persons living with HIV/AIDS (CIDPC 2004). However, in light of the information gathered by CAAN in March 2004, it is estimated that this study more likely represents the voices of 7.7% of APHAs in Canada. It is also important to point out that the study group represents APHA clients who currently access services offered by AIDS Service Organizations in their region. It does not capture information about APHAs who are unable or unwilling to use ASO services.

ETHICS PROTOCOL

Ethical considerations were guided by the Tri-Council Policy Statement (1998). Participation in this study was voluntary and informed. Each survey package contained an informed consent form along with an information sheet. Both the participants and the recruitment agencies were compensated with small honoraria for their involvement in the study. The information sheet provided a general outline of the nature and purpose of the study, and specified the measures taken to protect participant confidentiality and anonymity. Participants were provided assurances that they could withdraw from the study at any point and should they opt to do so, this would not affect their continued access to services.

The consent form, requiring the participant's signature, was provided with a separate envelope for return to the Praxis office. Confidentiality was ensured by the complete separation of consent forms (with names of APHAs) and completed surveys that contained personal information about their health status. All completed surveys were returned to the CAAN office. All consent forms were subsequently secured in a locked safe in a location (Praxis) separate from the completed surveys (at CAAN). Only the research consultant has access to the master code-list that matches names to surveys. Not only did the consent forms provide necessary consent by each participant for information to be used in the study, but it also allowed the consultant to identify duplicate surveys completed by the same individual [n=8], and to exclude these from the analysis.

The study was originally approved by the Carleton University Ethics Committee in October 2002 and renewed in October 2003.

DATA ANALYSIS

The analysis of survey data presented in this report has been performed using the Statistical Package for the Social Sciences (SPSS®). Pearson Chi-Square (χ^2)

tests have been performed to determine the statistical significance of the use of, and extent to which APHA's needs are met by 38 care, treatment and support services when cross-tabulated with Aboriginal identity, geographic region, age, gender, health status and transmission category.

On the survey form, these 38 services were grouped into five (5) categories. However, following a preliminary analysis workshop with the Research Team and National Research Advisory Committee (July 2004), it was decided to further break down the service categories to better reflect the themes emerging with respect to APHAs' responses regarding access and barriers to services. Eight (8) service categories were subsequently defined, including traditional Aboriginal services as well as medical, alternative/complementary, substance use, support and counselling services. Responses indicating use of one or more services within a category, have been translated into a positive response for that category (eg., a "yes" response to need/use of Elder services is taken as a "yes" to traditional Aboriginal services as a whole). Each category has been subjected to the same cross-tabulations (and Chi-Square Tests) as the specific services. Probability (P value) that results are true for the general APHA population in Canada, is discussed at both the 95% (χ^2 = .05 or less) and 90%(χ^2 = .05 - .100) levels of confidence (all cross-tabulation tables and Chi-Square results cited in this report are reproduced in Appendix B).

Participants were allowed to choose from a numbered list of 13 reasons why a service might not meet their needs, or they could provide a reason in their own words. While allowing this choice increased the content analysis component of the project, it allowed for a more meaningful (emic) assessment of what barriers APHAs face in accessing necessary services. Unexpectedly, APHAs also offered many positive comments about why a service met their needs, and why it is important to them. Overall, this approach resulted in valuable and substantial additions to the list of barriers originally conceived by the Research Team and Advisory Committee.

Responses to all open-ended questions (eg., health effects of residential school; additional barriers to services) were subjected to content analysis, assigned values and entered into the SPSS® database. For the final two open-ended questions (recommendations for improved service and additional comments), independent content analyses were performed by the principal investigator and the research consultant, who then agreed on a list of themes and collaboratively assigned multiple values to each response. These values were entered into the SPSS® database as multiple response sets (category), followed by frequency and cross-tabulation analyses.

It is important to point out that because the survey sample is not random, the Chi-Square results are not conclusive. At best, the purposive and relatively small sample of APHAs [n=195] allows for indicators of probability, some of which must be qualified because one or more cells have less than expected counts.

The analysis of the survey data is further limited with regard to questions about whether services met APHAs needs, and if not, why. Only those APHAs who used or needed a service provided responses about the extent to which the service met their needs, resulting in a lower number of valid cases. An assessment of the reasons why a service sometimes or did not meet APHA's needs is possible only through qualitative analysis, as the number of valid cases is limited to those who identified barriers. While these results are meaningful, caution must be exercised in generalizing beyond the study population.

CHAPTER 2

NATIONAL SURVEY RESULTS

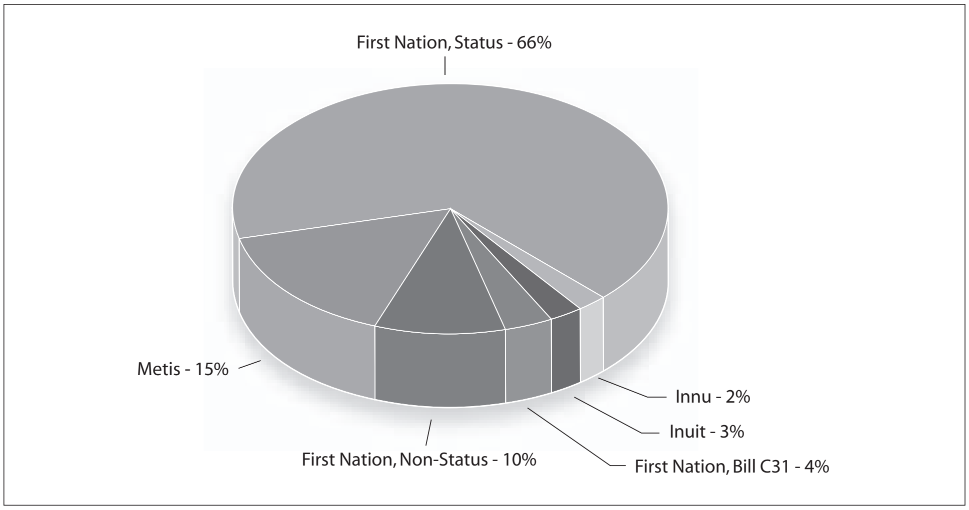
CHARACTERISTICS OF APHA PARTICIPANTS

The 195 participants in CAAN's Care, Treatment and Support Issues study represent First Nation (status and non-status), Métis, Inuit and Innu persons with HIV/AIDS from all regions of Canada, living in urban centres, isolated settlements and on Reserves. The information presented here is from Aboriginal women, men, transgendered and inter-sexed individuals who contracted HIV through blood contamination, sexual contact and/or drug use, and whose self-reported health status ranges from HIV positive with no symptoms to AIDS with serious health problems. Almost half of the Aboriginal persons living with HIV/AIDS (APHAs) in the study are Two-Spirit.

Aboriginal Identity

The majority of APHA participants are status First Nation; together with non-status and Bill C-31, First Nation APHAs number 155 participants (almost 80% of the study group). Thirty (30; 15%) Métis APHAs participated, as well as by five (5; 2.5%) Inuit and four (4; 2%) Innu (Table 1; see Figure 1 below).

FIGURE 1. APHA Study Group: Aboriginal Identity

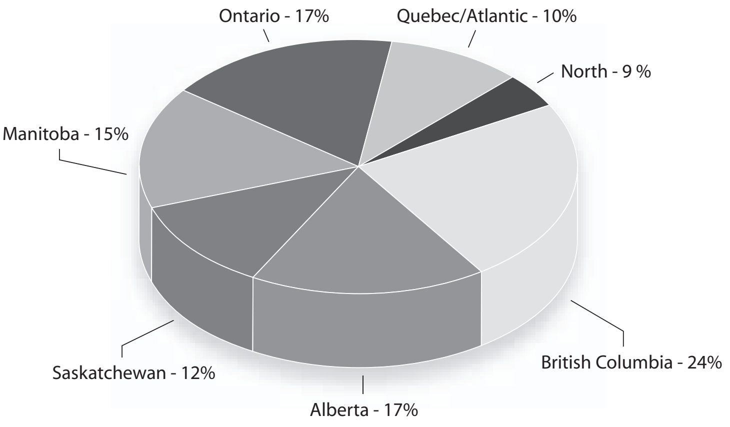


The representation of APHAs in this study is fairly consistent with recent estimates of AIDS Surveillance data on Aboriginal identity by Health Canada. The HIV/AIDS Epi Update released in May 2004 states that of "509 Aboriginal AIDS cases reported to June 30, 2003, 72.3% or 368 were First Nations, 8.3% or 42 were Métis, 4.1% or 21 were Inuit, and 15.3% or 78 were in the category Aboriginal Unspecified" (CIDPC 2004: 53).

GEOGRAPHIC REGION AND RESIDENCE

Geographic representation is fairly proportional (Tables 2a/b; see Figure 2 below). However, despite repeated efforts, few APHAs were recruited from Quebec and the Atlantic provinces/territories (Nova Scotia, New Brunswick, Prince Edward Island, Newfoundland and Labrador) and in order to ensure confidentiality and anonymity, these areas are collapsed into a single region in this study. The North region includes the Yukon and Northwest Territories. Inuit APHAs living in southern urban centres participated, as no recruitment agencies were located in Nunavut. The lack of front-line ASOs in both the North and the Quebec/ Atlantic regions is discussed at greater length in following sections of this report.

FIGURE 2. APHA Study Group: Geographic Region



Most APHAs in the study group live in cities (89%), a rate almost certainly related to the location of ASOs who agreed to participate as recruitment agencies for the survey (Table 3). The remainder live in smaller towns and hamlets (5%), on Reserves (3%), and in isolated or rural settlements (1%). Approximately 2% of the study group have dual residence on Reserves and in cities. Notably, almost half (43%) of APHAs indicate they have already moved or will need to move to be nearer HIV/AIDS services (Tables 4a/b).

In terms of housing, APHAs live primarily in their own private residences. Approximately 15% of the APHA study group resides in institutional or subsidized types of housing. Another 13% indicate they are homeless with no permanent address (Table 5).

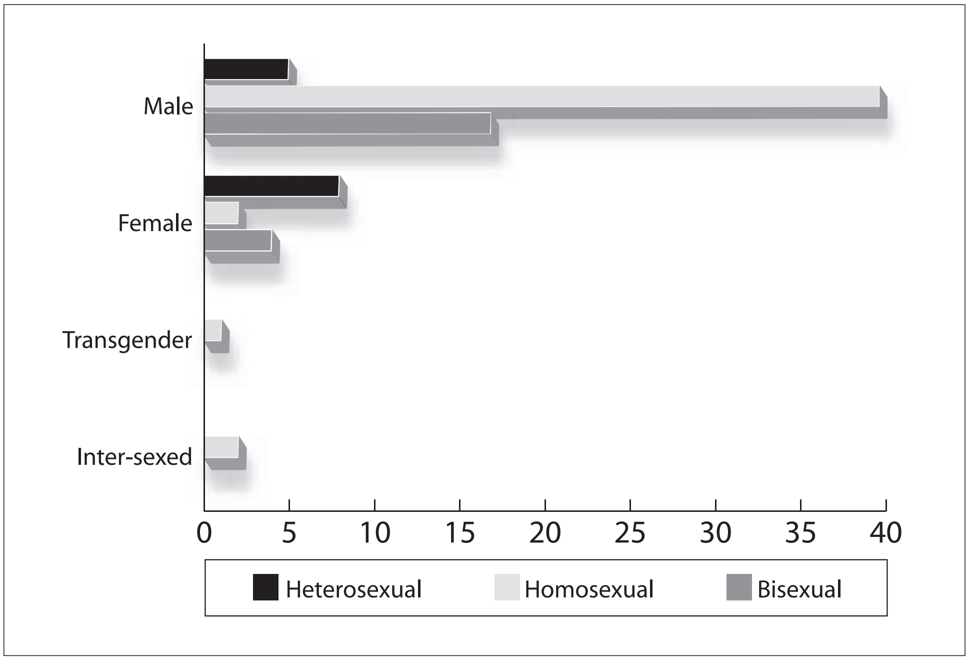
AGE AND GENDER

Most (80%) of the APHAs in the study are aged 30 - 50 (Table 6). Very few youth were recruited, although several APHAs in their 20s participated (13%). A few APHAs over 50 years of age also participated (5%).

There is an approximate 60:40 split between male (58%) and female (38%) participants, plus several transgender (2%) and inter-sexed (2%) APHAs (Table 7). About 55% of the APHAs who participated are heterosexual; 27% are homosexual and 17% are bisexual (Tables 8 and 9).

Almost half (46%) of the study group identified as Two-Spirit. Figure 3 shows a cross-tabulation of gender, sexual orientation and Two-Spirit identity (Table 10).

FIGURE 3. Two-Spirit APHAs: Gender & Sexual Orientation



TRANSMISSION CATEGORY AND HEALTH STATUS

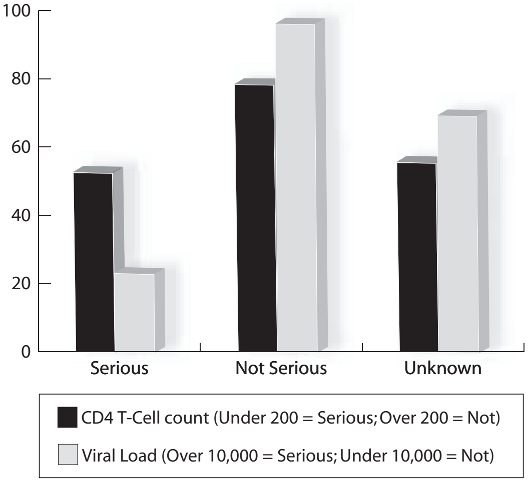
The most common reported means of HIV transmission are through sexual contact or sharing needles and other works related to drug use and tattooing (Table 11). Several APHAs in the study contracted HIV through blood contamination. Twenty-five APHAs report dual transmission; calculations of multiple responses to this question reveal that dual transmission involves mainly intravenous drug use (IDU) and sexual contact [n=21].

Self-reported health status indicates that 84% of the APHA study group are HIV+ with no symptoms or minor health problems (Tables 12a/b). Ten percent (10%) of the sample reported an AIDS diagnosis and health status ranging from good to serious problems.

Figure 4 shows APHAs' CD4 T-Cell counts relative to viral loads (self-reported) (Tables 13a/b; 14a/b). Of note is that if a CD4 T-Cell count of under 200 is interpreted as a probable AIDS diagnosis, the percentage of participants with AIDS is higher (28%) than the self-reported health status shown in Table 12b. This may be significant in light of the high number of APHAs who indicated they "do not know" their CD4 T-Cell counts or viral loads (30-35% respectively), including several who volunteered comments that they did not want to know, or were afraid to know these measures of HIV/AIDS health status.

When calculated as a single indexed variable (Table 15), over half of the APHAs in the study do not have serious health problems (CD4 t-cell count over 200 and viral load under 10,000). Among 42% of APHAs, either their CD4 t-cell count or viral load is serious; 8 APHAs in the study have very serious health problems (CD4 t-cell count under 200 and viral load over 10,000).

FIGURE 4. CD4 T-Cell Counts and Viral Loads



Almost half (48%) of the study group report use of anti-retrovirals (Table 16). Traditional Aboriginal medicines are used as an alternative or complement to prescription drugs by 11% of the APHA study group. A quarter of the study group use two or more drugs, treatments or therapies.

Residential School

Thirty-two (16%) of APHAs who participated in the study attended residential school (Table 17). Approximately half of this group attended five years or less, and half attended between 5-10 years (Table 18). A much higher percentage (60%) of the study group reported that a parent attended residential school, and over 85% reported that a parent, guardian or grandparent attended residential school (Tables 19 and 20). Of these, 22% (43 APHAs) indicate that their health has in some way been affected by the residential school legacy.[1] The most common effects are poor mental health (including low self-esteem) as a result of psychological and physical abuse, and tendencies toward high-risk behaviour (addictions; unhealthy sexuality). Comments regarding poor parenting and family breakdown indicate that APHAs lack the family support they may require in the struggle to live with HIV/AIDS (Table 21).

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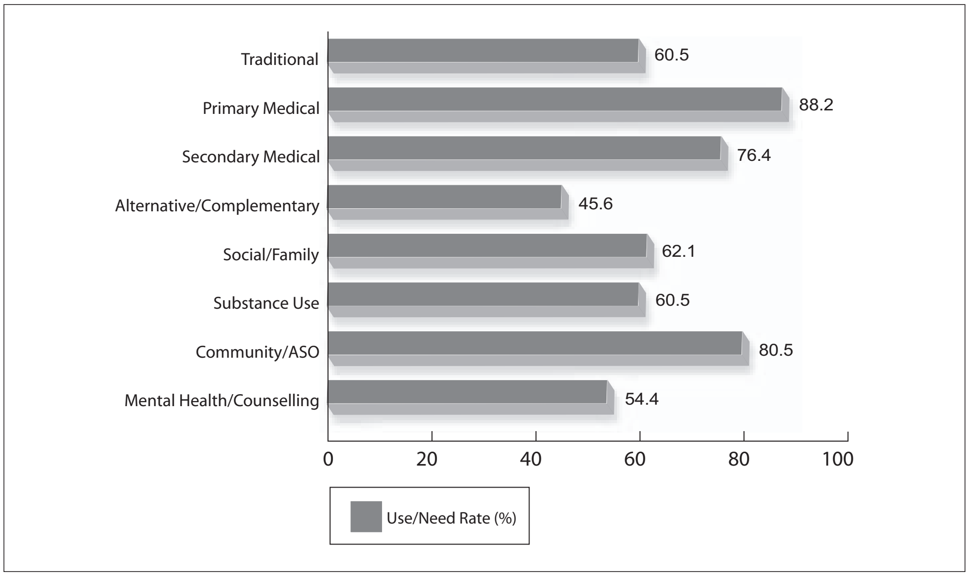
[1] The survey results relative to Residential School questions are the subject of future research by CAAN.

CARE, TREATMENT AND SUPPORT SERVICES: USE/NEED RATES, SATISFACTION RATES AND BARRIERS

The fundamental objective of the survey is to ascertain the care, treatment and support services being used by Aboriginal persons living with HIV/AIDS, the extent to which these services are meeting their needs, and the reasons why services do not meet the needs of APHAs. Figure 5 shows the rate of use/need of services categorized as eight types of services:

- Traditional Aboriginal Health and Wellness Services
- Primary Medical Services
- Secondary Health Services
- Alternative/Complementary Therapies
- Social and Family Services
- Substance Use Services
- Community-based and AIDS Service Organization (ASO) Services
- Mental Health and Counselling Services

FIGURE 5. APHA Use/Need of Service Categories

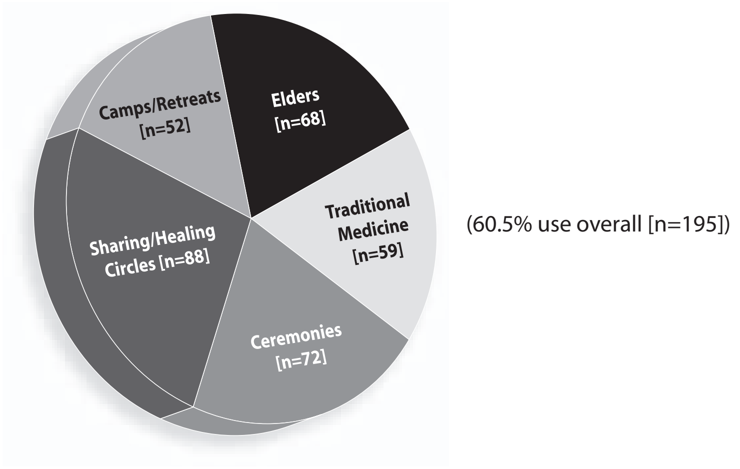


Not surprisingly, the services most widely used by APHAs are primary medical services. However, community-based and ASO support services are of almost equal importance, indicating that Aboriginal persons living with HIV/AIDS seek a wellness approach that goes beyond the physiological aspects of the disease. Relatively high use and need rates for other support services confirm the importance of an holistic approach that addresses APHAs' mental, emotional, social and spiritual needs.

Traditional Aboriginal Health and Wellness Services

Approximately 60% percent of APHAs in the study indicate that they need or use one or more traditional services (Table 22). Traditional health and wellness services were defined to include Elders, traditional medicine, ceremonies, sharing/healing circles, camps/retreats. Between 35 - 45% of APHAs seek the support of sharing and healing circles, traditional ceremonies (eg., sweat lodge) and Elders (Figure 6). Between 25 - 30% need or use traditional Aboriginal medicines, and attend traditional camps or retreats.

FIGURE 6. APHA Use/Need of Traditional Aboriginal Services



APHAs in the study group offered numerous unsolicited positive comments about why traditional aboriginal health and wellness services are important to them (see Table 24):

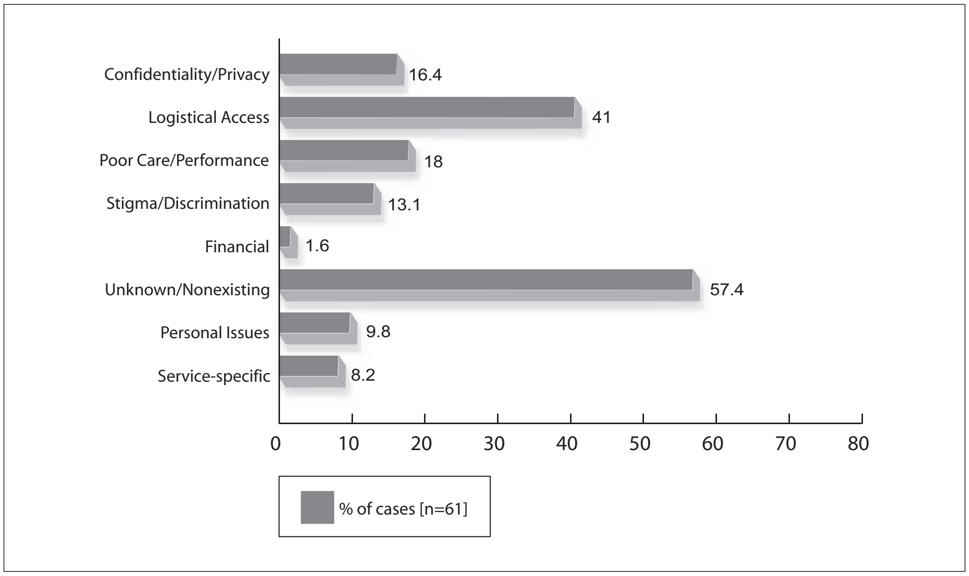
- Elder advice is very useful.
- [My Elder] spoke to me in a way that I understood.

- [Traditional medicine] help calms my body.
- [In a sharing circle I am] able to talk with others and share info, I or they may have.
- Ca fait beaucoup de bien de parli et de s'exprime librement! [It helps a lot to talk and express yourself freely.]
- I have gone to [an] Inuit Centre for healing circle. Going to healing circle helps.
- HIV Retreats helped share status with others infected and was relaxing away from home.

Unfortunately, many APHAs in the study group indicate that their needs are only sometimes or never met by one or more traditional services, and this category of services received one of the highest dissatisfaction rates measured in this study (35.8% of responses; Table 23). The most common barriers to traditional services are (Table 24; Figure 7):

- Services are non-existing or unknown to APHA's in their current place of residence (57.4% of cases [n=61]);
- Logistical barriers such as distance (to access Elders, ceremonies, etc. in home communities) and lack of transportation (41% of cases);
- Because sharing and healing circles – used or needed by 45% of APHAs – are by definition group-oriented, the main barrier is confidentiality/privacy (24.2% cases [n=33]).

FIGURE 7. Barriers to Traditional Aboriginal Services



Analysed a category of services, traditional health and wellness is statistically significant mainly in relation to Aboriginal identity. The use/need rates of traditional services differ significantly by Aboriginal identity: 66.5% of First Nation APHAs [n=155] need or use traditional services; in contrast, 35% of Inuit, Innu and Métis [n=39] need or use traditional services ([χ^2 = .012]; Table 25). With respect to measures of health status, APHAs with CD4 T-cell counts under 200 (Serious) tend to use/need traditional services less frequently (52.8%) than do APHAs whose counts are over 200 (Not Serious, 70%; [χ^2 = .044]; Table 26).

Results for specific traditional Aboriginal health and wellness services indicate the following (refer to Figure 6 and Tables 22 - 24 for frequency results):

Elders

- Overall, 35% of the study group indicate that they need or use services offered by Elders. For over 40% of these APHAs [n=65]; needs are only sometimes or not met. This is mainly due to logistical barriers (29.4% of cases [n=34]). For example APHAs who have moved to urban centres have difficulty accessing Elders who reside in distant home communities/reserves. The second barrier is that Elder services do not exist or cannot be found where APHAs currently reside (23.5% of cases).

- Status First Nation APHAs need/use Elders at the highest rate (40.4%); in comparison, few Métis APHAs need/use services offered by Elders (16.7%) ([$\chi^2 = .074$]; Table 27).

- The extent to which APHAs needs are being met by Elders appears also to differ significantly by Aboriginal identity [$\chi^2 = .058$; 6 cells > 5]: two-thirds (66%) of Status First Nation APHAs state their needs are being met, compared to 66.7 - 75% of Non-Status First Nation and Métis APHAs who indicate that Elders only sometimes or do not at all meet their needs (Table 28).

- Regionally, APHAs in the Quebec/Atlantic region (80.0%), Ontario (69.2%) and the North (50.0%) regions indicate the highest dissatisfaction rates with respect to Elders meeting their needs. APHAs in Saskatchewan (83.3%) indicate the highest satisfaction rate [$\chi^2 = .098$; 7 cells > 5]; Table 29).

Traditional Medicines

- Overall, 30% of the study group indicate that they need or use traditional Aboriginal medicines. Of these 59 respondents, 42.4% indicate their needs are not fully met. The main barrier/ reason is that APHAs do not know where to access traditional medicine services (24% of cases [n=25]).

- Status First Nation APHAs indicate the highest need/use rate of traditional medicines (37.5%); in contrast, Métis APHAs indicate a low need/use rate of traditional medicines (16.5%) ([$\chi^2 = .008$]; Table 30).

- There is also a significant difference in the need/use rates of male and female APHAs: traditional medicines are needed/used by 35.4% of male APHAs, but only by 21.6% of female APHAs ([$\chi^2 = .044$]; Table 31). Female APHAs also indicate a higher dissatisfaction rate (62.5%) stating that traditional medicines only sometimes or never meet their needs. In comparison, 67.5% of male APHAs are satisfied ([$\chi^2 =.039$]; Table 32).[2]

- Finally, the majority (52.2%) of APHAs who report a serious viral load (over 10,000) indicate they use/need traditional medicines; in contrast, 29.9% of APHAs whose viral load is not serious (under 10,000) use/need traditional medicines ([$\chi^2 = .043$]; Table 33).

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[2] Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], three participants indicate they need/use traditional medicines, and one participant indicated needs were not met; however, when factored into Chi-Square analysis, results are not significant.

CEREMONIES

- The overall need/use rate of traditional ceremonies by APHAs in the study population is 37%. The ceremonial needs are sometimes or never met by almost a third of these APHAs. Again, the most common reason is that APHAs do not know if or where traditional ceremonies are available to them (25.9% of cases [n=27]).
- Status First Nation APHAs need/use traditional ceremonies (44.1%); in contrast, Métis APHAs need/use ceremonies at a much lower rate (13.3%) ([χ^2 = .011]; Table 34).
- At a 90% level of confidence, the extent to which needs are met by traditional ceremonies differs with respect to health status: APHAs with serious to very serious CD4 T-cell counts and viral loads appear more satisfied that their needs are met (82.6%) than do APHAs whose health status is not serious (59.1%) ([χ^2 = .082]; Table 35).

SHARING AND HEALING CIRCLES

- Sharing and healing circles are the most frequently needed/used traditional service (45%). Over 35% of APHAs who attend circles do not feel their needs are being fully met. As noted above, the main reason is that as a group activity, sharing and healing circles do not ensure confidentiality or privacy with respect to HIV status (24.2% of cases [n=33]).
- Although not statistically significant [χ^2 = .110]; it is notable that Non-Status First Nation APHAs show the highest need/use rate (52.6%) of sharing and healing circles, when compared to PHAs of other Aboriginal identities (Table 36).
- It is also notable that among Non-Status First Nation and Métis APHAs, sharing/healing circles stand out as the traditional service they most frequently need/use (Table 37).

TRADITIONAL CAMPS AND RETREATS

- The overall need/use rate of traditional camps and retreats by APHAs in the study population is 27%. Again, about one-third (32%) of these APHAs indicate their needs are not met. The primary barrier is that traditional camps or retreats do not exist or APHAs do not know where or how to access them (50% of cases [n=18]).

- Differences in the need/use rates of camps and retreats is not significant by Aboriginal identity. However, significant differences do exist regionally ([$\chi^2 = .039$]; Table 38): APHAs in BC show the highest need/use rate (41.3%); APHAs in Manitoba, Saskatchewan and Ontario indicate need/use rates of between 26 - 33%; Alberta and the North and Quebec/Atlantic regions indicate low need/use rates (10-12%).

- There are also significant differences with respect to age ([$\chi^2 = .016$]; Table 39): almost no APHAs under the age of 30 indicate they need or use traditional camps or retreats; approximately 30% of APHAs over 30 use/need camps and retreats. However, APHAs over 40 are less satisfied that camps and retreats are meeting their needs (44.4%), compared to APHAs in their 30s of whom 90% are satisfied ($\chi^2 = .005$]; Table 40).

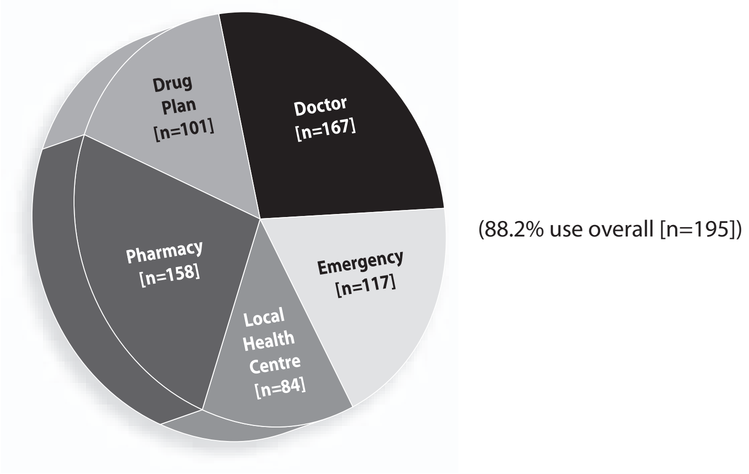
- Finally, indicators of significant difference exist depending on transmission category ([$\chi^2 = .053$]; Table 41): One-third (33.7%) of APHAs who contracted HIV through sexual contact indicate they need/use camps and retreats, compared to APHAs who contracted HIV through intravenous drug use (IDU) and sharing other drug related works or tattoo needles.

- The extent to which needs are met by traditional camps or retreats differs significantly with respect to health status: APHAs with serious to very serious CD4 T-cell counts and viral loads are more satisfied that their needs are met (92.9%) than APHAs whose health status is not serious (60.9%) ([$\chi^2 = .034$; 1 cell > 5]; Table 42).

PRIMARY MEDICAL SERVICES

Not surprisingly, a high proportion (88%) of APHAs in the study group use or need primary health care services (Table 43). Primary medical services were defined to include physician, hospital emergency, local health centre/nursing stations, pharmacy and drug plans. Physicians and pharmacies are used by most APHAs; hospital emergency centres and local health centres are used less by fewer APHAs (Figure 8). Approximately half of the study group requires access to a drug plan.

FIGURE 8. APHA Use/Need of Primary Medical Services



Statistical analysis of primary health services as a whole is significant mainly in association with self-reported health status (CD4 T-cell count and viral load index). The use of several specific primary medical services are also significant in relation to geographic region and gender (discussed below). Aboriginal identity and age are not factors in the use or need of primary medical services.

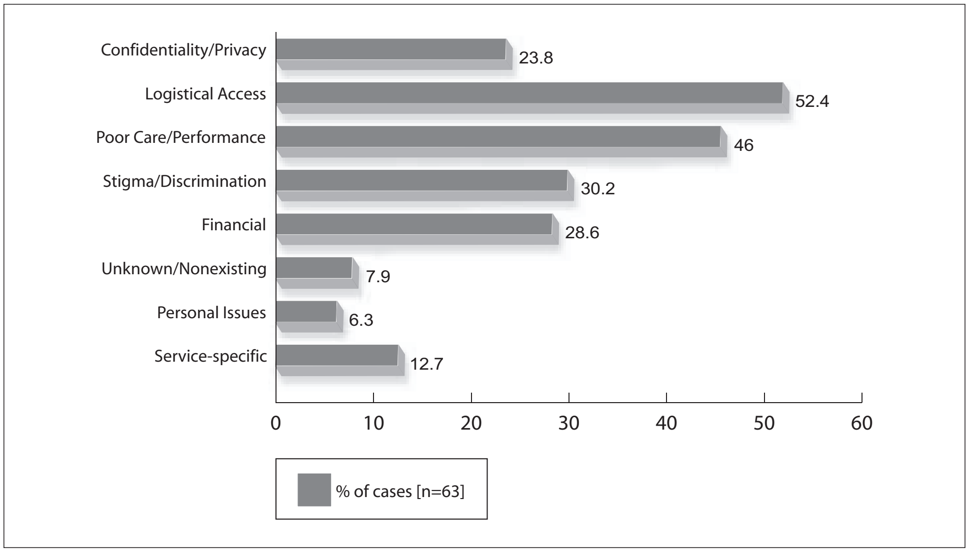
The association between the rate at which APHAs need or use primary health services and their health status as measured by self-reported CD4 T-cell counts and viral loads, is significant at a 95% level of confidence ([$\chi^2 = .023$; 2 cells > 5]; Table 46). However, the results are not very meaningful as they indicate high and fairly equal use/need rates for both serious and not serious health status (87.3% and 98.3% respectively).

Multiple response analysis indicates that generally, the primary health care needs of APHAs are being met (75% of responses); 25% of responses indicate that needs are sometimes or not met (Table 44). The most common barriers to primary medical services are (Figure 9; Table 45):

- Logistical access barriers (52.4% of respondents [n=63]): this is particularly the case with doctors and emergency rooms where long wait-times are a problem;
- The sense that medical services are not providing adequate care to APHAs (46% of respondents): this is especially the case for physician services about which 38.2% of respondents [n=34] indicate they receive "poor care"; for example, several APHAs indicate that they visit the doctor "mainly to get meds."

- Expressions of HIV/AIDS stigma, racial prejudice and homophobia also prevent full access to some primary health services (30.2% of respondents). Situations in which doctors and pharmacies are hesitant to issue narcotics for pain to an Aboriginal PHA (assuming a predilection to addiction or drug abuse), or in which local health clinic staff are perceived as judgmental (the APHA is to blame for his/her illness), are examples of this type of barrier in which some APHAs do not feel welcome and hence avoid medical services except in extreme circumstances.

FIGURE 9. Barriers to Primary Medical Services



Results for specific primary medical services indicate the following (refer to Figure 8 and Tables 43 - 45 for frequency results):

Physicians

- Overall, 85.6% of APHAs in the study group use or need a doctor. Just over a quarter (26.6%) of the APHA study group do not feel their physician needs are fully met. The reason most frequently identified is that doctors do not provide adequate care for patients living with HIV/AIDS (38% of cases [n=34]).
- Need/use is consistently high across geographic region (mean = 85.6%), except for the North region where only 55.6% of APHAs indicate they use/need physicians ([$\chi^2 = .046$; 6 cells > 5]; Table 47). This low use/need rate in the North is likely attributable to the shortage of physicians in more remote

areas, and several APHAs from the North (eg., Yukon) indicated the need for "more doctors."

- At a 90% level of confidence, the need/use rates of doctors differ with respect to indexed CD4 T-cell counts and viral loads ([$\chi^2 = .054$]; Table 48). However, the results are not particularly meaningful as they indicate high and fairly equal use/need rates for both serious and not serious health status (83.6% and 94.8% respectively).

HOSPITAL EMERGENCY

- 60% of APHAs in the study group indicate they use or need hospital emergency services. Approximately 35% of APHAs indicate their needs are sometimes or not met, the main problem being logistical access barriers such as long wait times (53.6% of cases [n=28]).
- The use of emergency room services varies significantly by self-reported health status ([$\chi^2 = .022$]; Table 49). APHAs diagnosed with AIDS indicate they visit emergency centres more frequently (82.6%) than those who are HIV positive but not diagnosed with AIDS (57.8%).
- Differences by gender are also evident at the 90% level of confidence ([$\chi^2 = .083$]; Table 50): female APHAs tend to visit emergency centres at a slightly higher rate (67.6%) than do male APHAs (54.9%).[3]

LOCAL HEALTH CENTRE/NURSING STATION

- Less than half (43%) of the APHA study group use/need local health clinics or nursing stations. Almost 40% of these APHAs indicate their needs are sometimes or not met, primarily because they feel that local nursing stations and health clinics do not provide good medical care for HIV/AIDS patients (29.6% of cases [n=27]).
- Statistically significant correlations are indicated at the 90% confidence level: by gender, female APHAs (51.4%) utilize the services of local health centres more often than male APHAs 38.1%; [$\chi^2 = .073$]; Table #51).[4]

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[3] Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], four participants indicate they need/use emergency services; however, when factored into Chi-Square analysis, results are not significant.

[4] Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], two participants indicate they need/use local health clinic services; however, when factored into Chi-Square analysis, results are not significant.

- With regard to self-reported health status, APHAs who are diagnosed with AIDS indicate a higher use/need rate (60.9%) than those who are not (HIV+ = 40.4%; [$\chi^2 = .063$]; Table 52). This is supported by results of health status measured by CD4 T-Cell counts (Table 53). Furthermore, 52.9% APHAs with serious CD4 T-cell counts (under 200) are not satisfied that local health centre meet their needs, compared with those whose counts are not serious (28.9%) ([$\chi^2 = .087$]; Table 54).

Pharmacy

- Overall, 81% of APHAs in the study use or need pharmacies for prescription drugs and related services. In general, APHAs are very satisfied with the case and service they receive from pharmacies (88.4% satisfaction rate).

- Use/need rates are statistically significant by region at the 90% level of confidence, indicating that a majority of APHAs in all regions rely on pharmacy services ([$\chi^2 = .077$]; Table 55). Use/need is lowest in the North and Alberta (about 65%) and highest in British Columbia and Saskatchewan (approximately 90%).

- The extent to which needs are met are also significant regionally ([$\chi^2 = .050$; 7 cells >5]; Table 56), and indicate that except for APHAs in the North (50% not satisfied), elsewhere in Canada APHAs are very satisfied (85-100%) with the care they receive through pharmacies.

Drug Plan

- Half (52%) of the study group relies on a drug plan to help with the cost of HIV/AIDS medications and treatment (Figure 8). These APHAs are generally satisfied with the benefits offered by drug plans (80.2% satisfaction rate). The primary dissatisfaction stems from limited coverage of the cost of HIV/AIDS-related drugs and treatment (73.7% of cases [n=19]).

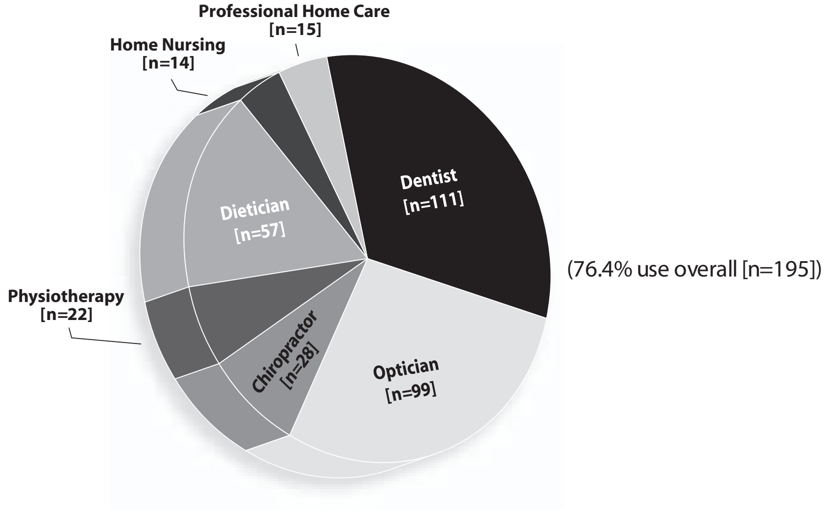
- However, the need for or access to HIV drug treatment under federal, provincial, territorial or private drug plans varies significantly by region ([$\chi^2 = .005$; 2 cells >5]; Table 57): the results indicate that APHAs in the North (22.2%) and in Manitoba (26.7%) use/need drug plans the least; APHAs in Saskatchewan indicate the highest use/need rate (73.9%).

- Use/need rates also vary significantly depending on health status ([$\chi^2 = .026$]; Table 58): almost 75% of APHAs with AIDS diagnosis need/use a drug plan; compared to 50% of APHAs who are HIV positive.
- A common barrier expressed by APHAs relates to financial inability to access HIV treatments that are not covered by existing drug plans (73.7% of respondents).

SECONDARY HEALTH SERVICES

Three-quarters of the APHA study group indicate they need or use one or more secondary health services (Table 59; see Figure 10). Secondary health services were defined to include dentists, opticians, chiropractor, physiotherapy, dietician, home nursing, and home care. Dentists and opticians are by far the most commonly used of this service category (57% and 51% respectively). Dieticians are accessed by almost a third of APHAs (29%). Chiropractors, physiotherapists, professional home care and home nursing are used by few APHAs (7-14%).

FIGURE 10. APHA Use/Need of Secondary Health Services

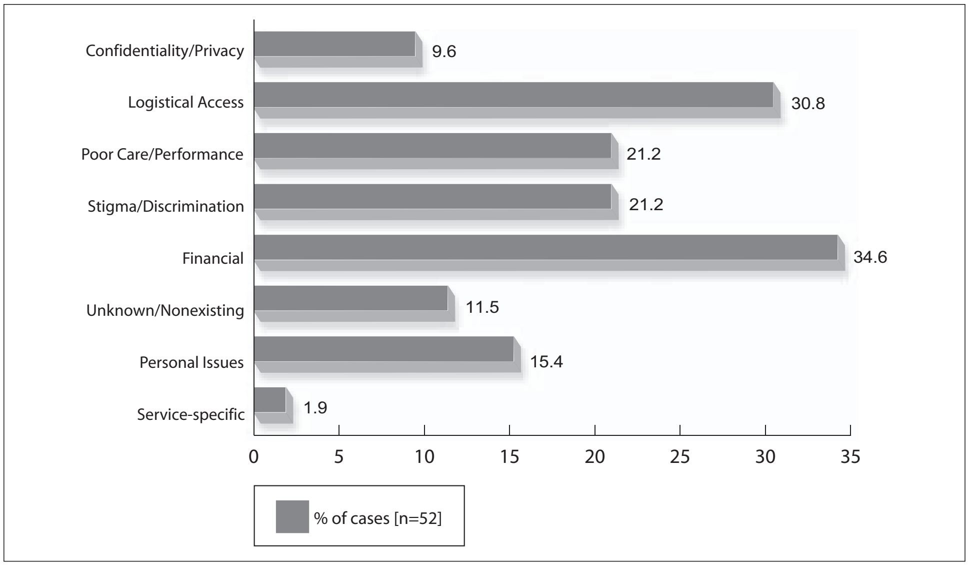


The rates at which APHAs access secondary health services vary mainly by geographic region and age, although for some specific services, health status is also a factor. Regionally, APHAs in Alberta (47.1%) and in the North (55.6%) indicate they need or use one or more secondary health services less frequently than in other geographic regions of Canada (77% - 89%; [$\chi^2 = .000$; 2 cells > 5]; Table 62). Age also appears to be factor: the results indicate that use of secondary health services increases incrementally with age, from 59.3% in the under-30 age group, to 74.7% in the 30-39 age group, and to 83% among APHAs 40 years and older ([$\chi^2 = .037$]; Table 63).

The secondary health needs of APHAs are generally being met (72.9% responses; Table 60). However, for those APHAs who indicated their needs are not fully met, the most common barriers to secondary health services are (Table 61; see Figure 11):

- Financial barriers associated with the costs of services not covered by Medicare or other plans (30.8% of respondents [n=52]).
- Logistical access barriers, for example: lack of transportation to and limited hours of service of clinics and offices (30.8% of respondents).

FIGURE 11. Barriers to Secondary Health Services



Results for specific secondary health services are as follows (refer to Figure 10 and Tables 59 - 61 for frequency results):

Dentist

- 57% of APHAs in the study access dentists. Of these, 25.7% indicate that dentists sometimes or did not meet their needs. The most common reason given is a perceived problem of HIV/AIDS stigma, particularly as this relates to disclosure of HIV+ status (26.7% of cases [n=30]). Financial barriers ("too costly") were the second most common (16.7% of cases).

- The need/use of dental services is statistically significant in relation to age: only 33.3% of APHAs under age 30 indicate they access dentists, compared with an average 60% of APHAs over 30 ([$\chi^2 = .026$]; Table 64). The extent to which APHAs needs are met by dental services also differs significantly by age: APHAs under the age of 30 tend to be least satisfied with dentists (66.7%), than APHAs over 30 (20 - 24.4% dissatisfied) ([$\chi^2 = .013$; 1 cell > 5]; Table 65).

- The need/use of dental services is also statistically significant in relation to health status: indexed CD4 T-cell counts and viral loads indicate that APHAs with serious health problems use/need dentists less commonly (52.7%) than do APHAs whose health status is not serious (74.1%) ([$\chi^2 = .018$]; Table 66).

OPTICIAN

- 51% of APHAs in the study need/use the services of an optician. APHAs express a high satisfaction rate (84.5%) with optician services. For those APHAs whose needs are not fully met, the main barrier is financial (eg., cost of corrective lenses).

- The need/use of optician services is statistically significant in relation to age: only 25.9% of APHAs under age 30 indicate they use/need an optician, compared with an average 55% of APHAs over 30 ([$\chi^2 = .019$]; Table 67).

- APHAs whose CD4 T-cell count is serious (27.6%) tend to be less satisfied with optician services than those who counts are not serious (8.3%) ([$\chi^2 = .024$; 1 cell > 5]; Table 68).

CHIROPRACTOR

- Few (14%) APHAs in the study group access chiropractors. Close to 30% do not feel their needs are fully met, mainly because of the high cost of chiropractic therapy and limited coverage by Medicare or other health plans (40% of cases [n=10]).

- Among those APHAs who do use/need chiropractic therapy, those with serious viral loads (30.4%) indicate a higher frequency than do APHAs whose viral loads are not serious (12.4%) ([$\chi^2 = .033$; 1 cell > 5]; Table 69).

PHYSIOTHERAPIST

- A small percentage (11%) of the APHA study group use physiotherapy services. However, of the 19 APHAs who responded, 60% indicate their needs were only sometimes or not met. Logistical access, including long wait times (eg., for appointments) and transportation, and financial issues were most the most common barriers to physiotherapy.

DIETICIAN

- 29% of APHAs in the study access the services of a dietician. A third of these APHAs indicate their needs are sometimes or not met, mainly because the service provided by dieticians is inadequate, failing, for example, to "educate for self-reliance" (41.7% of cases; [n=12]).
- The use/need rates of dietician services differs significantly by geographic region: APHAs in Ontario, Manitoba and Saskatchewan indicate the highest rates of use (39 - 44%), followed by APHAs in the North region and British Columbia (26 - 33%). APHAs in Alberta (14.7%) and the Quebec Atlantic region (5.3%) indicate low need/use rates of dietician services ([χ^2 = .017; 1 cell > 5]; Table 70).
- There is some indication (90% level of confidence) that APHAs diagnosed with AIDS are less satisfied that dieticians meet their needs (66.7%) than APHAs not diagnosed with AIDS (28.3%) ([χ^2 = .059; 2 cells > 5]; Table 71).

HOME NURSING

- Very few (7%) APHAs in the study require the services of a home nurse. Of the 13 APHAs who responded, about half (46.2%) indicate their needs are not fully met, primarily due to logistical access barriers such as long waiting lists.
- The use/need of home nursing is statistically significant at the 90% level of confidence with respect to self-reported health status: APHAs diagnosed with AIDS use/need home nursing care at a rate of 17.4%, compared to a rate of 6.2% among APHAs who are HIV positive (no AIDS diagnosis) ([χ^2 = .059; 1 cell > 5]; Table 72).

PROFESSIONAL HOME CARE

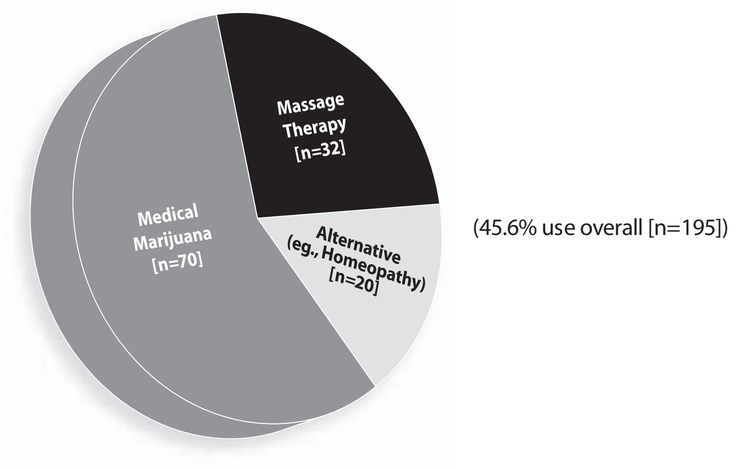
- A small percentage (8%) of the APHA study group use or need home care (Figure 10). Five of the 14 APHAs who responded indicate their needs are not always met, mainly due to logistical access barriers such as long waiting lists due to a shortage of home care professionals.

- Among the 15 APHAs who do use/need professional home care services, those diagnosed with AIDS indicate a higher need/use rate (21.7%) than APHAs who are HIV positive - no AIDS diagnosis (6.2%) ([$\chi^2 = .011$; 1 cell > 5]; Table 73). These results are supported by self-reported CD4 T-cell counts ([$\chi^2 = .002$; 1 cell > 5]; Table 74).

ALTERNATIVE/COMPLEMENTARY THERAPIES

Alternative and complementary therapies such as massage, homeopathy and marijuana for medical use are accessed by less than half of the APHA study group (Table 75; see Figure 12). Alternative and complementary health services were defined to include massage therapy, homeopathic therapy, and marijuana for medical purposes. Of these services, the most commonly used is marijuana for medical purposes (35.9%).

FIGURE 12. APHA Use/Need of Alternative & Complementary Therapies

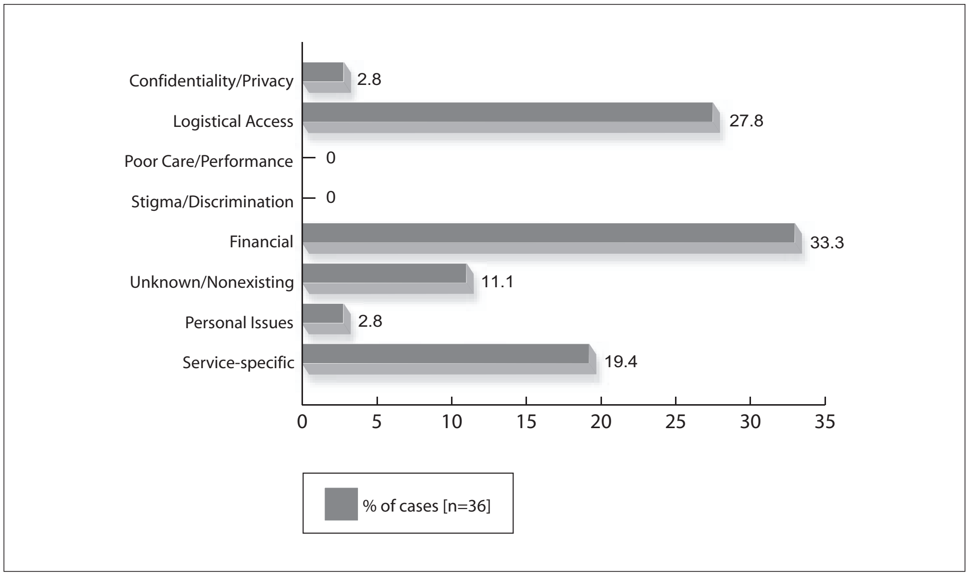


Access to these alternative and complementary therapies differs significantly by geographic region and to a lesser extent on health status as indicated by self-reported viral loads. Over half of APHAs in the North, Manitoba, Ontario and British Columbia access one or more of these types of services, compared to a minority of APHAs in other regions ([$\chi^2 = .001$; 2 cells > 5]; Table 78). There is also indication that APHAs with serious viral loads (69.6%) tend to access alternative/complementary therapies more commonly than APHAs whose viral loads are not serious (45.4%) ([$\chi^2 = .037$]; Table 79).

Taken as a whole, APHAs' needs are generally being met by these alternative and complementary therapies (71.3% of responses; Table 76). However, the following barriers are indicated (Table 77; see Figure 13):

- Financial barriers (33.3% of cases [n=36]): this appears to be more of a problem in accessing massage (50% cases [n=6]) and homeopathic therapies (50% cases [n=8]), than it is for marijuana for medical purposes (17% cases [n=30]).
- Logistical access barriers (27.8% of cases): for example, massage therapists not available when needed or offices closed, and irregular availability of marijuana for medical purposes.

FIGURE 13. Barriers to Alternative & Complementary Therapies



Results specific to each service are provided below (refer to Figure 12 and Tables 75 - 77 for frequency results):

MASSAGE THERAPY

- APHAs indicate a low need/use rate of massage therapy (16.4%). Seven (22.6%) APHAs report that their needs are sometimes or not met, primarily because of logistical access barriers (66.7% of cases [n=6]) such as limited appointment times or therapists not available. Also, fee-based massage therapy poses a financial barrier for several APHAs (50% of cases).

- The use of massage therapy differs significantly by region: APHAs in the North indicate the highest rate of use (44.4%); in Ontario, Manitoba, and British Columbia the use/need rate is approximately 20%; elsewhere the use/need rates are 10% or less ([$\chi^2 = .048$; 4 cells > 5]; Table 80).

- Results are also significant with regard to health status as measured by viral load: 39.1% of APHAs with serious viral loads (over 10,000) use massage therapy, compared with 14.4% of APHAs whose viral loads are not serious ([$\chi^2 = .007$; 1 cell > 5]; Table 81).

Homeopathic Therapy

- Alternative/complementary therapies such as homeopathy are also seldom used by APHAs (10.3%). Of 17 APHAs who responded, 29.3% indicate their needs are not met mainly because these services are cost prohibitive (50% of cases [n=8]).

- The need/use rates of homeopathic therapies differs by region, significant to the 90% level of confidence: APHAs in the North and Ontario indicate higher rates (33.3% and 20.6% respectively); elsewhere the use/need rates are 10% or less ([$\chi^2 = .054$; 7 cells > 5]; Table 82).

Marijuana for Medical Purposes

- Marijuana is the most commonly used alternative or complementary therapy (35.9%). Almost a third (31.7% [n=60]) of APHAs who use marijuana indicate their needs are sometimes or never met.

- The use of marijuana differs significantly by region: 45 - 50% of APHAs in Manitoba, Ontario and British Columbia use/need marijuana for medical purposes; in the Quebec Atlantic region, the need/use rate is 36.8%; elsewhere the use/need rates are between 12% and 22% ([$\chi^2 = .007$; 1 cell > 5]; Table 83).

- Marijuana for medical use also differs significantly by gender: Male APHAs indicate a need/use rate of 41.6%; female APHAs indicate a rate of 27% ([$\chi^2 = .042$]; Table 84). Interestingly, it appears that female APHAs are more satisfied that marijuana meets their needs (88.2%); among male APHAs who use marijuana, 39% indicate it only sometimes or did not met their needs ([$\chi^2 = .041$]; Table 85).[5]

- Results are also significant with regard to health status: 60.9% of APHAs with serious viral loads (over 10,000) use marijuana compared with 35.1% of

APHAs whose viral loads are not serious ([$\chi^2 = .023$]; Table 86). However, data on self reported CD4 T-cell counts indicates that APHAs with serious health problems (count under 200) are less satisfied with the extent to which marijuana meets their needs (47.8%), than APHAs whose counts are not serious (20%) ((([$\chi^2 = .041$]; Table 87).

- Illegal access is the most frequently identified barrier specific to marijuana for medical use. APHAs also identified logistical barriers related to illegal access, such as unpredictable availability or not knowing where how to obtain marijuana. Together these types of barriers specific to marijuana for medical use account for 33.3% of cases.
- Marijuana for medical use received a relatively high rate of unsolicited positive comments (60% of cases). APHAs report benefits for appetite, sleep, pain relief, spiritual and mental effects.

Social and Family Services

Social and family services are accessed by 62.1% of the APHA study population (Table 88; see Figure 14). Social and family service were defined to include social work, child care, family planning or access to workshops, etc., that provide parenting skills. However, these results are due almost entirely to the services of social workers (58.5%). Child care, family planning and parenting skills programs are needed/used much less commonly (7.2 - 9.2%).

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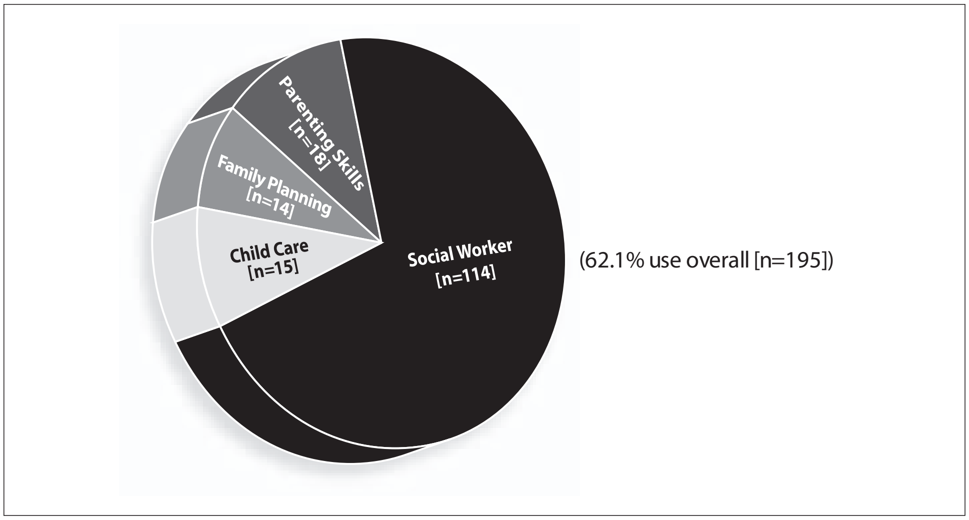
[5] Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], three participants indicate they need/use marijuana for medical purposes, and one participant indicated needs were not met ; however, when factored into Chi-Square analysis, results are not significant.

FIGURE 14. APHA Use/Need of Social & Family Services

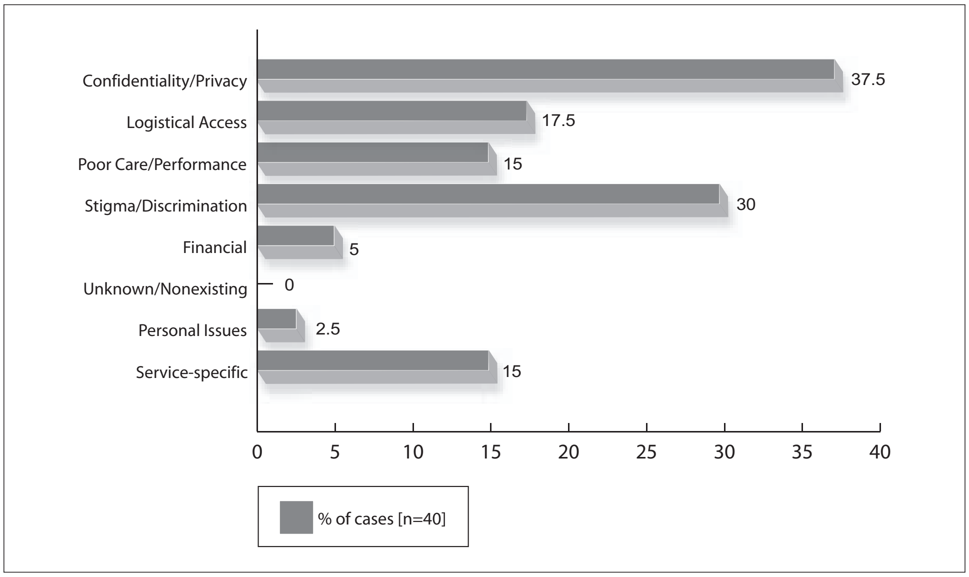


The rate at which social and family services are needed/used varies significantly by region, and to some extent by health status. APHAs in Manitoba (83.3%), the North (77.8%) and British Columbia (76.1%) rely most heavily on these services ([$\chi^2 = .001$; 1 cell > 5]; Table 91). In Alberta and Saskatchewan, 53 - 60% of APHAs need/use social and family services. APHAs in the Quebec-Atlantic region and in Ontario indicate lower need/use rates (36.8% and 44.1% respectively). In terms of health status, results significant at the 90% level of confidence indicate that APHAs with serious CD4 T-cell counts (77.4%) tend to rely more on social services than do APHAs whose counts are not serious (61.3%; [$\chi^2 = .052$; Table 92). Specific family services also differ significantly by gender (see below).

Among all categories of services addressed in this study, social and family services received the highest dissatisfaction rate; approximately 40% of responses indicate that APHAs needs are sometimes or not met (Table 89). The main reasons why needs are not met are (Table 90; see Figure 15):

- Confidentiality and privacy issues (37.5% of cases [n=40]): APHAs do not feel that their privacy is respected with regard to their HIV status.
- Stigma and discrimination (30% of cases): APHAs feel that social workers in particular are judgmental and unsympathetic, both because of their HIV status and their aboriginal identity.

FIGURE 15. Barriers to Social & Family Services



Results specific to specific social and family service are provided below (refer to Figure 14 and Tables 88 - 90 for frequency results). It should be noted that when analysed separately, the small number of valid respondents precludes significant results for the extent to which specific services meet APHAs needs by region, gender, age, or health status.

Social Worker

- 58.8% of the APHA study group indicate they need/use social workers. Over 40% of these APHAs indicate their needs are not fully met.
- The results relevant to the two main barriers listed above are due mainly to APHAs' responses about their experiences with social workers. APHAs do not feel that confidentiality is assured nor that privacy is respected (33% of cases [n=33]). Furthermore, APHAs feel stigmatized by social workers who are "judgmental" or "rude." Several APHAs indicate they do "not feel welcome" and describe their meetings with social workers as "stressful" (33% of cases).
- As indicated above, need/use rates vary by region, although results for social workers specifically are significant at the 90% level of confidence ([$\chi^2 = .057$; 1 cell > 5]; Table 93). The majority of APHAs in British Columbia (71.7%), Manitoba (70%), the North (66.7%), Saskatchewan (60.9%) access social work services. Just over half of APHAs in Alberta (52.9%) and less than half in Ontario (44.1%) and the Quebec/Atlantic region (36.8%) need/use social workers.

- In terms of health status, results significant at the 90% level of confidence indicate that APHAs with serious CD4 T-cell counts (71.7%) tend to rely more on social workers than do APHAs whose counts are not serious (56.3%; [$\chi^2 = .072$]; Table 94).

Child Care

- Fifteen (7.7%) of the APHA study group indicate they need/use child care services. Among four of these APHAs, needs were not met. Financial (cost of day care) and confidentiality issues are cited as barriers to child care services.
- The need/use of child care services differs significantly by gender: 17.6% of female APHAs and 14.3% of trans-gender/trans-sexual/inter-sexed APHAs require child care services, compared to less than 1% of male APHAs ([$\chi^2 = .000$; 1 cell > 5]; Table 95).
- Not surprisingly, age is also a factor: 18.5% of APHAs under 30 need/use child care services, compared to 6% of APHAs over 30 years of age ([$\chi^2 = .024$; 1 cell > 5]; Table 96).

Family Planning

- Fourteen APHAs (7.2%) access family planning services. Of these, four indicate their needs are not met. Issues of confidentiality/ privacy and stigma/ discrimination are reasons why needs were not met.
- The need/use of family planning services also differs significantly by gender: 16.2% of female APHAs and 14.3% of trans-gender/trans-sexual/inter-sexed APHAs access these services, compared to less than 1% of male APHAs ([$\chi^2 = .000$; 1 cell > 5]; Table 97).

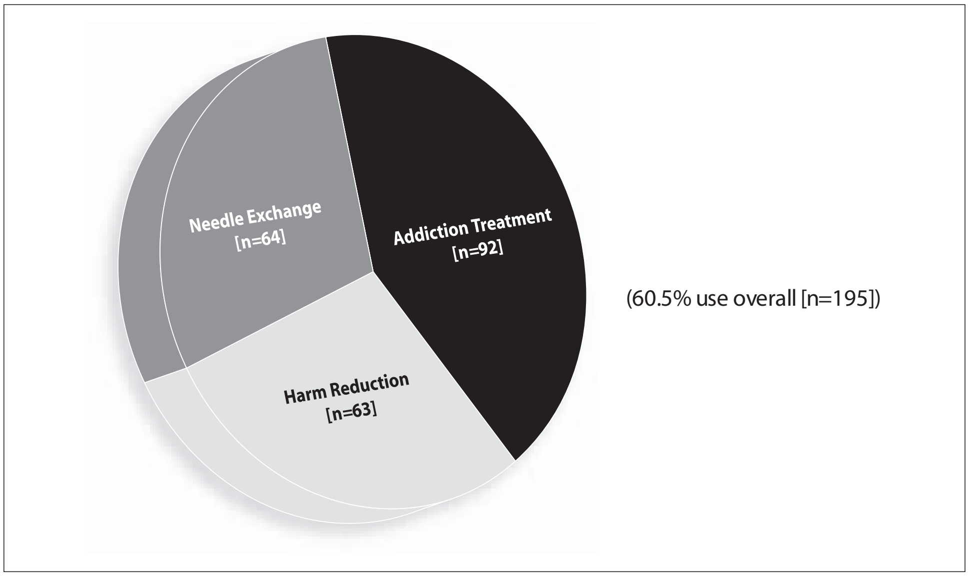
Parenting Skills Programs

- A low percentage (9.2%) of the APHA study group access parenting skills programs. Four indicate their needs are not fully met; only one individual provided a reason, indicating that confidentiality/privacy issues were a problem.
- Again, gender is a factor in the need/use of parenting skills programs: 18.9% of female APHAs and 14.3% of trans-gender/trans-sexual/inter-sexed APHAs access these services, compared with 2.7% of male APHAs ([$\chi^2 = .000$; 1 cell > 5]; Table 98).

Substance Use Programs

A majority (60.5%) of APHAs use/need one or more substance use services (Table 99; see Figure 16). Substance use programs were defined to include addiction treatment, harm reduction, and needle exchange services. Addiction treatment programs are accessed by almost half (47.2%) of the APHA study group; about a third of the study group need or use harm reduction and needle exchange programs.

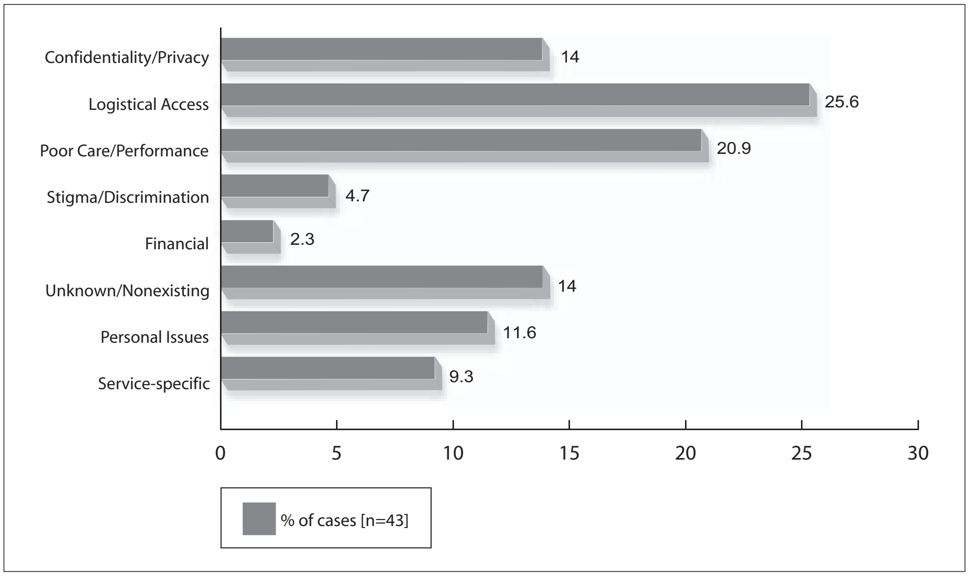
FIGURE 16. APHA Use/Need of Substance Use Programs



Need/use rates of substance use programs differ significantly by geographic region and transmission category. APHAs living in the North indicate a very high need/use rate of 88.9%; APHAs in Ontario indicate the lowest use/need rate of 41.2%. In all other regions, a majority of APHAs (52 - 72%) use or need substance use programs ([$\chi^2 = .044$; 1 cell > 5]; Table 102). Not surprisingly, the highest need/use rate by transmission category is among APHAs who contracted HIV through intravenous drug use, and sharing other drug-related works and tattoo needles (82.7%; ([$\chi^2 = .000$; 2 cells > 5]; Table 103).

Over 25% of responses indicate that for APHAs who need or use substance use services, needs are not being fully met (Table 100). Figure 17 shows that overall, the most common barriers to substance use services appear to be logistical (25.6% of cases [n=43]) and inadequate care and/or job performance (20.9% of cases). As well, a barrier of specific relevance to this category of service is an objection by several APHAs to the "abstinence approach" (10% cases [n=40] – as noted in connection with both addiction treatment and harm reduction programs).

FIGURE 17. Barriers to Substance Use Programs



The results specific to each substance use program are presented below (refer to Figure 16 and Tables 99 - 101 for frequency results).

Addiction Treatment Programs

- Almost half (47.2%) of APHAs in the study have used or needed an addition treatment program. For about 40% of these APHAs, their needs have not been met. Taken together, logistical access barriers such as long wait times, closed facilities and lack of transportation constitute the most commonly cited type of barrier (19.4% of cases [n=31]). However, the single most commonly cited barrier is lack of confidentiality/privacy (16.1% of cases).

- APHAs in the IDU transmission category indicate the highest need/use of addiction treatment (65.4%; ([$\chi^2 = .021$; 2 cells > 5]; Table 104).

HARM REDUCTION PROGRAMS

- A third (32.3%) of the APHA study group need/use harm reduction information and programs 16). Of these, 14 (24.1%) do not feel their needs are being fully met. APHAs most frequently indicate that harm reduction programs are inadequate (38.5% of cases [n=13]) or such programs are unknown or nonexisting (23.1% of cases).

- Results on the need/use of harm reduction programs are significant at the 95% level of confidence by region, transmission category, and health status.

- Regionally, approximately half of APHAs in the North (55.6%), Saskatchewan (47.8%) and Manitoba (46.7%) access harm reduction programs; elsewhere the rates range from 17.6% to 30.4% ([$\chi^2 = .049$; 1 cells > 5]; Table 105).

- APHAs in the dual transmission category (sexual contact, IDU and/or blood product) indicate the highest need/use of harm reduction information and programming (60%; ([$\chi^2 = .002$; 2 cells > 5]; Table 106).

- By health status (measured by CD4 T-cell count and viral load index), 40% of APHAs with serious to very serious health problems need/use harm reduction, compared with 19% of APHAs whose health status is not serious ([$\chi^2 = .014$; Table 107; see also Table 108: CD4 T-cell count [$\chi^2 = .006$]). Of (cautious) note is that APHAs with good health appear completely satisfied that harm reduction programs meet their needs, while about a third of APHAs with serious to very serious health problems are not satisfied ([$\chi^2 = .035$; 2 cells > 5]; Table 109).

NEEDLE EXCHANGE PROGRAMS

- A third (32.8%) of the APHA study group also need or use needle exchange programs. Most APHAs are satisfied their needs are met (87.3% [n=63]). Of those whose needs are not met, the most common reasons are logistical barriers, including inadequate hours of service (“often closed”) or lack of transportation to get to the exchange (33.3% of cases [n=9]).

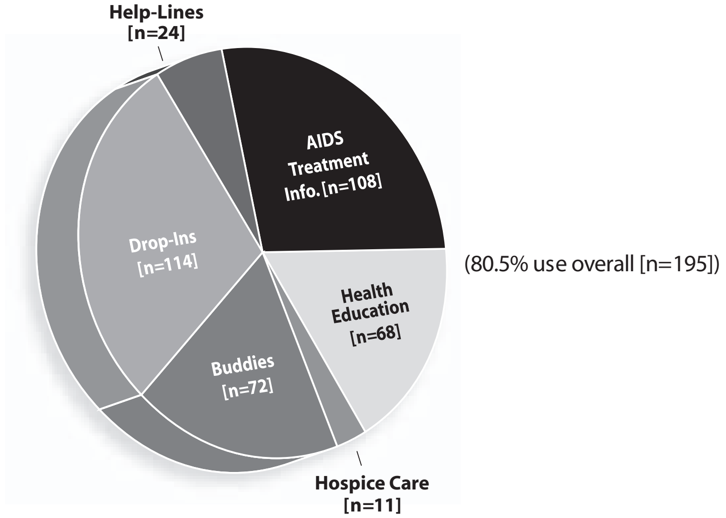
- By region, a high percentage of APHAs in the North (77.8%) indicate they need/use needle exchanges. Need/use is lower in British Columbia, Alberta and Saskatchewan where rates range from 37 - 47.8%; in the Quebec/Atlantic region, Ontario and Manitoba need/use rates range from 15.8% - 20% ([$\chi^2 = .002$; 1 cell > 5]; Table 110).

- APHAs in the IDU and dual transmission categories (53.8 - 60%) indicate higher need/use of needle exchanges than APHAs in sexual contact or blood contamination category (14.1% and 28.6% respectively; [$\chi^2 = .000$; 2 cells > 5]; Table 111).

COMMUNITY-BASED AND AIDS SERVICE ORGANIZATION (ASO) SERVICES

APHAs in the study group indicate a high need or use of community and AIDS Service Organization (ASO) services (80.5%) (Table 112; see Figure 18). This service category was defined to include AIDS treatment information, health education, hospice care, buddies, drop-in and help-lines. Drop-Ins (58.5%) and AIDS treatment information (55.4%) are most commonly accessed, followed by buddy programs (36.9%) and health education programs (34.9%). Few APHAs make use of crisis help-lines (12.3%) or hospice care (5.6%).

FIGURE 18. APHA Use/Need of Community-based & ASO Services



APHAs' need or use of community and AIDS organization services varies significantly by region (95% confidence level), and to some extent by health status as well (90% confidence level). By region, almost all APHAs in the North, Manitoba and British Columbia need/use one or more community/ASO service

(91.3 - 100%). In other regions, 60 - 85% of APHAs access these services ([$\chi^2 = .002$; 3 cells > 5]; Table 115). By self-reported health status, 95.7% of APHAs with AIDS diagnosis access one or more community/ASO services, compared with 78.9% of APHAs who are HIV positive/no AIDS diagnosis ([$\chi^2 = .055$; 1 cell > 5]; Table 116).

With respect to meeting the needs of APHAs, community and AIDS service organizations received a positive response rate of 75% (Table 113). This is reflected in the fairly high rate of unsolicited positive comments about community and ASO services (66% of cases [n=50]; Table 114). For example:

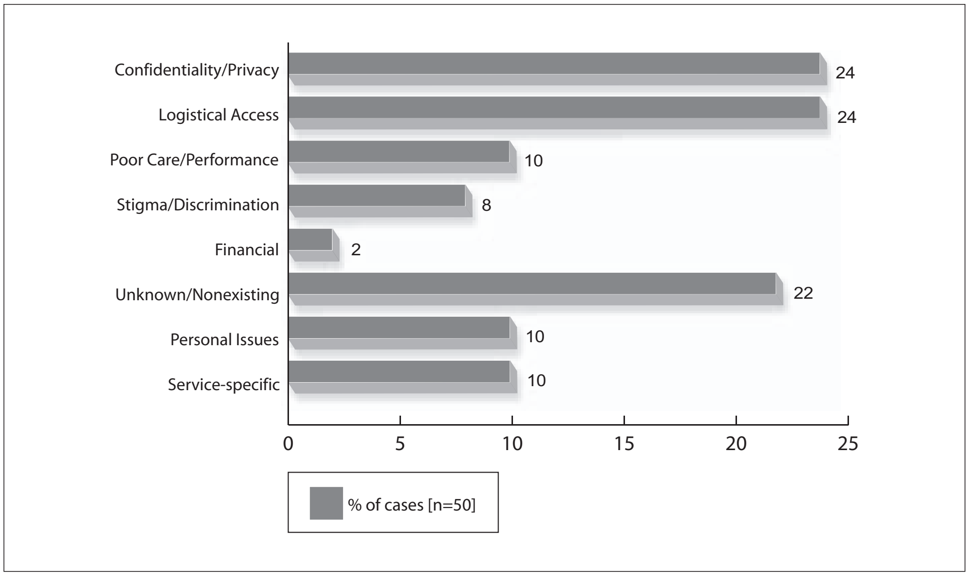
- [The drop-in is] good for sharing my story & hearing others.
- I go to drop-in and get information for people with HIV/AIDS.
- [The Buddy program provides] emotional support.
- Sa me fait du bren de ne pas etu seul. [It helps not to be alone.]
- Can be helpful to have a person to unload on.
- Support from peers.

Of the 25% APHAs who indicate their needs are only sometimes or not at all met, the main reasons are (Table 114; see Figure 19):

- Confidentiality and privacy issues (24% of cases [n=50]): this barrier is associated mainly with group programs such as Buddies and Drop-Ins.
- Logistical barriers (24% of cases): for example, APHAs indicate that AIDS treatment information is either not available (eg., the person with expertise is not available) or requests for additional information are not answered.
- APHAs do not know if some community and ASO services exist in their community, or where to find certain services (22% of cases): this is especially a barrier to health education programs and hospice care.

Results specific to community and ASO services indicate the following (refer to Figure 18 and Tables 112 - 114 for frequency results):

FIGURE 19. Barriers to Community-based & ASO Services



AIDS Treatment Information

- Over half (55.4%) APHAs in the study group indicate they need/use AIDS treatment information. Of these, 24% indicate their needs are not always met, mainly because of service-specific barriers such as information requests left unanswered, or information is offered at inappropriate levels of comprehension (eg., too complicated) or is outdated (19.2% of cases). A second barrier is logistical, relating primarily to HIV/AIDS information providers not available when needed (11.5% of cases).

- The highest rate of need/use for AIDS treatment information is among APHAs in Manitoba and British Columbia (73.3% and 71.7%, respectively). Elsewhere, need/use rates average in the 50% range ([$\chi^2 = .002$; 2 cells > 5]; Table 117).

- By self-reported health status (90% confidence level), 73.9% of APHAs with AIDS need/use AIDS treatment information compared with 54% of APHAs who are HIV positive/no AIDS diagnosis ([$\chi^2 = .072$]; Table 118).

Health Education

- 35% of APHAs in the study group need/use health education. For the most part, APHAs' needs are met by these programs (85%). Among those whose needs are not met, the reason is mainly that APHAs do not know if or where such programs are available (50% of cases [n=8])

- The need/use of health education programs varies significantly by region. APHAs in Manitoba indicate the highest rate (56.7%). Elsewhere, need/use rates range in from 20 - 40% ([$\chi^2 = .032$; 1 cell > 5]; Table 119).
- By self-reported health status (90% confidence level), 52.2% of APHAs with AIDS need/use health education programs; fewer (32.3%) APHAs who are HIV positive/no AIDS diagnosis indicate they need/use this service ([$\chi^2 = .061$]; Table 120).

HOSPICE CARE

- Only 11 APHAs (5.6%) in the study group need or use hospice care. For 3 of these APHAS, needs were not fully met. Reasons given are stigma issues, financial barriers, and that hospice care does not exist or cannot be found in the APHAs place of residence.

BUDDIES

- 36.9% of APHAs in the study group access buddy programs. Of these APHAs, 22 (32.8%) indicate their needs are not fully met. The main barrier is the perceived lack of confidentiality and privacy associated with this type of program (27.3% of cases [n=22]). However, it is noteworthy that over half of these 22 APHAs gave unsolicited positive evaluations of the benefits of Buddies (see above).
- Access to buddy programs varies significantly by region. APHAs in the North, British Columbia, the Quebec/Atlantic region, Manitoba and Saskatchewan indicate need/use rates from 40 - 55%. Rates are lower in Alberta and Ontario (12 - 24%; [$\chi^2 = .004$; 1 cell > 5]; Table 121).
- Also significant is the degree to which APHAs' needs are met by buddy programs: a majority of APHAs who responded from Alberta (80% [n=5]) and Saskatchewan (62.5% [n=8]) indicate their needs are sometimes or not met ([$\chi^2 = .046$; 9 cells > 5]; Table 122). Elsewhere, needs are generally being met. While the results are inconclusive, they may indicate the need for an evaluation of buddy programs in these two provinces in terms of meeting the needs of Aboriginal PHAs.

DROP-INS

- Almost 60% of the study group access Drop-In programs. A third of these APHAs (27.9%) indicate their needs are not fully met. The two main barriers are logistical access such as transportation and limited Drop-In hours (21.7% of cases [n=23]), and personal issues such as feeling "uncomfortable" in this type of setting, or a personal dislike of other Drop-In participants (eg., those under the influence of alcohol or drugs) (17.4% of cases).
- The need/use of drop-ins varies significantly by region, at a 90% level of confidence. APHAs in the North indicate a very high rate (88.9%). In Manitoba, APHAs access drop-in programs 76.7%. Elsewhere, need/use rates range in from 42 - 61% ([$\chi^2 = .064$; 1 cell > 5]; Table 123).
- Significant at the 90% level of confidence is the degree to which APHAs' needs are met by Drop-In programs in the North: 62.5% [n=8] of APHAs in the North region indicate their needs are sometimes or not met ([$\chi^2 = .055$; 5 cells > 5]; Table 124). Elsewhere, needs are generally being met. Again, the results are inconclusive but may indicate the need for an evaluation of Drop-In programs in the North in terms of meeting the needs of Aboriginal PHAs.

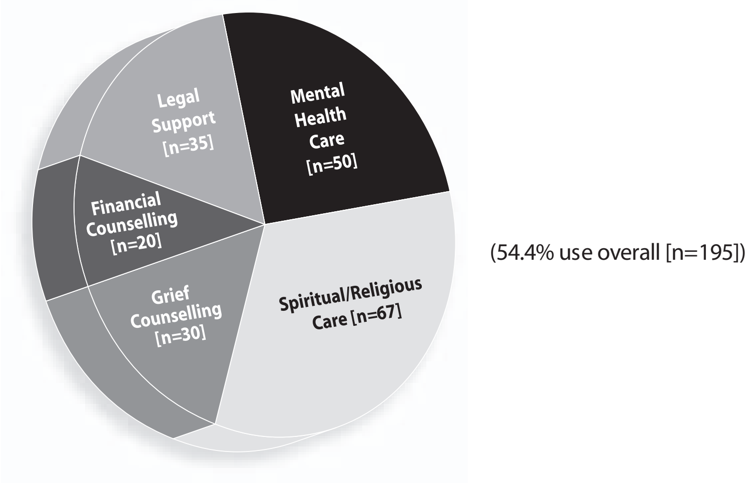
HELP-LINE

- 12.3% of the APHA study group indicate they need or use Crisis/Help-lines. For the most part, APHAs needs are met (81% [n=21]). Reasons why needs are not fully met relate to distrust of confidentiality, or individuals do not know of any help-lines for PHAs in their area.

MENTAL HEALTH AND COUNSELLING SERVICES

Just over half (54.4%) of the APHA study group needed/used one or more mental health or counselling service (Table 125; see Figure 20). Mental health and counselling services were defined to include all forms of mental health care (i.e., psychologists, etc.), religious/spiritual support, grief, financial or legal counselling and sport. Spiritual care (34.4%) and mental health care (25.6%) are the most commonly used/needed counselling services. Grief, financial and legal counselling are sought by fewer than 20% of APHAs.

FIGURE 20. APHA Use/Need of Mental Health & Counselling Services

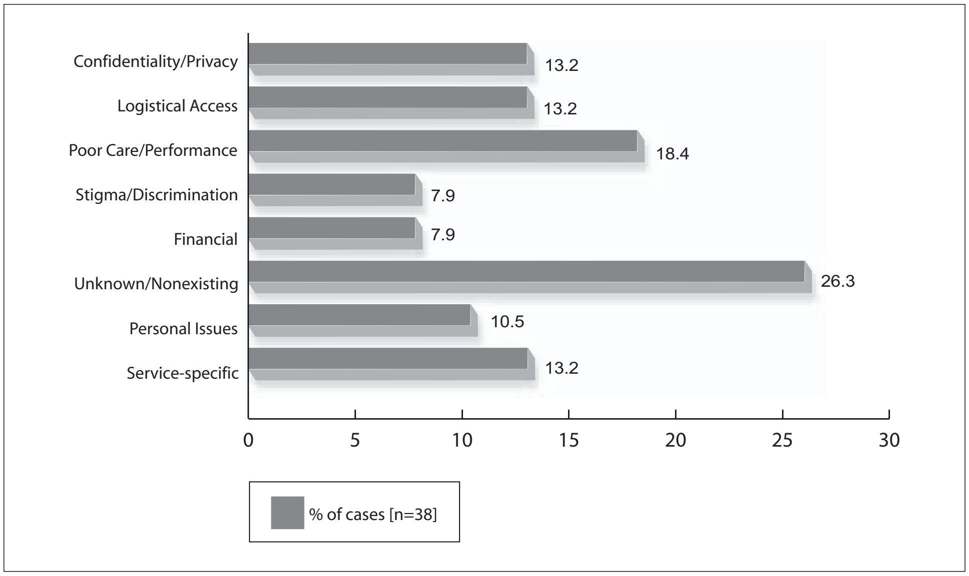


As a category of services, mental health care and counselling services use/need rates do not vary significantly by aboriginal identity, region, age, gender, health status or transmission category. Several service-specific results are provided below.

Compared to other services, there is a relatively high dissatisfaction rate (37.2%) among APHAs': 37.2% of responses indicate that needs not being met by mental health and counselling services (Table 126). The most common barriers to mental health and counselling services are (Table 127; see Figure 21):

- Services are unknown or nonexisting (26.3% of cases [n=38]): this is particularly true for financial and grief counselling.
- Services provide inadequate care or do a poor job (18.4% of cases): for example, several APHAs indicate that mental health services provide poor care and do "not help to resolve problems.

FIGURE 21. Barriers to Mental Health & Counselling Services



Results specific to community and ASO services indicate the following (refer to Figure 20 and Tables 125 - 127 for frequency results):

MENTAL HEALTH CARE

- A quarter (25.6%) of the APHA study group need or use mental health care.
- There is a high rate of dissatisfaction with mental health services; 47.8% of APHAs who responded indicate their needs are not fully met. These results are significant with regard to age: all (100%) of APHAs under 30 who responded indicate their needs are sometimes or not met; almost half (47.8%) of APHAs over 40 are not satisfied their needs are met; a third (33.3%) of APHAs in their 30s are dissatisfied ([$\chi^2 = .016$; 2 cells > 5]; Table 128). Results are also significant when cross-tabulated with CD4 T-cell counts: most APHAs (90.9%) with serious counts (under 200) indicate mental health care did meet their needs, compared with less than half (42.9%) of APHAs whose counts are not serious ([$\chi^2 = .009$; 1 cells > 5]; Table 129).
- APHAs indicate that the main barrier to mental health services is that they do not provide good care, stating for example, that these services "do not help to resolve problems" (38.9% of respondents).

Spiritual/Religious Counselling

- Over a third (34.4%) of APHAs in the study group seek spiritual counselling or religious ministry. Needs are met for the most part (72.1% [n=61]) Among those whose needs are not fully met (27.9%), the reason most commonly identified is apprehension regarding confidentiality and privacy (20% of cases [n=15]).

Grief Counselling

- Thirty (15.4%) APHAs in the study need/use grief counselling services. Of these, twelve (41.4%) were not satisfied their needs were met. The main reason is that APHAs do not know where to access this type of service, or it does not exist in their area (37.5% of cases [n=8]). Several APHAs also indicated that it was due to personal reasons that grief counselling did not meet their needs (25% of cases).

Financial Counselling

- Twenty (10.3%) APHAs in the study need/use financial counselling services. Of these, half were not satisfied their needs were met.

- Results are significant with regard to transmission category and self-reported health status, but caution is advised due to the small number of respondents [n=21]. 66.7% of APHAs in the sexual contact category indicated financial services sometimes or did not meet their needs, while all in the IDU category indicated their needs were met ([$\chi^2 = .022$; 4 cells > 5]; Table 130). With regard to health status, all of the APHAs with AIDS who responded indicate their needs are not met, compared to 38.9% of APHAs who are HIV positive (no AIDS diagnosis ([$\chi^2 = .050$; 2 cells > 5]; Table 131).

- The main reason is that APHAs do not know where to access this type of service, or it does not exist in their area (42.9% of cases [n=7]).

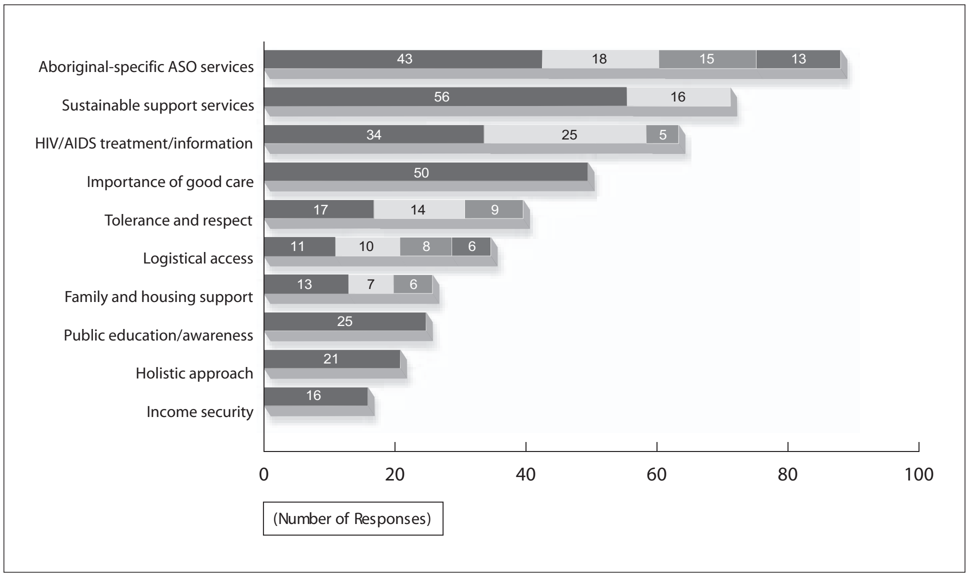
Legal Counselling/Support

- 17.9% of APHAs in the study group indicate they need/use legal support services. Of these, eight (26.7%) were not satisfied their needs were met. Two main reasons are given: 1) APHAs feel that legal support systems do not provide adequately defend their needs (42.9% of cases [n=7], and; 2) APHAs cannot financially afford legal assistance / representation (28.6% of cases).

THE VOICES OF PARTICIPANTS: BEST APPROACHES TO IMPROVE SERVICES

Almost 85% of APHA participants provided comments on ways to improve care, treatment and support services. These responses were subjected to content analysis and grouped into 23 themes. Figure 22 shows a summary of results of the content analysis of the two open-ended questions that concluded the survey.

FIGURE 22. "Best Ways to Improve Care, Treatment and Support Services for APHAs"



Definitions for each improvement are provided below, showing frequency of respondents (see Table 132):

Aboriginal-Specific Services (20.3% of responses)

Aboriginal workers/services (43 responses; 26.4% of respondents):

> Recommendations for more Aboriginal-specific services, especially front-line workers at ASOs, clinics, drop-ins; includes requests for first-language services.

Traditional support services (18 responses; 11.0% of respondents):

> Recommendations to encourage a traditional support system, including resident Elders at Health Centres & ASOs, healing and talking circles, country food.

On-Reserve/Rural support services (15 responses; 9.2% of respondents):

Recommendations for support services on Reserves, in rural/isolated communities, and in towns/suburbs distant from large urban centres.

APHA/Client-based front-line service (13 responses; 8.0% of respondents):

Recommendations that more PHAs be placed at the front-line of services (eg., volunteer and peer counselling programs) and that services generally become more HIV+ client-based.

Sustainable Support Services (16.4% of responses)

More/sustainable support services (56 responses; 34.4% of respondents):

Comments indicate the general need for more sustainable support services and programs, for example, drop-ins, counselling, group and peer sessions.

Funding for support services (16 responses; 9.8% of respondents):

Calls for increased, sustainable, and accountable funding for support services.

HIV/AIDS Treatment and Information (14.6% of responses)

More/better information (34 responses; 30.9% of respondents):

Requests and recommendations for more information about medications, treatment and HIV/AIDS generally, written and presented for audiences at various literacy-levels.

HIV/AIDS medical treatment services (25 responses; 15.3% of respondents):

Recommendations about medical treatment services, eg., the need for more doctors; faster/easier access to both existing and new treatments and medications (including medical marijuana; coverage for medications, and; informed options of treatment.

Find a cure for AIDS! (5 responses; 3.1% of respondents):

Comments aimed directly at the hope for a cure for AIDS.

Importance of good care (11.4% of responses)

Keep up the good work! (50 responses; 30.7% of respondents):

> Positive comments about ASOs, medical staff, and HIV/AIDS care generally.

Tolerance and Respect (9.1% of responses)

Address issues of stigma and prejudice (17 responses; 10.4% of respondents):

> Expressions of feelings, beliefs or experiences in which services or communities judge and/or discriminate against APHAs because they are gay, HIV positive or Aboriginal.

Recognize diversity (14 responses; 8.6% of respondents):

> Recognize and accommodate the diversity of APHAs requiring support services; eg., substance abusers; cultural identity; different backgrounds; Elders of the same tribe; stage of illness; gender and language.

Enhance privacy and confidentiality (9 responses; 5.5% of respondents):

> Comments that indicate an ongoing need for services that can ensure confidentiality; also the need for services that provide trustworthy, private and/or anonymous counselling.

Logistical Access (8.0% of responses)

Home outreach services (11 responses; 6.7% of respondents):

> Recommendations for outreach programs that allow APHAs to receive care at home and/or to be contacted at home on a regular basis (eg., health check).

Travel/transport assistance (10 responses; 6.1% of respondents):

> Recommendations and concerns about travel to visit home communities, and transportation to treatment services.

Hours of service (8 responses; 4.9% of respondents):

> Recommendations that hours of service be extended to include evenings and weekends; i.e. that services be open and available when needed.

On-line and phone-line assistance (6 responses; 3.7% of respondents):

Recommendations for on-line and phone-line assistance for crisis and other support, and to request home visits to individuals who cannot be reached.

Family and Housing Support (5.9% of responses)

Housing and hospice services (13 responses; 8.0% of respondents):

Recommendations for HIV+ housing and hospices and comments indicating the need for a healthy home environment.

Women-specific services (7 responses; 4.3% of respondents):

Recommendations for services aimed specifically at women living with HIV/AIDS.

Children-specific services (6 responses; 3.7% of respondents):

Recommendations for services aimed at children in families living with HIV/AIDS, eg., day-care services at ASOs, clinics, etc.

Public Education and Awareness (5.7% of responses)

Public education / awareness (25 responses; 15.3% of respondents):

Recommendations for continued education and awareness among both the Aboriginal and general public leading to a greater understanding of living with HIV/AIDS; also with respect to Aboriginal history and circumstances leading to increased risk behaviour and higher incidence of HIV/AIDS.

Holistic Approach (4.8% of responses)

Emotional, mental and spiritual support (21 responses; 12.9% of respondents):

Expressions of need for understanding, compassion and kindness from health care and support workers; includes comments that indicate the emotional side of living with HIV/AIDS, and the need for mental and spiritual support.

Income Security (3.7% of responses)

Income security (16 responses; 9.8% of respondents):

Concerns about personal financial matters, eg., expenses associated with living with HIV/AIDS.

CHAPTER 3

DISCUSSION: CARE, TREATMENT AND SUPPORT ISSUES

This chapter synthesizes the survey results with a review of the literature regarding issues faced by Canadian Aboriginal people living with HIV/AIDS. The discussion below demonstrates how the words of APHA participants[6] in the study group resonate with themes that emerge from a review of literature regarding HIV/AIDS care, treatment and support services.

Statistically, Aboriginal people are over-represented in groups that are more vulnerable to HIV infection (Health Canada 1997:2). One APHA participant in the study group addressed this fact:

> *[There is a need to] provide training for potential candidates of Aboriginal descent to be more visible and to speak out about this disease that is attacking our brothers and sisters. They are dying. It looks like [there is] a high increase, especially among Aboriginal persons.*

The literature on persons living with HIV/AIDS, and particularly Aboriginal people so affected, has identified several basic barriers to receiving care, treatment and support. These barriers are discussed below under six main themes:

- Cultural competency issues
- Medical treatment and information issues
- Issues related to the availability, accessibility and sustainable funding of services
- Prejudice, stigma and confidentiality issues
- Public education and awareness issues
- Women's issues

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[6] Quotes are edited for grammar and spelling.

CULTURAL COMPETENCY ISSUES

Canadian Aboriginal Cultural Diversity

Several authors have commented on the need to address HIV/AIDS issues within the culturally diverse context of the Canadian Aboriginal population (Windal 1997:6; Centre for Infectious Disease Prevention and Control 2003:35; Hall et al 1990:875; Weaver 1999:28). The term 'Aboriginal' refers to not only the broad categories of First Nations, Métis, Inuit and Innu peoples (CAAN 2002a), but to rural/urban contexts where Aboriginal peoples from many cultural backgrounds (CAAN 2004b:8). It is important then, to recognize not only the differences but also the connections that individuals have whether they live in cities or on reserves (Matiation 1999c:33).

Various cultural identifications within particular communities must be recognized, which may create bridges between those who live with HIV/AIDS and those within the same community who may be at risk (Windal 1997:11). Therefore, developing one strategy to cope with HIV/AIDS in a broad Canadian context may not be appropriate or adequate for all Aboriginal communities (Monette and Albert 2001:11; Weaver 1999:32). For example, promoting the services of Elders in wellness centres may not be sufficient if, as pointed out by a participant, the Elder is not "of the same tribe" as APHAs.

One problem is that reporting of HIV/AIDS status generally does not record ethnicity (Weaver 1999:31). Without this it is difficult to establish the extent of the problem among Aboriginal peoples generally, or by differences with respect to First Nation, Métis, or Inuit identity (Vernon 2001:4). Indeed, this lack of reporting by cultural identity was an obstacle in the design of a representative sample for survey distribution (see Chapter 1). Consequently, designing programs that will reflect Aboriginal diversity is a challenge, and one that must be addressed according to community-based principles.

Strong affiliations to cultural and ethnic identity among Aboriginal peoples can at times override the negative impact of poverty and discrimination, and the effects of symbols and relationships attached to ethnic identification can be powerful in promoting better health (Karlsen and Nazroo 2002:5). In fact, Karlsen and Nazroo (2002:16) suggest that even in places where there is great diversity in the number of ethnic identities, there will be shared identity and experience among those who belong to a 'stigmatized' group, regardless of ethnic affiliation. This means that APHAs, while having diverse cultural backgrounds, share similarities in terms of HIV/AIDS experience. This similarity prompted an APHA to recommend that:

> *[Services] should always be run by Native people for Native people. I prefer someone who also is affected with the disease.*

HISTORICAL ISSUES

The historical decimation of Aboriginal populations by smallpox, tuberculosis and influenza among other diseases carries a long memory (Rowell 1997:86), including among APHAs in this study:

> *Educate people about our history so they will have a clear perspective where we come from and what happened to us as a people. And this will show them why we are in the situation we find ourselves.*

Weaver (1999:28) commented that Aboriginal peoples have not only suffered "disproportionately from infectious diseases", but that many of these illnesses have been epidemic in nature. Added to that, centuries of intervention and manipulation by Christian ideology has established an atmosphere of negative moral evaluation of Aboriginal peoples in general, and doubly penalizes those living with HIV/AIDS; the resultant shame that is created places barriers around those who seek help and counselling (Defert in Mann and Tarantola 1996b:447). A "history of hopelessness" and shame may keep people from being tested in the first place, and in some places, the sense of hopelessness may be so strong that those living with HIV/AIDS no longer care about their health (Vernon 2001:4,18).

Often the effects of poverty, discrimination, and the weight of historical events such a the residential school system lead to negative and destructive coping mechanisms, such as substance abuse (Ship and Norton 2001:25; Barlow 2003:3-4,7-8; Craib et al 2003:22). Thirty-two APHAs who participated in this study attended Residential School; one individual spoke directly to its effects on his life:

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

One of the barriers that must be overcome is the mistrust by Aboriginal people toward government and health organizations. A lack of trust in these services means that many do not use them for diagnosis and treatment (Vernon 2001:4; Williams and Guilmette 2001:2). This mistrust is built on many historical elements ranging through colonialism, assimilation policies, and residential schools (Barlow 2003:4; Marsden et al 2000:137). This means that support systems are not always considered "friendly" (Rowell in Mann and Tarantola 1996a:438). Hence, APHAs commonly advocate for increased Aboriginal representation at the front-line of HIV/AIDS services:

> *It helps if the [care person] is HIV+ and Aboriginal. I don't really trust white people. More people that are HIV + [need to be] trained in support services.*
>
> *To have an Aboriginal counsellor available to me at this time is very helpful, but to have more Aboriginal-centred centres would make it easier for a lot of other people I know who are living positive. Some of these people do not like or trust going to places like this [urban ASO].*

LANGUAGE ISSUES

A culturally competent health care service would provide services and information in languages as required, do so at appropriate comprehension levels, frame information in the context of an individual's cultural and belief practices, and be willing to listen and learn from members of the culture (Chin 2000:26). However, it is important to recognize that diverse languages can pose significant challenges in urban areas where programs are developed to support First Nations, Inuit and Métis people alike (CAAN 2002e). A barrier to appropriate care may therefore be based in mismatches of linguistic and comprehension bases (Chin 2000:28).

The survey results indicate that almost 15% of APHAs' information needs are not met, in part because of language and comprehension issues (Table 113). For example, with regard to HIV/AIDS treatment counselling one APHA suggested: "Don't use big words. Use words at a grade 8 level." Another APHA commented that for her, the best way to improve services would be:

> *Service workers who can talk my first language. Many would like the choice to speak to a First Nation woman in an exclusive Aboriginal HIV/AIDS office.*

TRADITIONAL ABORIGINAL SERVICE ISSUES

There is evidence that the more individuals learn about and connect with their traditional culture, the stronger their coping ability for other negative encounters and events (Walters and Simoni 2002:522; Assembly of First Nations 2001:4). Indeed, over 60% of the APHA study group access one or more traditional Aboriginal services, and approximately 10% recommend that these services be made more widely available (see Tables 22; 132). For example, APHAs emphasize the benefits of Elders' advice that is both respected and trusted:

> *Resident Elders are needed in Health Centres or available at all times.*
>
> *I was told by my Elder to use both modern or western meds and to also use traditional meds, because they are there to help us.*

Offering some level of traditional health and wellness programming within conventional health care services, can help ensure that APHAs are more likely to accept future intervention and support (Vernon 2001:29; London et al 1998:484). At the very least, if patients are unsatisfied with the care they receive by mainstream medical providers, they will tend not to comply with treatment recommendations (Roberts 2003:44; Ickovics and Meade 2002:311). As Brown et al (2001:79) state, being satisfied with care primarily means that there is clear communication and the experience of respect on the part of health care providers. This becomes even more important when varying social and cultural contexts need to be addressed (Brown et al 2001:81).

The ideal situation would be to give traditional healers the same respect and access to patients as the mainstream medical professionals (Assembly of First Nations 2001:3). APHAs advocate for "more participation of volunteer spiritual healers," and "increased access to traditional healing practices such as sweats, talking circles, and healers." The survey results demonstrate a high demand for traditional Aboriginal support services, particularly among First Nation and Inuit APHAs. The greatest barrier is that in most places, such services are not available (see Tables 22-24).

Of particular importance is the positive sense of self some APHAs receive from traditional Aboriginal healing and support services (Marsden et al 2000:131). Mental health is an often overlooked aspect of treatment regimes for illness, but among traditional healing approaches, a healthy mind is the basis for balancing health in the body. Survey results indicate that over 25% of APHAs require mental health services, but that almost half of these are dissatisfied that current services are meeting their needs (Table 125; 126). This is particularly the case among younger APHAs under 30 years of age (Table 128), and APHAs who are experiencing serious health problems (Table 129). Pleas for emotional, mental and spiritual support in the struggle to lie with HIV/AIDS is a striking theme in the open-ended responses (13% of respondents; Table 132).

A mind that is not in balance with the body leads to feelings of poor self-worth, which can cause a downward spiral of poor nutrition, anger, and hopelessness (Healing Our Nation 2003:4). Traditional healing systems also tend to reflect a patient-centred perspective in which it is assumed that an individual already has a sense that something is out of balance, and therefore seeks a healer in order to regain balance. Wellness is essentially the state of having mind, body and spirit in balance (Napoli and Gonzalez-Santin 2001:316; Friday 2004:21). One APHA in the study commented on the need for an holistic wellness approach:

> *[I need] less stress – a good healthy home, financial help, being with others such as group therapy – have more Native Traditional sessions, ceremonies.*

Indeed, the numerous unsolicited positive comments about traditional Aboriginal healing circles and ceremonies, and counselling from Elders is testimony to the wellness that traditional services can provide for some APHAs (see Section 2.2.1; Table 24).

However, it is important to respect those communities and individuals who are not willing to accept traditional wellness strategies (Special Working Group on Aboriginal Issues 1999:47). Survey results indicate, for example, that traditional Aboriginal support services are less important to Métis APHAs, than to those of other Aboriginal identity (see Table 37). This point was made by one participant as follows:

> *You need to understand that we're not all culturally sensitive. I may be Native but I was raised in the city – urbanization and assimilation. Therefore, I don't really identify with cultural views. You can't paint us all with the same brush.*

MEDICAL TREATMENT AND INFORMATION ISSUES

HIV/AIDS Treatment Issues

Health and Welfare Canada stated in 1990 that Aboriginal communities were at risk for HIV/AIDS "due to poor health status, higher rates of STDs and reduced access to health care" (Cooper et al 2000:121; Métis National Council 2003:23). This means that Aboriginal persons tend to be diagnosed at a later stage of the disease (Cyr and Dunn 2000:2). The overall health condition of Aboriginal people is also a concern (McLeod 1997:24). Poor nutrition and other stresses leave people more susceptible to disease, which, for Aboriginal peoples is not only HIV/AIDS, but also tuberculosis and particularly diabetes (Vernon 2001:6).

In rural and isolated communities there are relatively few health care professionals to serve a large and scattered population. Because of this, the burden on medical personnel is heavy, and the turnover rate is high:

> *In Whitehorse there is not enough doctors, you have to go to walk-in clinics. NO FAMILY DOCTORS... Not enough in Whitehorse.*

This leads to not only inconsistent service, but the expectation that one person, for example a nurse, can be the community's doctor, social worker and psychologist as well (Cree 1999:13).

Mainstream medicine generally focusses on what is "wrong". As authority figures, doctors tend to tell people whether they are ill or not, and to instruct patients on how to manage their illness. The mainstream medical model had tended toward patient passivity rather than participation (Morse et al 1991:1362). About 8% of APHAs in the study addressed the issue of client-centred treatment and support, for example:

> *[Services can be improved] by bringing the people in as part of planning. Finding out what their needs are, not telling them what they need. Being responsible for the actions done by an ASO. Do not have people work there (ASO) for money but because they care about the people who are suffering from this curse. Listen to the people when they speak. Do not patronize the APHAs – they are a lot smarter than you think...*

> *A group for HIV people to come together for brainstorming...*
>
> *More client-based services based on engagement and empowerment through organizing APHA's.*

In addition, mainstream models take little time to understand who an individual is as a whole person within their communities and their overall social context (Schoepf 2001:339). APHAs wish to be included in decision making about treatments, and be ensured that the doctor spends a sufficient amount of time to accurately communicate treatment information:

> *[I need] more visits with the Nurses at a Drop-In. I need pills but I haven't got them yet. I'd like to see the HIV doctor twice a week. Make my appointments ahead of time. There's someone else I'm supposed to see and its hard to find her. I want to see the Nurse alone without other people at the Drop-In. PRIVATELY so other people don't know. I need a long quiet time with the Nurse.*
>
> *[It is difficult] finding a doctor or someone that has time for troubled people; [Doctors who] do not over-book their appointments.*

Because a medical professional is one of the few contacts an APHA will encounter who is an expert on HIV/AIDS, it is crucial that patients be able to connect with them (Roberts 2003:44,46,49). Health care workers also need to understand that a patient may want to have greater involvement in treatment decisions at certain stages of the illness, and that they may prefer physicians to make decisions at other times. For example:

> *I think for people living long term on anti-retrovirals, the side effects of living on a number of anti-retrovirals should be addressed more, such as lipodystrophy, etc.*

There will also be stages where patients actively engage in the role of 'knowledge gatherer', which, if health care providers are sensitive to this, can lead to much more equal partnerships in the delivery of care (Marelich et al 2002:18-19).

HIV/AIDS Information Issues

In terms of medical information, doctors need to ensure that the explanations for how to use medications and why they are important are clear (Sanderson in Atlantic First Nations AIDS Task Force 1996:51). In addition to the complexity of dosage regimes, patients may also not anticipate taking medications that make them feel worse for a time (Morse et al 1991:1362; Oggins 2003:57). In this case, a strong relationship between patients and health care providers can overcome mistrust, particularly if patients recognize that HIV/AIDS specialists have the most current treatment knowledge, and specialists are able to provide sensitive and clear information (Marelich et al 2002:23). An APHA from the Quebec/Atlantic region remarked:

> *[I need] to have a Dr. who is knowledgeable about the illness. My Dr. has no such knowledge because I asked him.*

Several other APHAs commented that their physicians do not provide sufficient information or they visit a doctor "mainly to get meds." Taken together, these characteristics of "inadequate care" were identified by almost 40% of APHAs who listed barriers to physician care (see Table 45).

It is important that the information on understanding HIV/AIDS, and the strategies for coping with and getting support for the disease is provided in plain language. Those who provide information have to be able to speak knowledgeably about HIV/AIDS, as well as translate concepts into an appropriate cultural context (Rowell in Mann and Tarantola 1996a:438). It is also vital that the language not dictate what to do, but rather invite participation (Windal 1997:21). In communities where there is some illiteracy and/or a strong oral tradition, approaches to support and care must incorporate more intensive interaction by appropriate personnel (Rowell in Mann and Tarantola 1996a:438).

An additional concern is status differentiation between Aboriginal persons and health care professionals at all levels. In certain circumstances, it may be very difficult for a patient to manage their own care and express wishes that will be considered, particularly when a hierarchical system is involved in decision-making (Israel et al 1998:183; Windal 1997:22). Aboriginal peoples themselves say that empowerment comes from within, which is an important perspective in managing health as it means taking control of decision-making and creating a balanced life (Cyr and Dunn 2000:20; Trussler and Marchand 1997:163). Therefore, language and strategies on the part of health care providers need to be constructed with the intention of partnership and an equal sharing of knowledge and experience. This means that if relationships of unequal status exist between patients and health professionals, feelings of empowerment become extremely important in how people develop strategies for coping with illness and survival (Osborn 1996:306;

de Guzman 2001:668). For some, empowerment means taking control of their medical care by researching medical information that is becoming more available through various media, including the internet (Marelich et al 2002:18). One APHA recommends that issues of inadequate treatment information be partly solved through "networks" of APHAs:

> *By having a wider support group of counsellors and infected persons to contact on a regular basis for such things as exchanging information, latest programs and treatment; to be able to access (through networking for example) treatments and programs more readily available.*

AVAILABLE, ACCESSIBLE AND SUSTAINABLE SUPPORT SERVICES

Availability Issues

APHAs indicate that some types of services simply do not exist where they reside. This is particularly an issue with respect to traditional Aboriginal health and wellness services (see Figure 7; Table 24). For example, APHAs are either unaware of or cannot find sufficient information about traditional Aboriginal medicines:

> *I haven't found a person to give guidance [about traditional medicines] or just to teach me culture.*
>
> *Ils ya trop de choix cela devient beaucoup difficiles a choisir. (There are too many choices [of traditional medicines]; it becomes difficult to choose.)*
>
> *I think a lot of today's meds do not meet the need [of] the Native immune system. So I'm saying we need to find meds that are more adaptable to are [our] immune system.*

APHAs also indicate that they do not know where to find support services such as health education programs and hospice programs (see Figure 19; Table 114). In open-ended responses, APHAs also identified a lack of outreach programs for homeless APHAs and for APHAs who cannot leave home:

> *Support services need to be easier to find as well as access. Support programs need to be able to go to the one who needs them - NOT always the other way.*

A number of variables affect whether a patient will adhere to a particular treatment regime including depression, substance abuse, and lack of social support which may put APHAs at risk of missing doses of medication (Ickovics and Meade 2002:310). Interruptions in the daily routine are at the root of non-adherence to treatment (Ickovics and Meade 2002:314). In addition, HIV/AIDS is now becoming more of a chronic illness requiring long-term treatment, which makes it difficult for some to maintain a routine (Cyr and Dunn 2000:8). Stable housing for the homeless or disadvantaged is crucial to ensuring adherence to treatment (Melchior et al 2001:47). A homeless APHA in Alberta indicates the need for outreach programs "on the street":

> *I like the people of [the ASO] and the needle exchange. They don't tell me what to do. They are helpful when needed. I would like to see more like that... More information is needed on the streets.*

Among the survey participants, 46 APHAs (24%) reside in hotels, boarding houses or shelters (Table 5). Of these, over half (13%) are homeless with no permanent address. Approximately 8% of respondents called for housing initiatives specific to APHAs, and another 7% point to the need for home-outreach programs (Table 132):

> *Aboriginal people need to have a housing unit for P.W.A's.*
>
> *There is a lack of affordable housing. Lack of support for HIV+ mothers / fathers to raise their own children.*
>
> *A place a person can hang out at and stay off the street.*
>
> *I have a vision of the future: HIV home care. This is where all the people that need time to get back their health. This is what we need to understand about HIV/AIDS. So I will be waiting for this good thing to come true because I'm one of those people that need this home care.*
>
> *Housing – its hard to get affordable housing for myself and my partner.*
>
> *I need more workers that will do home visits regularly, maybe twice a week or so... And a phone call now and then to see if I'm OK or in need of something...*

For APHAs with no permanent address, access to support services that provide regular nutrition through a Meals-on-Wheels program may be impossible

(Sanderson in Atlantic First Nations AIDS Task Force 1996:51). This problem may also be acute in correctional facilities, where traditional foods, and a meal routine that favours regular medication intake are not available (Tait in Atlantic First Nations AIDS Task Force 1996:55).

Residence in isolated areas may have protected Aboriginal peoples from urban problems like drug use, and from HIV/AIDS when it first appeared, but this is no longer the case (Friday 2004:30; CAAN 2002b). Inuit communities are particularly at risk regarding this misplaced belief in isolation. Furthermore, problems related to family violence, substance abuse, lack of health care professionals, and confidentiality are magnified in remote Arctic communities (CAAN 2002d; Vernon and Bubar 2001:52). One APHA voiced concern for those living in isolated areas:

> *More attention needs to be given to APHA's living in isolation – sometimes in a shack on the land – I believe that there is a silent majority of isolated and disenfranchised APHA's living in fear with no voice.*

The isolation of northern communities such as those in Nunavut, northern Quebec and Labrador also results in under-reported cases of AIDS, and makes the establishment of ASOs a difficulty, as evidenced in CAAN's attempt to locate agencies to participate in the national survey (cf. Vernon 2001:3).

Small and isolated communities generally lack health care professionals, transportation, and counselling services, and confidentiality is a greater concern (Heckman et al 1998:266, 372). Any treatment program for those who choose to remain on their Reserve or isolated community, may need to provide caregivers who are able to travel from urban centres (Indian and Northern Health Services Directorate 1995:56). There may be less access to people who can provide information about diverse coping mechanisms within a rural context (McDaniel 1997:171). In some cases, APHAs live part-time in their home community and part-time in an urban centre where HIV/AIDS services are available. Among the APHAs who participated in the survey, only 2% (4 APHAs) reported dual residence on their Reserve and in the city (Table 3).

Lack of resources and issues of confidentiality and HIV/AIDS stigma in small, remote communities compel APHAs to seek medical and support help in urban centres (Vernon 2001:24; Marsden et al 2000:128). In Quebec, for example, it appears that Aboriginal persons living with HIV/AIDS (APHAs) tend to leave their communities and settle in urban centres, where they can get the support they need from organizations outside their communities (First Nations of Quebec and Labrador 2003). However, APHAs in Quebec indicate that even when moving to the city, insufficient services are available to them:

> *I think many services are missing in Quebec compared to other Provinces in Canada. I have visited several other Provinces – BC and Ontario – and Montreal and Quebec [City] are very behind in media, TV, newspapers, publicity. It is a glaring lack of information for Quebec Aboriginals as well as non-Aboriginals. There should be greater access to HIV community centres in Montreal and elsewhere in Quebec, because I think the Quebec government lacks financial resources to fund HIV programs. In any case all aspects of HIV programs can be improved in regards to Aboriginal people. Please wake up; stop sleeping.*

This deficiency is consistent with CAAN's difficulty in finding find front-line ASOs in Quebec who were able to recruit Aboriginal clients for the survey.

Accessibility Issues

In many cases where support services do exist, logistical and financial barriers prevent or limit access by APHAs. Income security is of particular concern. Aboriginal peoples are at increased risk of contracting HIV due to behaviours connected to poverty (Barlow 2003:4; CAAN 2002c; Matiation 1999a:8):

> *Poverty is a big problem with Aboriginal people. Due to people not caring about becoming infected with HIV, the problem with the rising numbers of Aboriginals being infected will continue to rise. We need to focus on a younger generation. Schools need to deliver stronger messages about the seriousness of dying by AIDS.*

Low socioeconomic status leaves people in a condition of inequality and those at the impoverished end of the spectrum have difficulty accessing resources, including the time and/or money to be tested or to afford medication (Vernon 2001:6). This is echoed in comments made by APHAs:

> *Paying for meds should be disregarded (thrown out). We can't get these medicines in the reserve. The travel, like to [my northern*

> *community] and to come to [the city] and where to stay [is a problem]. The reserves need more money for medical.*
>
> *Medications are vital to HIV / AIDS patients there should be no cost to patient even $75.00 per month is hard for me to come up with on a limited monthly income. I often have to sign for meds (get them on credit).*
>
> *Have medical coverage for the meds that are not covered now; such as the ointments and pills that deal with the side effects from the prescribed meds.*

Income security is a need identified by almost 10% of APHAs (Table 132). Monette et al (2001:60) report in a study of Two-Spirited men that of those living on reserves, up to two-thirds are not employed. Those who end up moving to urban centres would not return to the reserve because of poor services and no employment opportunities. Many of the factors that relate to low socioeconomic status, like unemployment, inadequate housing and substance abuse, are strongly related to poor health status (Williams and Guilmette 2001:4). As indicated in the quote above, even for those who have insurance for some services, the requirement to pay first and apply for reimbursement later, may make these services financially inaccessible. Furthermore, the availability of loans for band members can be inconsistent (BC Aboriginal HIV/AIDS Task Force 1999:25; Ship and Norton 2001:30). The fear of stigmatization may also keep many APHAs from asking for financial help if they are required to reveal the reason for the loan.

Fee-based services such as dentists, chiropractors, and physiotherapists and opticians are primary examples: financial barriers constitute the most common factor in limited access by APHAs to these types of treatment (31% of respondents; Table 61). Even finding money to pay for transportation to certain services can be beyond the financial reach of some (6.1% of respondents; Table 132). For alternative/complementary therapy such as marijuana for medical purposes, financial issues are compounded by legal considerations:

> *The [ASOs] should fight harder for people with HIV/AIDS to get a prescription for marijuana. Reimbursement for medical marijuana – more funding for APHAs.*

APHAs tend to specifically target ASOs as the agency responsible for making these types of services more accessible:

> *[We need] a strong advocacy role for Aboriginal AIDS Service Organizations. Provincially and nationally [Aboriginal ASOs are] too passive, specifically for APHAs and families who struggle with Social Services.*
>
> *Support alternative therapies, as they have worked wonders for me, my health and over all well-being. My life is more full and complete, or wholesome now than it has ever been.*

Community and ASO services such as harm reduction and needle-exchange programs are accessed by a third of APHAs in the study group, but for some these programs fall short in terms of hours of service and provision of adequate care (see Figure 17; Table 101). Furthermore, almost half of the study group accesses addiction treatment services. APHAs also indicate that better integration is required with respect to treating addictions for APHAs who are also being treated for HIV/AIDS:

> *Addictions and HIV support initiatives [should] include methadone treatment. For those infected, [are] meds clashing with methadone? What harm it may cause to treatment and physical [effects]?*

For APHAs who reside in remote communities, transportation to resources and services can be a major problem both logistically and financially (Rowell 1997:90; BC Aboriginal HIV/AIDS Task Force 1999:24). The "Trends and Issues" report presented at A Gathering of Spirit estimated that 56% of Canadian Aboriginal people say they have to travel to access health services (Anonymous 2000). Approximately 6% of respondents made direct recommendations related to travel and transportation requirements, for example:

> *I have to drive an hour and a half from the city I live in to a larger centre for HIV care/treatment. If healing circles were easier to find that would be a good place to start.*
>
> *Transportation through centres for HIV+ clients [should be] be available, and services on weekends be continued as clients are not able to take the week[days] off.*

As the survey results show, transportation issues are frequently identified as barriers to accessing services in both urban and rural contexts. This barrier has been identified in other North American urban centres as well: a key barrier for one-third of a sample population in a Chicago study was no access to a service directory that indicated where services could be found in areas close to individuals' residences (Kenagy et al 2003:241). This was also the case in London, England (Petrou et al 1996:474). Newsletters have been touted as a non-threatening way to provide information about HIV/AIDS (Windal 1997:9), although the confidentiality issues centred on receiving material that explicitly states affiliation with organizations that deal with HIV/AIDS may be insurmountable for some recipients.

With increased geographic distances between resources, people rely more heavily on other community members for care and support (de Guzman 2001:671). This means that support and information is gained from social networks rather than relying on outside agencies (McDaniel 1997:170). Very isolated communities that rely on air access rather than roads face greater difficulties in scheduling medical appointments (Special Working Group on Aboriginal Issues 1999:42). Consequently, APHAs tend to move to larger centres in order to be nearer the medical services they require. Close to half (43%) of the study group indicated they had already moved or know they will need to move in order to access HIV/AIDS care, treatment and support services.

In correctional institutions, the prison bureaucracy may create barriers to accessing certain services such as Elders, traditional ceremonies and foods (Ontario Federation of Indian Friendship Centres 1995:26; Tait in Atlantic First Nations AIDS Task Force 1996:55-56). As well, certain medication regimes may not be easily accommodated in the prison meal routine (Roe 2003:10-13). Several APHAs who were incarcerated in at the time of the survey, indicate a lack of knowledge about HIV/AIDS and treatment regimes among staff in correctional facilities:

> *Corrections Canada needs to know more about HIV meds, how important it is not to miss your meds.*
>
> *Corrections [needs] sensitizing and understanding the [Aboriginal HIV/AIDS] issues at hand.*
>
> *The justice system does not work in favour of HIV positive people.*

An additional concern is the availability of services to inmates once they are released (CAAN 2002b; cf. Ehrmann 2002:79).

Finally, accessing basic care in urban centres can be a problem in terms of waiting times for appointments or procedures. Long waiting times can become very stressful if money and housing is limited and people are travelling to urban centres from reserves (Rowell 1997:92; Petrou et al 1996:474). APHAs identified long wait-times as a main barrier to several health and support services, including primary medical services such as emergency rooms, and secondary health services such as physiotherapy (Tables 45; 61). As a result, even those who are well off, and who live in urban centres where many resources are available, may not use them if they feel their lives are too busy to make the time (Vernon 2001:18).

Sustainable Funding Issues

> *[We need] more stability – APHA's know Aboriginal ASO's doors could close without core funding.*

Make sure that more funding is there for people with HIV/AIDS, where they need it. Many programs have been cut due to lack of funding when we need the help, [and then the] support its not there. There needs to be more support groups to people with HIV/AIDS than what is currently.

There exist layers of varied jurisdictional levels and boundaries that have created a "considerable structural barrier" in ensuring equal access to HIV/AIDS services (Cree 1999:15; Special Working Group on Aboriginal Issues 1999:41). The rigid requirements by many government organizations are also restricting opportunities to create suitable programs (CAAN 2004b:19). Some APHAs have lived in urban contexts all their lives and may be used to thinking of the conventional medical system as their primary health care provider. For many, however, whether they live in urban or rural contexts there are issues of alternative medical treatments, funding for those services, and questions of which group makes policy and administers these programs (Weaver 1999:28; Special Working Group on Aboriginal Issues 1999:43-44). An urban APHA remarked:

> *[There is a need to improve] funding for therapeutic needs such as chiropractor, massage therapist, as well as funding for traditional therapies and direction, guidance and support from Elders, family.*

Giving Aboriginal people more control over their health care on reserves is an important empowerment issue (Special Working Group on Aboriginal Issues

1999:46), but will be ineffective if the funding is not there to support initiatives. Recommendations regarding sustainable funding for support programs were made by about 10% of APHAs in the study (Table 132).

Jurisdictional problems also relate to whether treatment can be accessed both on and off reserves (FNQLHSSC 2003:6). While the transfer of services to Aboriginal peoples is important regarding the right to create culturally sensitive programs, the transfer of health services to band administration means that they must take greater responsibility for all Aboriginal peoples including non-status Aboriginals and those living off-reserve (Matiation 1999c:11). As a result, these latter two groups are often at a disadvantage in finding appropriate services.

At the level of governance, funding continues to be a problem. On reserves the demand for health services outstrips the dollars that can be applied (Gregory et al 1992:220). Several APHAs directly address the need for HIV/AIDS medical services on Reserve:

> *D'etre en mesure d'entree sur une reserve qui auraient un ou des hopitaux et vivre avec d'autres autochtones qui ont le V.I.H... Pour le moment je suis bien traite, meme en vivant hors reserve, si je vivais sur ma reserve a Marite (Gesgapegiag) je n'aurais aucun soutient et il faudrait que je me deplace a l'exterieur et par mes propres moyens. Ma carte Indienne est efficace meme a l'exterieur de ma reserve.*
>
> *[Have reserves with a hospital and to be able to live with other Aboriginal people with HIV... For now I am well treated, even living off-reserve. If I lived on my reserve I would have no support and I would have to relocate outside by my own means. My Indian (Status) card is effective even off reserve.*
>
> *[Need] more health care workers on and off reservations that would understand Native peoples where their coming from. Get their act together. Hear and promote more awareness to the Aboriginal communities.*

The complicated funding process as well as the need to serve geographically distant client groups creates a further barrier for establishing programs (BC Aboriginal HIV/AIDS Task Force 1999:vi). Off reserve, Aboriginal peoples are thrust into the mainstream health care service, which may not always meet their needs. McLeod (1997:16) has discussed the difficulties of funding services for APHAs who inhabit multiple jurisdictions, where the policies covering jurisdictions do not adequately serve the needs of individuals who have to migrate on and off reserves to gain the treatment that they require. Because of the mobility of Aboriginal populations, some people will fall into the jurisdictional gap and simply not be able to find the services they need (Matiation 1999b:10).

PREJUDICE, STIGMA AND CONFIDENTIALITY ISSUES

Racial Prejudice

Windal (1997:14) has reported that the level of care Aboriginal peoples receive from clinics and hospitals in the United States may be less than adequate because of negative stereotyping/racism directed toward Aboriginal people. This is a problem for those affected by HIV/AIDS, because negative labelling over time may result in a feeling among APHAs that they do not deserve attention and treatment (Windal 1997:15; Karlsen and Nazroo 2002:3). This prejudice has an impact on the ability of individuals to access services (Marsden et al 2000:131). Jackson (2003:1-2) has written eloquently on the prejudice and stigma that is attached to Aboriginal people in general, being gay, and living with HIV/AIDS (also see Matiation 1999a:10-11). In commenting on barriers to service at pharmacies, APHAs in the study group shared similar experiences related to stereotypes of Aboriginal people and addictions:

> *[It is] difficult to get prescriptions filled because of my past drug use. With pain medication the pharmacist doubts me at times and causes me troubles.*

APHAs have reported that not only do they fear disclosing HIV/AIDS status to some organizations, they may also disguise their ethnicity to avoid discrimination or be more welcome at the services they access (Manitoba Aboriginal AIDS Task Force 1996:2). The "Trends and Issues" report presented at A Gathering of Spirit estimated that 33% of Canadian APHAs do not seek health services because of fear of discrimination due to being Aboriginal (Anonymous 2000). This is likely a major factor in the call by so many APHAs (26% of respondents) for more Aboriginal front-line workers in HIV/AIDS related services (Table 132).

It is also important to point out, however, that simply staffing services with Aboriginal people and providing materials that are Aboriginal specific, do not in themselves constitute culturally relevant programs. As discussed with respect to cultural diversity, Aboriginal peoples do not all share the same cultural beliefs and history (Weaver 1999:31).

HOMOPHOBIA AND HIV/AIDS STIGMA

Within the Aboriginal community, much of the stigma associated with sexual orientation has historical roots in the early European missionary and colonial activities that condemned sexual diversity (Cannon 1998:2). Where traditionally many First Nation cultures not only accepted but respected varied gender identities, over time European attitudes about "homosexuality," for example, limited the gender relations that once existed in Aboriginal communities (Cannon 1998:5; Assembly of First Nations 2001:4; Monette and Albert 2001:29). Indeed, 79 APHAs in the study group identify as Two-Spirit, crossing all boundaries of gender and sexual orientation (see Figure 3). Two-Spirit APHAs spoke about the stigma that persists:

> *The labelling/stigma is fierce. All in this [HIV/AIDS] field should do sensitivity/awareness training. Understanding the origins and path of the disease is admirable as well as working towards a cure. Often, people associated with an inflicted person and the inflicted person are/is treated unfairly. Professionalism should always be a trait to aspire to, but being human with love and understanding is just as, if not more important.*
>
> *[I want] support services for Two-Spirited people who [can go] where they feel welcome.*

The two most common transmission activities – intravenous drug use and homosexuality – are linked to vulnerable groups already stigmatized by many in society as 'immoral' (Herrell 1991:203; Ontario Federation of Indian Friendship Centres 1995:33). Those who then contract HIV from these activities are then doubly stigmatized. A male bisexual APHA recommends the need for...

> *...more healthy sexuality education to deter homophobia and homophobic attitudes within society.*

Affected persons often hide their illness to avoid discrimination due to the tendency to associate HIV/AIDS with homosexuality (Vernon 2001:7; Rowell 1997:89; McDaniel 1997:170-171). For example:

> *The stigma in the Aboriginal community is too great. As a result I have not explained my situation to my family.*
>
> *There needs to be better places to live. I'm the only person in my rooming house who has HIV. The other roommates don't know. I'm scared that they'd mistreat me if they found out. There needs to be nicer places – like nice apartment building for people with HIV.*

A national needs assessment titled, "Trends and Issues Related to Aboriginal People Living with HIV/AIDS" presented at A Gathering of Spirit in March 2000, estimated that 47% of APHAs say they have felt discriminated against because of their HIV/AIDS status (Anonymous 2000). In the present survey, 10% of respondents directed their comments at the need to address issues of stigma and discrimination (Table 132). An overview of cross-tabulations of barriers to services and gender reveal that the majority of responses identifying stigma and discrimination are from male APHAs (Table 135).

Quam (1990:37) has reported that in some cases a moral evaluation of persons living with HIV/AIDS occurs by medical staff and other caregivers. Judgmental attitudes were noted by several APHAs in the study group, particularly among social service staff:

> *Find a better way for First Nations people with HIV. For help instead of the welfare who always question and make you feel small when you really do need help. And then you will get deducted if you ask for help from them when you are really sick.*
>
> *I wish that the HIV social worker would be a little compassionate. Treats me and others as if we were contagious also wish that she would be more respectful and not treat me as a number and as if I was a walking contagious down and out person.*
>
> *Maybe some people could be a little kinder to us. We get treated like we have leprosy.*

Those who are 'innocently' infected (i.e. children who are infected by their mothers) may receive a higher standard of care than those who are infected through purposive risk behaviours (CAAN 2003:25). This may be a critical problem for those Aboriginal people who tend to visit emergency rooms only when forced to due to a "catastrophic illness", often linked to addiction rather than

HIV/AIDS (Goldstone et al 2000:156; Napoli and Gonzalez-Santin 2001:323; FNQLHSSC 2003:7). An additional problem that has arisen in the USA centres on individuals who cannot prove their Indian status, and who must then seek services from institutions that may not be as culturally sensitive to their needs (Vernon 2001:29).

The feeling of not being welcome at some services leaves APHAs in the position of continually seeking out the next service that might be more appropriate (Manitoba Aboriginal AIDS Task Force 1996:9). Survey results specify APHAs "do not feel welcome" most frequently when accessing services of social workers (21.2% [n=33]), emergency centres (17.9% [n=28]), and dentists (16.7% [n=30]). The "Trends and Issues" report presented at A Gathering of Spirit estimated that 40% of Canadian Aboriginal people have reported being denied access to a dentist because of their HIV status (Anonymous 2000).

Fear of HIV/AIDS can prevent people from seeking information, and maintain the cycle of stigma towards APHAs (Friday 2004:23). Weaver (1999:28) has also discussed the idea that in some Aboriginal communities HIV/AIDS may be seen as a "death sentence", and this may affect how much support the family and community will offer. Women who are HIV positive carry the additional burden of wanting to protect their children from stigmatization, and may fear being labelled 'a bad mother' (Ship and Norton 2001:28).

Stigmatization has an effect not only on where attention and funding are allotted, but also profoundly affects decisions on seeking testing, treatment, and support. Fears about the disease and fears of the stigma attached to the disease may result in attitudes of denial among APHAs, for example:

> *I'm fairly new with the virus. I stayed away from [the ASO] because it hasn't really hit home. I don't know if it's denial but I do know a bit about this illness.*
>
> *I didn't want to know my last CD4 T-cell count or my last viral load because it would scare me and I might give up.*
>
> *Lately I haven't been really thinking about my disease. If I don't think about it is not there. I just don't want to deal with it right now but somewhere down the line I'm going to have to... I was thinking of making up a plan where a person that just found out he/she has HIV, they can find a person that already has HIV for someone to talk to.*

> *Like talk to someone who's been there. Sharing circles for people that are HIV.*

The degree of tolerance toward gay/bisexual Aboriginal persons varies within communities, but has a decided impact in many places on how those who test positive are treated and accepted by both community members/family and medical staff. It may also determine whether they seek help (Vernon 2001:7). HIV/AIDS that is associated with homosexual behaviour on Reserves where there is intense homophobia may never be diagnosed (Vernon 2001:23). As well, the hostility that exists towards Two-Spirited people in some communities means that Elders and other leaders are reluctant to speak about the issue (Monette and Albert 2001:19). A number of Two-Spirited people in urban centres report that they were forced to leave their home communities because of homophobia (Monette and Albert 2001:27).

Older gay men may face different issues than younger gay men in that they are more likely to internalize the general homophobia of society, and live more secretive lives. This may also create myths that older gay men are less vulnerable to HIV because they are less active (Vernon 2001:32). A study of Two-Spirit men in Toronto concluded that the core issue of homophobia must be addressed in order to reduce risk-taking behaviour among this group. More than any other factor, it was the sense of alienation that contributed to engaging in high-risk activities which makes Two-Spirit men vulnerable to HIV/AIDS (CAAN 2002j). It also made them less willing to access intervention services that generally did not convey respect, support and some sense of community for Two-Spirit men (Monette and Albert 2001).

Lesbians may also be particularly at risk because of the persistent belief that female to female transmission carries little risk (Vernon 2001:52). As a result there are practically no services that help lesbians get information for their particular concerns (Vernon 2001:52). Lesbians are also less likely to access health care than heterosexual women because of discrimination and the lack of trust in the health care services provided (Vernon 2001:53). However, a heterosexual APHA expressed concern that ASO services be "less oriented toward gay and lesbian people."

Face-to-face interaction within the community in an open and accepting manner can be crucial in developing a better understanding of the issues surrounding HIV/AIDS. There may still be considerable misunderstanding about the way HIV is transmitted, and blame may still be assigned by some to everything from tainted blood supplies to a focus on Two-Spirit persons as sources for transmission (Windal 1997:11-13). A frequent comment is that AIDS is a "white man's disease" or a "white gay male disease" creating the perception that if you do not belong to one of the 'at risk' groups, you are safe (Windal 1997:14; McDaniel 1997:174; Schoepf 2001:338; Friday 2004:23).

Confidentiality Issues

Confidentiality is a crucial issue for already marginalised and at-risk groups who experience discrimination and stigma (Matiation 1999b:33). Depending on the impact of cultural and religious structures within a given community, there may be reluctance to speak about HIV/AIDS and sexuality (Windal 1997:7-8). In contrast, communities that do not understand the nature of HIV/AIDS and fear it, may breach confidentiality in an attempt to 'protect' other members of the community from an APHA. This certainly happens informally though gossip, but has also been a potential threat at the level of community and health services boards (Matiation 1999b:34).

5.5% of APHA respondents said there is room for improvement in ensuring and enhancing confidentiality and privacy at all levels. As a barrier to services, issues of privacy and confidentiality are identified most commonly in relation to group-oriented activities such as talking and healing circles, and buddy programs, but also with respect to meetings with social workers and to treatment at addiction centres.

In small Reserve and isolated communities, it may become extremely difficult for members to conceal HIV/AIDS status, and even to receive information about managing the condition without making it known to others (CAAN 2004b:14; Matiation 1999b:37). This can even be difficult in clinics and counselling centres located within the community, where testing for HIV may be approached with trepidation or avoided altogether because there is no ultimate assurance of confidentiality (Windal 1997:15-16; Cyr and Dunn 2000:12). Even picking up a brochure about HIV may provoke the fear that if an acquaintance observes that action, there may be speculation in the community at large about whether that person is infected (Vernon 2001:53).

Many Aboriginal communities are small and family relations form the cornerstone of daily life (Napoli and Gonzalez-Santin 2001:315). Relatives, and people who are perceived as kin, hold positions in the community that allow them access to personal information – such as an individual's HIV status – that may lead to gossip throughout the community (Windal 1997:15). One APHA stated that she now lives in the city...

> *...only because too close-knit of a community and confidentiality, I feel, was a problem. And how would the people of my Reserve react?*

This kind of experience is unfortunate because not only does moving deprive an APHA of family support, but a key strength of Reserve communities is the presence of Elders who may provide constructive role models, and easier access to traditional healing practices (Gregory et al 1992:216). Elders, and other community leaders who are respected for 'the kind of person' they are quite often have more impact than persons who simply possess a certain skill or knowledge (Napoli and Gonzalez-Santin 2001:317; Cree 1999:14). It is critical then, that communities have strong, respected leaders who are not afraid to speak about HIV/AIDS issues in order to seriously combat problems (CAAN 2003:11).

The organization of support groups within communities may be difficult because of confidentiality issues. While support groups are extremely valuable in providing a shared sense of experience, and the opportunity to establish networks that will help in coping with HIV/AIDS, many will avoid them because even to be seen going to a group that is publicized as providing information about HIV will potentially link the attendee with the disease (Windal 1997:16). An APHA in the study group promoted the idea of exactly this type of "network":

> *By having a wider support group of counsellors and infected persons to contact on a regular basis for such things as exchanging information, latest programs and treatment; to be able to access (through networking for example) treatments and programs more readily available.*

Heckman et al (1998:373) have discussed the potential of telephone-linked support groups that may be a viable alternative to face-to-face interaction. Several APHAs (3.7% of respondents) pointed to the need for confidential and anonymous phone-line and on-line support groups (Table 132):

> *Easier access to "on-line" support services for Reserves with "automatic" contacts for physical/emotional support through a buddy system. For example, "So-and-So" hasn't [been at] their house/Apt/Abode, and [go] check up on them.*

> *I feel the best way for us to get a better grip on what is happening, and what we can or should do in any HIV/AIDS situation is to have a 24-hour toll-free line to call.*

Major government institutions have also had difficulties maintaining confidentiality, as revealed in a 1991 US study of the Indian Health Services, so the fear of having private matters made public may be all too real (Vernon 2001:8). This lack of confidentiality has been called "alarming" at some Quebec Health Centres (FNQLHSSC 2003:23). And, while physicians are bound to patient confidentiality, there is a fine line in terms of protecting other sexual or IDU partners that a client may come in contact with (Matiation 1999b:35).

However, telephone networks would not be appropriate in correctional facilities where confidentiality is major issue. Telephone calls and visits are logged and may be monitored, which means that trying to access information from outside service providers or making appointments with visiting HIV/AIDS specialists means automatic disclosure (Roe 2003:8, 14). An APHA who was incarcerated at the time of the survey suggested broad-based "sensitivity" training within the Canadian correctional system:

> *Make all Justice System workers, i.e. guards, cops, nurses, take HIV/AIDS sensitivity-awareness courses.*

PUBLIC EDUCATION AND AWARENESS ISSUES

There still seems to be a lack of HIV education and awareness, particularly on Reserves (Vernon 2001:9; Monette and Albert 2001:77). Several researchers have identified denial as a barrier, meaning that communities deny the reality of HIV/AIDS and its effects because they are geographically or socially isolated (Cooper et al 2000:123; Weaver 1999:27; CAAN 2002d). APHAs who indicate the "best way to improve services" is to "to go on Reserves to speak of HIV" and to maintain and even accelerate public education and awareness about HIV/AIDS, represent over 15% of respondents (Table 132).

Gregory et al (1992:218) report that in one community surveyed only about half of respondents knew how HIV/AIDS is spread, and that information primarily came from television and newspapers (also Oggins 2003:58). Communities must be given enough material and role models to help support and accept those with HIV/AIDS regardless of how the virus was contracted (Marsden et al 2000:132).

Funding, however, remains a key problem for creating appropriate programs for Aboriginal communities (Vernon 2001:81).

Aboriginal people who are willing to speak publicly about their experiences living with HIV/AIDS and educate others are particularly good role models (Windal 1997:10). An APHA in the study group agrees:

> *Aboriginal persons living with HIV – in sobriety if possible – [are needed as] good role models.*

While some Elders may not feel knowledgeable enough to provide educational material on HIV/AIDS, it is important that the community sees that Elders endorse strategies for disseminating material and providing support (Windal 1997:19-20; McDaniel 1997:172; Vernon 2001:31). Traditional Elders who recognize and accept Two-Spirit persons also need to speak out (Rowell 1997:89). This may be particularly important for Aboriginal youth on reserves, who may be in greater need of education and support than urban Aboriginal youth (Vernon 2001:73).

One of the simplest forms of denial is believing that you will know just by looking at someone whether they are infected or not (Weaver 1999:29). Some communities will think of HIV/AIDS as a "gay white male disease" (Vernon 2001:8), and that 'straight people' cannot get HIV/AIDS (Ontario Federation of Indian Friendship Centres 1995:22; Brassard et al 1996:346). For some, this means utilizing 'language of blame' that specifically targets certain groups as those who cause AIDS, or those who get AIDS (Osborn 1996:307). An example is the belief that AIDS is a problem of urban Aboriginal peoples (Rowell 1997:89; Weaver 1999:29), as indicated in a comment by an APHA from British Columbia:

> *I believe there should be more Aboriginal-based services for peoples of the north. More information; more education. The small communities around the north need educated individuals to do workshops at schools, etc. [Also,] less discrimination within our communities an families. More education to alleviate distrust and anger.*

An APHA living on-Reserve in Saskatchewan reiterates the need to "educate on Reserves, for example the health workers, Chief and council." The Ontario Federation of Indian Friendship Centres (1995:21;32) has indicated that denial that HIV/AIDS is a serious health issue for Aboriginal peoples, and thinking that HIV/AIDS will not happen within Aboriginal communities is a significant barrier to ensuring that education regarding transmission and safe practices is disseminated (cf. Special Working Group on Aboriginal Issues 1999:51):

> *[We require] better public awareness of advancements in HIV treatments and clarifying the ways of transmissions. This would help erase the predetermined convictions that people have regarding HIV and AIDS.*

WOMEN'S ISSUES

Many of the female APHAs in the study group commented specifically on the need for women-centred support services. The HIV/AIDS literature has also focused some specific attention on women's issues, stating for example, that empowerment means ensuring that other women are involved in providing health care and counselling (Melchior et al 2001:32).

Aboriginal women are being infected with HIV at a higher proportional rate than white women (Rowell 1997:87; Marsden et al 2000:128; Métis National Council 2003:31). Indeed, poor women and women of colour cross-culturally are being infected at alarming rates, and at younger ages than the rest of the population (Kenagy et al 2003:235; Schoepf 2001:344; CAAN 2002h; Overall in Overall and Zion 1991:37). HIV infection among Aboriginal women is transmitted mainly through unprotected heterosexual activity and intravenous drug use (Ship and Norton 2001:25). Within the APHA study group, women reported transmission categories as follows: unprotected heterosexual activity (48%); intravenous drug use (26.0%); a combination of both (15%) (Table 133).

For many Aboriginal women today, the impact of colonialism, religion and patriarchal ideologies has resulted in less political power than men, a lower social status than men, and a greater dependence on male partners (Vernon 2001:43; Loppie and Gahagan 2001:6; Ship and Norton 2001:25). There is evidence that women may be very aware of how HIV is transmitted, but do not have the status or power to ensure their own safety by negotiating condom use (de Guzman 2001:665-666; Ship and Norton 2001:26). This leads women into survival strategies that leave them at higher risk for contracting HIV (Northern Health Research Unit 1998:14). The moral devaluation of women who are sex-trade workers creates an atmosphere where women may be hesitant to use services, or avoid seeking treatment altogether (Baylis and Loyie 2001:125; Matiation 1999a:10).

Research indicates that increasing numbers of Aboriginal women are moving into urban centres or simply moving away from Reserves or remote communities in order to escape family violence (Ship and Norton 2001:27). The present survey results show that 46% of women have already moved or will need to move to be closer to services; another 14% are unsure if they will need to move (Table 134). Female APHAs from across Canada voice their need for support services specifically aimed at Aboriginal women living with HIV/AIDS:

> *As an Aboriginal women, I need to get in touch with other HIV/AIDS women. There isn't much for women in [the Atlantic region] who are First Nations. I do know a lot of men. Need more representation for APHA women. I don't know what's out there for me.*
>
> *I think there needs to be more for women specifically. Not enough in place right now [in Alberta]. I would like to see treatment services that target me as an Aboriginal woman.*

The context of women's lives, and subsequently their health needs, contain issues that are not normally seen in health for men ((Huba et al 2001:55; Melchior et al 2001:31; see also Vernon 2001:50-51; Ship and Norton 2001:26; Kenagy et al 2003:235; Loppie and Gahagan 2001:7; Schoepf 2001:336; Métis National Council 2003:32; Swaminathan et al 1998:9; Walters and Simoni 2002:521; de Guzman 2001:666). For example, there is a lack of knowledge and understanding of women's concerns with regard to HIV/AIDS and how it affects not only them, but also the infants they carry and breast-feed (Vernon 2001:58, 63). A female APHA in the study required information on exactly these issues:

> *I would like to know more about how HIV/AIDS can affect an unborn child and what is the survival rate of the infant. I would like to know where to obtain this information and I would like for it to remain confidential.*

AIDS education for Aboriginal women must incorporate not only cultural values, but a solid understanding of gender politics from not only the traditional culture but the dominant culture (Worth 1990:128). It must be recognized that relationship dynamics may result in women being left as the head of the household. As such they bear an additional burden of concern for the psychological and social effects of discrimination against their own children should their HIV status become known (Ship and Norton 2001:28; Vernon 2001:58).

It has also been shown that women cross-culturally, are more likely to shoulder the burden of home-based care giving for HIV-positive family and friends, even if they themselves are affected with HIV/AIDS (de Guzman 2001:670; Ship and Norton 2001:27, 29).

The survey results also show that it is mainly female APHAs who require access to child care services (Table 95). Other research indicates that APHA single-mothers face greater risks for earlier death from AIDS because they are too busy to seek help early (Kenagy et al 2003:236). Whatever money they have tends to be allocated to the family before their own needs (Vernon 2001:49). In addition to this, isolation in rural areas becomes a significant barrier for women who have no day care access on days when they must travel for medical appointments (Vernon 2001:50; cf. Martin 1996:411; Kenagy et al 2003:236; Huba et al 2001:67). APHA mothers, therefore, are not as able to access health care because of lack of transportation and the absence of child care, for example:

> *I would like to have help with childcare for appointments. Sometimes people do not qualify for daycare yet they do not have the supports in place. HIV programs should coordinate appointments better for children and parents, especially for out of town patients. Relevant information for rural HIV+ people who are needing information on ASO's treatment and support.*

An additional concern that may keep women from seeking an HIV/AIDS diagnosis and/or treatment is the fear of losing custody of their children (Huba et al 2001:62).

However, APHA women have also become vocal advocates for improved services, are currently actively involved in ASOs across Canada, and promote HIV/AIDS awareness and education within their communities (eg., CAAN 2004b). Nevertheless, these women also struggle with the need for child care services:

> *Child care funds for when single mothers have to go out to speak or for conferences. The provider needs to get paid.*

CHAPTER 4

RECOMMENDATIONS AND FUTURE RESEARCH

The primary goal of this study is to document the extent to which service needs are being met for Aboriginal people living with HIV/AIDS. Service utilization and effectiveness are examined by Aboriginal identity, geographic region, disease stage, gender, age and mode of transmission. The identification of deficiencies in the provision of services through the national survey of APHAs, point directly to ways in which access to and delivery of services can be improved. What follows are recommendations for improving policy and practice in the eight service categories discussed in this report. This is followed by an outline of future research relevant to this topic.

POLICY AND PRACTICE RECOMMENDATIONS

The national survey results provide strong support for the policy and practice recommendations made here. The validity of survey questions and interpretation of findings is assured through the participatory action research process involving members of the Aboriginal HIV/AIDS community who guided the project from inception to completion. The rigour of survey administration resulted in higher than expected responses from 195 APHAs, representing all Aboriginal groups in regions across Canada, thus providing a high degree of reliability to the study. Attention to social scientific standards of qualitative content analysis and quantitative statistical analysis lends a level of confidence in the results about Aboriginal persons living with HIV/AIDS that is unprecedented in the Canadian research literature.

Nevertheless all research, no matter how carefully designed and executed, has limitations. The national survey results presented in this report cannot, in all instances, be applied to all APHA population groups in all regions of Canada. The fact that the survey sample is, by necessity, purposive means that statistically significant findings should be interpreted as probable, but not conclusive. Furthermore, survey results for questions that were answered by relatively few participants are necessarily analysed qualitatively. While these results are considered meaningful, caution must be exercised in generalizing beyond the study population. Finally, it is important to note that the study was confined to APHA clients who currently access services offered by AIDS Service Organizations in their region. As such, findings do not capture information about the 'invisible' APHA population who are unable or unwilling to use ASO services (see 'Suggestions for Future Research', below).

Recommendations for Traditional Aboriginal Health and Wellness Services

The extent to which the study population (60.5%) uses or needs traditional Aboriginal health and wellness services also reflect the extent to which cultural values, belief and practices shape individual responses to HIV illness. APHAs offered numerous unsolicited positive comments about their experiences using traditional health and wellness services. For example, APHAs benefited from advice by Elders, and received social support by participating in sharing and healing circles. Other researchers have also concluded that when Aboriginal people are afforded opportunities to learn and re-connect with their culture, they generally build stronger coping mechanisms for negative life experiences associated with the disease (Walters and Simoni, 2002; Assembly of First Nations, 2001).

Cultural competence emerges as an important design and health system delivery consideration when providing care to Aboriginal people living with HIV/AIDS. In some areas of the country, notably Saskatchewan (83.3%), APHAs report higher levels of satisfaction with traditional health and wellness services. How this province organizes to respond to the traditional health care needs of their APHAs may prove of benefit to others responding to similar needs in other regions of Canada.

Key policy/practice recommendations for traditional Aboriginal health and wellness services are:

- Dedicated funding and human resources are required to promote existing or establish new traditional Aboriginal health and wellness services. Types of traditional services recommended include: Elders who are knowledgeable about HIV/AIDS available at local health centres and ASOs; access to traditional medicines accompanied by information on the application and effects of these medicines, and; access to ceremonies near APHAs' place of residence. A useful model is the brochure produced by the Canadian AIDS

Treatment Information Exchange which outlines traditional ceremonies and medicinal treatments; this type of information can be expanded to address application and effect of these traditional therapies in relationship to HIV medication. Coverage by federal and/or provincial/territorial health insurance programs is recommended for the necessary components of traditional Aboriginal health and wellness services. Such coverage may reduce or eliminate the financial barriers to participation in health services that support cultural identity and positively shape how individuals respond and adapt to HIV/AIDS.

- Service design and delivery must account for logistical barriers (i.e., transportation, etc.) that compromise access. Lower use of traditional Aboriginal health and wellness services may be partially explained, for example, by Aboriginal people in poorer health who lack viable options to circumvent such logistical barriers. Program design and funding must be made available, beyond public transit, to accommodate those in particularly poor health who wish to access traditional health and wellness supports. Eliminating logistical barriers to access are important considering that APHAs who are less healthy tend to use traditional services at a lower rate (52.8%) than do more healthy individuals (70%).
- Traditional sharing and healing circles need to ensure confidentiality. Clearly, the study population understands the risk/benefits associated with such group activities. However, these programs can be designed to reassure APHAs, for example by establishing boundaries of participation, and/or penalties if confidentiality and privacy are violated.
- Community-based AIDS service organizations and local primary health care centres are best able to determine how traditional health and wellness services can effectively be incorporated into existing programs to best meet the needs of APHAs they serve. Community organizations must take the lead in designing features of traditional health and wellness that can be incorporated into their overall care models.

Recommendations for Primary Medical Services

Not surprisingly, a high proportion of APHAs in the study use or need primary medical services (88.0%). Consistent with what others report in the literature, common barriers to care experienced by the APHA study group include logistical access barriers such as long wait times (52.4%), the perception they receive poor care (46.0%), or experiences of racial prejudice or homophobia (30.2%). It is important to note that although a relatively high proportion of study participants use one or more of these services, approximately 12.0% state they do not use any primary medical services. Addressing barriers to primary health care may prompt individuals to use services they currently avoid. To ignore calls for health services to address these barriers, may lead to continued "poor health, reduced access and/or later stage diagnoses" among Aboriginal people with HIV/AIDS (CIDPC, May 2004; Cyr and Dunn, 2000).

Key policy/practice recommendations for primary medical services include:

- Hospital emergency room wait-times must be reduced. It is recommended that primary medical care staff, including those in hospital emergency rooms, receive professional development training related to the care needs that are characteristic of Aboriginal people living with HIV/AIDS. It is particularly important for primary medical professionals to be cognizant that persons with HIV/AIDS tend to use such services when they are in particular ill health. A significantly higher proportion of APHAs diagnosed with AIDS (i.e., in poorer health) visit hospital emergency rooms (82.6%), than do APHAs who are HIV-positive but not diagnosed with AIDS (57.8%). Also significant is that female APHAs tend to visit emergency centres at a slightly higher rate (67.6%) than do male APHAs (54.9%). This result is given greater meaning by members of the research/advisory teams who stated that in their experience, women tend to take care of the needs of others (eg., their children) before themselves. Although unforeseen circumstances (i.e., more pressing medical emergencies, etc.) at times interfere with the length of a wait during a visit to a hospital emergency department, it is important that individuals be informed of these circumstances before losing them to care they may urgently require.

- There is a need for family physicians to be more knowledgeable about HIV/AIDS, and for such physicians to be positioned in rural, northern and remote communities. Slightly more than one-quarter (26.6%) of APHA participants in this study perceive the care they receive from physicians to be less than adequate. Another 15.0% of APHAs in the study group do not use physician services at all. In circumstances where local health clinics and nursing stations are the first line of defence against the disease, study participants indicate a rate of dissatisfaction almost double (40.0%) to that of physicians generally. Lack of access to knowledgeable medical service providers continue to be a barrier for APHAs, particularly for those living on Reserves and in isolated communities.

- Professional development and continuing education programs are required to eliminate attitudes associated with HIV/AIDS stigma, racial prejudice and homophobia within the primary medical system. Internalized homophobic and racial attitudes compromise quality of care. Almost one-third (30.2%) of Aboriginal PHAs in this study indicate that these prejudices remain prevalent among primary health care providers. That such prejudices negatively impacts access to services is also documented in the literature (Marsden and Nazoo, 2002; Jackson, 2003). In responses to open-ended questions, for example, APHAs report situations in which a physician or pharmacist assumed a predilection to addiction and drug abuse based on ethnicity. This may lead APHAs to feel they are not welcome and to avoid these services except in extreme circumstances. (This may help explain the almost 15.0% non-use rate of physicians by the APHA study group.) It is important that primary health care providers increase their levels of cultural competence, and reduce their levels of discomfort when providing treatment to APHAs.

- It is strongly recommended that an APHA's perspective be considered as a factor in drug plan coverage for HIV/AIDS medication and treatment. Drug program officials who are responsible for approving medications/treatments unto or off formularies require additional information beyond assessments of potential risk/benefits associated with any particular medication/treatment under consideration. More than half (52.0%) of the APHAs in this study rely on provincial, territorial and/or federal drug plans to assist with the cost of HIV/AIDS medication and treatment. These participants report high levels of satisfaction (80.2%) with such programs. However, many APHAs (48.0%) are not accessing medication or treatment under such programs. This is a serious concern in light of repeated responses that access is limited by financial barriers, particularly the limited coverage of HIV/AIDS medications/treatments.

Recommendations for Secondary Health Services

A high proportion of APHAs in this study (roughly three-quarters) report they need or use one or more secondary health services, such as a dentist, optician, chiropractor, physiotherapist, home nurse and home care professional. However, when considering actual reported usage, the services of chiropractors, physiotherapists, and home nursing/care are low (between 7.0% and 14%). In almost all cases, lower than expected use was most strongly correlated with financial barriers (30.8%) and by logistical access barriers (30.8%). Addressing these barriers to care may prompt APHAs to more readily use these types of health care services where such may significantly improve their quality of life.

Key policy/practice recommendations for secondary health services are:

- Provincial, territorial and federal health insurance programs need to consider ways to expand coverage for Aboriginal persons with HIV/AIDS who require secondary health services. This is a quality of life issue, particularly as it relates to the burden of a serious health condition such as HIV/AIDS. In the Aboriginal context, extreme poverty may prevent APHAs from using such services. This is true particularly for youth who generally possess less financial power to access services not covered under health insurance programs. The national survey indicates, for example, that use/need increases incrementally with age (for the under 30 age group use/need rates were 74.7% compared to those 40 years and older (83.0%).
- Hours of operation as a logistical barrier to secondary health services also require consideration. Secondary health care providers who know they serve Aboriginal HIV/AIDS patients, may need to be flexible in their hours of service, taking into account APHAs' different health statuses and transportation needs.

Recommendations for Alternative and Complementary Therapies

Access and use of alternative and complementary therapies are equally important when considering quality of life in the context of HIV/AIDS. Almost half (45.6%) of APHA study participants indicate they use or need massage, homeopathy, and/or medical marijuana. While use/need of marijuana for medical purposes was high (35.9%), access differed by region (the North, Manitoba, Ontario, British Columbia reporting the highest rates), and by health status (where those in poor health reported more common use/need). Again, financial and logistical barriers were most common for those whose needs are not being met.

Key policy/practice recommendations for alternative and complementary therapies include:

- Continued attention to ways of improving access to marijuana for medical purposes for those APHAs who require this alternative form of therapy, is recommended. More than one-third of APHAs in the study group rely on medical marijuana to alleviate symptoms associated with HIV/AIDS or the side effects of treatment regimes. However, the legal and financial issues surrounding purchase, possession and growing of marijuana continue to limit access by APHAs.
- It is recommended that provincial, territory and federal medical plans find ways to expand coverage for APHAs to access the health benefits of massage therapists and homeopathic physicians. For the APHA study group, cost was the main barrier to both of these types of therapy.

Recommendations for Social and Family Services

A majority (62.1%) of APHAs access social and family services in relation to their HIV/AIDS care. Of importance is that this was mainly confined to the services of social workers (58.5%). Child care, family planning and parenting skills programs were needed far less (7.2 - 9.2%). Rates of use vary significantly by region and to some extent by health status. APHAs in Manitoba, the North and British Columbia report the most frequent usage of social and family services (76.1 - 83.3%) . Those with more serious health problems (77.4%) report greater use than those were health problems are not serious (61.3%). This category of service received the highest dissatisfaction rate (40%). APHAs are dissatisfied mainly because they do not trust that confidentiality/privacy is respected (37.5%), and they experience and/or perceive stigma and discrimination (30.0%).

Key policy/practice recommendations for social and family services are:

- Policies within Social Service organizations with Aboriginal PHA clients must address the vital importance of assuring confidentiality and privacy.
- Social Work curricula and professional development and continuing education within social service institutions must address attitudes associated with HIV/AIDS stigma, homophobia and racial prejudice.

Recommendations for Substance Use Programs

A high proportion (60.5%) of APHAs in our study indicate they use or need one or more substance use programs. Not surprisingly, use/need rates were highest among APHAs who indicated injection drug use (sharing needles) and tattoos as a dominant mode of HIV transmission (82.7%). However, use of addiction treatment, harm reduction and/or needle exchange programs is compromised by lack of availability, inadequate care or objections to an abstinence-based approach. More specifically, particularly in connection with either addiction treatment and harm reduction programs, commonly cited barriers included long waits, closed facilitates, or lack of transportation. Additionally, confidentiality and privacy were also cited as concerns of the APHA study population. It is important to note that use/need generally increased (40.0%) with serious to very serious health status compared to those who reported better health (19.0%).

Key policy/practice recommendations for substance use programs include:

- Where substance use programs exist, there is a need to address barriers such as objections to an abstinence-based approach, long wait-times to enter facilities, transportation needs, as well as issues of confidentiality and privacy. The overall use/need rates demonstrate that when afforded opportunities to access substance use programs, APHAs will do so.

Recommendations for Community-based and AIDS Service Organizations Services

APHAs in this study indicate a high need/use of community-based AIDS service organizations (80.5%). This in not an entirely unexpected result given our chosen recruitment method: participants were approached within the context of their existing connection with ASOs. Drop-in programs and treatment information are the most widely used services, followed by buddy support programs and health education programs. Comparatively few APHAs used crisis help-lines or hospice care. It appears that community organizations generally rise to the challenge of meeting the needs of APHAs (75.0%). However, APHAs did express concerns related to privacy/confidentiality issues and a lack of services such as hospice programs.

Key policy/practice recommendations for community-based and ASO services are:

- Community programs need to address privacy/confidentiality concerns, particularly as they arise though participation in group programs such as buddies and drop-in support.
- Treatment information was highlighted as an important area of concern for APHA in this study. Specifically, written information is needed at various literacy levels. As well, given the complexity of treatment information and the

desire to be active participants in the care process, APHAs may require face-to-face counselling by knowledgeable HIV/AIDS care providers.

- Buddy systems and hospice care programs should be considered as a component of a comprehensive approach to providing care to APHAs, particularly to those experiencing serious health problems.

Recommendations for Mental Health and Counselling Services

Slightly more than half (54.4%) of the APHA study group need or use one or more mental health or counselling services. Mental health care and spiritual care are the most commonly accessed types of service within this category. Where needs are not being met, APHAs indicate they do not know if or where such services exist (26.3%), they feel the care or service they receive is inadequate (18.4%), or they feel that confidentiality is compromised.

Key policy/practice recommendations for mental health care and counselling services include:

- Given mental health challenges associated with living HIV/AIDS, there is a clear need to establish programs and/or promote existing mental health services to APHAs that require care. Of significance is that mental health care issues are increasingly important to APHAs whose health is declining, or who are experiencing grief associated with the loss of a loved-one due to the disease.
- There is a need to address privacy/confidentiality issues, particularly in relation to the spiritual care needs of APHAs. Findings indicate there is a lack of trust of spiritual care providers, possibly the result of historical circumstances (eg., residential schools).

APHA VOICES: BEST APPROACHES TO IMPROVE SERVICES

As a group with a tremendous amount of experience in accessing care and treatment for HIV/AIDS, 85.0% of APHA participants provided comments and/or recommendations on how best to adapt services to meet support needs. Although there is some agreement that services are doing the best possible work under extraordinary circumstances (30.7%), APHAs in this study also recognize the need for better approaches to improve services.

APHAs recommend the following best practice approaches to improving care, treatment and support services:

- First and foremost, APHAs express the need for cultural competence in their care, treatment and support. Recommendations pertaining to Aboriginal - specific and traditional services constitute the greatest number of open-ended comments. We therefore advocate for more Aboriginal service providers and front-line workers, more traditional support programs, and more attention to issues of diversity.

- There an equally strong call by APHAs not only for new support services (eg., logistical access support such as transportation assistance), but also that existing services be sustainable. Under the new Federal Initiative on HIV/AIDS, and as funding allocations are finalized, we recommend that community agencies that provide HIV-related services be allowed to access funding and develop programs under core funding arrangements. Time-limited project funding does not adequately address the issue of sustainable service provision. Clearly, programs are developed based on needs which do not disappear when project funds terminate.

- APHA's clearly acknowledge their need for HIV/AIDS treatment information. The complexity of HIV-related information is such that attention to literacy levels of written documents are an important concern. Written information should be supplemented with optional verbal and one-on-one information services.

- APHAs emphasize the importance of tolerance and respect as a fundamental component of effective care, treatment and support. To that end, we advocate for the continuation and enhancement of public education and awareness initiatives.

- Income security, family and housing matters are concerns common to many APHAs. In terms of housing, for example, approximately one third of the study group are homeless or live in institutional/subsidized type settings. In the context of health generally, and for HIV/AIDS specifically, we recommend that safe and healthy housing assistance be added as a component of program funding arrangements.

- Finally, APHAs speak eloquently of their emotional, mental and spiritual needs that, together with the need for treatment of their physical condition, call for holistic support programs and services that aim toward overall health and wellness in the context of living daily with HIV/AIDS.

SUGGESTIONS FOR FUTURE RESEARCH

- Further research is required to collect information about APHAs who are unable or unwilling to use ASO services. Innovative recruitment approaches need to be developed and tested to reach these 'invisible' APHAs. For example, a qualitative study could be conducted among a smaller study sample recruited using a street outreach method. These APHAs could also be asked to participate in a future study related to similar questions posed by this research (e.g., personal and systemic barriers to access to HIV-related services).

- A qualitative follow-up study to the national survey should focus on the lived experiences of Aboriginal persons as they seek out and access care, treatment and support related to HIV/AIDS. With regard to all service categories addressed in the survey, in-depth interviews should focus on illness narratives that will broaden our understanding of the use of services, the relative importance attributed to the various services in meeting APHAs needs, and the perceptions of barriers encountered in accessing needed services. Interviews can also elicit a greater understanding of use/need patterns and barriers shown in the survey to differ by Aboriginal identity, geographic region, disease stage, gender, age and transmission category.

- With respect to traditional Aboriginal services, further research should focus on what service design and delivery features exist in Saskatchewan that account for higher satisfaction rates by APHAs in that province. Exploration may be of benefit to regions that indicate lower rates of satisfaction (i.e., Quebec/Atlantic, Ontario and the North, etc.) where design features may be adapted to meet specific needs in those areas.

- With respect to primary medical services, and social and family services, action research is needed to develop policies and education options aimed at changing negative attitudes related to HIV/AIDS stigma, homophobia and racial prejudice. The national survey demonstrates the importance of building on CAAN's current initiatives on this subject, for example: stigma and its influence on access to health care; anti-discrimination policy framework, and; the impact of homophobia in the context of HIV/AIDS.

- Mental health needs are identified as a significant challenge for a majority of APHA participants. Evidence from the national survey supports the direction taken by CAAN to conduct research that addresses the experience of depression for this population group.

CONCLUDING STATEMENT

It is heartening that APHAs who participated in this study indicate that, generally, the services they access are meeting or exceeding their needs. Certainly our knowledge of the grassroots role and work of service providers supports this finding. Often individuals who provide services to Aboriginal people living with HIV/AIDS go above and beyond their duty to ensure quality of services. The recognition that participants give to this type of dedication to work is extraordinarily insightful.

However, enthusiasm is slightly dampened by findings that indicate the need to reduce barriers to care, treatment and support, as well as by calls for improvements to policy and practice. In particular, attention needs to be focussed on the key findings related to cultural competence of caregivers and to logistical access barriers. The position of the Canadian Aboriginal AIDS Network on this point is to mount a strong and forceful advocacy campaign for appropriate allocation of funding to account for these concerns under the newly announced Federal Initiative on HIV/AIDS in Canada.

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Canadian Aboriginal AIDS Network
602-251 Bank Street
Ottawa, Ontario, K2P 1X3

INFORMATION SHEET

CARE, TREATMENT AND SUPPORT STUDY FOR CANADIAN ABORIGINAL PERSONS LIVING WITH HIV OR AIDS (2004)

The Canadian Aboriginal AIDS Network (CAAN) and Carleton University researchers set up this study. We want to learn if the care and treatment for Canadian Aboriginal people living with HIV or AIDS meet their needs. The study will help us suggest ways to improve services.

Who can be a part of the study?

We invite you to be a part of our study if you are an Aboriginal person living with HIV or AIDS in Canada who is Inuit, Innu, Métis, or First Nations.

Your role in the study

You can decide if you want to be a part of this study. Your role in the study will not affect your right to receive services or care. If you do participate, we will ask you to answer questions in the Survey. You do not have to answer every question in the Survey if you do not feel safe.

To be a part of the study, you must sign a Consent Form. The form tells us you agree to be part of the study. It also tells us that you understand why we are doing the study, and how the information you give us will be used.

If you participate, you will get $20. First you must fill in and return the Survey and signed Consent Form. You will get envelopes for the Consent Form (small white Envelope #1) and the survey (large brown Envelope #2).

About the study

The information from all the surveys will be put together into a report. The report will be shared with many other people, in a journal or at a conference. CAAN will use the report for fact sheets.

The Survey is confidential. We will use a code number to track each Survey. Your name will only be on the Consent Form. We will not share your name with anyone. The Surveys and Consent Forms are kept locked up and in separate places. We will destroy all the Surveys and Consent Forms seven (7) years after the study ends.

If you need help with the survey, you may call between 8:30 am - 4:30 pm EST:

Randy Jackson at CAAN at 613-567-1817 (ext.109) or 1-888-285-2226

OR

Carleton University researchers: Gwen Reimer (English) & JP Chartrand (Français) at 613-830-7198 (collect if you wish) or Email: gwen.praxis@rogers.com.

Ethics: Carleton University in Ottawa, Ontario found this study to meet ethical standards (Approval - Oct.28/02; Renewed Oct.29/03). For information about this, call Klaus Pohle, Chair of the Ethics Committee, Carleton University at (613) 520-7434 (Email: klaus_pohle@carleton.ca).

You may keep this information sheet.

Canadian Aboriginal AIDS Network
602-251 Bank Street
Ottawa, Ontario, K2P 1X3

Carleton University Ethics Approval:
October 28, 2002 (Renewed Oct.29/03)

Code

CONSENT FORM

CARE, TREATMENT AND SUPPORT ISSUES: CANADIAN ABORIGINAL PERSONS LIVING WITH HIV OR AIDS (2004)

I agree: I have read the information about this study.

I understand:

- It is my choice to take part in this study.
- If I take part, I do not have to answer all the questions.
- After I start the Survey, I can decide to stop.
- I will get $20 for filling out the Survey.
- My part in the study will not affect my right to receive care and services.
- Survey information will be combined into a report for journals, books, fact sheets.
- My name will not be shared with anyone. Surveys and Consent Forms will be kept separate. The Surveys will be kept at the CAAN office, and the Consent Forms will be kept by Carleton University researchers in their office, in locked cabinets.
- The Surveys and Consent Forms will be destroyed after seven years.

If I have questions about the survey, I can call between 8:30 am - 4:30 pm EST:

Randy Jackson at CAAN at 613-567-1817 (ext.109) or 1-888-285-2226

OR

The Carleton University researchers: Gwen Reimer (English) & JP Chartrand (Français) at 613-830-7198 (call collect if you wish) or Email: gwen.praxis@rogers.com.

If I have questions about the ethics of this project, I can call Klaus Pohle (Carleton University) at 613-520-7434 or Email: klaus_pohle@carleton.ca

Please print your name and sign below:

I ________________________________ agree to take part in this study.
Print your name

________________________________ **________________________**
Sign in ink **Date**

How to hand in your Consent Form and Survey:

1. Put this Consent Form in the small white envelope (Envelope #1).
2. Put your completed Survey Form in the large brown envelope (Envelope #2).
3. Seal both envelopes and put some 'X's across the seals. This tells us that no one has opened the envelopes.
4. Hand in both envelopes to the person at your agency who gave you the survey. They will mail it for you.
5. When your agency gets your sealed envelopes, you will get $20.

Canadian Aboriginal AIDS Network
602-251 Bank Street
Ottawa, Ontario, K2P 1X3

Carleton University Ethics Approval:
October 28, 2002 (Renewed Oct.29/03)

Code

SURVEY FORM

CARE, TREATMENT AND SUPPORT ISSUES: CANADIAN ABORIGINAL PERSONS LIVING WITH HIV OR AIDS (2004)

The Canadian Aboriginal AIDS Network (CAAN) and Carleton University researchers set up this study. We want to learn if the care and treatment for Canadian Aboriginal people living with HIV or AIDS meet their needs. The study will help us suggest ways to improve services.

YOU are invited to be a part of this study if you are an Aboriginal person living with HIV or AIDS in Canada who is Inuit, Innu, Métis, or First Nations.

This survey is confidential. Do not put your name on the survey form.

The survey is in three (3) parts: 1) Basic Information; 2) Needs & Services; 3) In Your Own Words.

You do not have to answer a question if you do not want to. If you do not want to answer a question, check the "No Answer" box, or skip over and go to the next question.

If you have any questions about this survey, you may call between 8:30 am - 4:30 pm EST:

CAAN: Randy Jackson: **613-567-1817 ext.109**, or **1-888-285-2226**;
OR
Carleton University Researchers: Gwen Reimer (English) & JP Chartrand (Français): **613-830-7198**
(collect if you wish)

START HERE

PART 1: BASIC INFORMATION

Check ✓ or mark an X in the box beside your answer.

1. What is your status as an Aboriginal person?

Inuit	☐
Innu	☐
Métis	☐
First Nations, status	☐
First Nations, non-status	☐
Other (eg., Bill C-31, Treaty)	☐

(Please specify): ____________________

2. How is your health right now?

HIV positive, no symptoms ☐
HIV positive, some small health problems ☐
AIDS diagnosis, good health ☐
AIDS diagnosis, some small health problems ☐
AIDS diagnosis, serious health problems ☐
I do not know ☐
No answer ☐

3. What is your gender or sex?

Male ☐
Female ☐
Transgender (live as the opposite sex) ☐
Transsexual (sex-change operation) ☐
Inter-sexed (born with physical traits of both male and female) ☐
No answer ☐

4. Do you consider yourself to be Two-Spirit?

Yes ☐
No ☐
I do not know ☐
I do not understand this term ☐
No answer ☐

5. What is your sexual orientation?

Heterosexual (straight) ☐
Homosexual (gay or lesbian) ☐
Bisexual (like both sexes) ☐
Unsure of my sexual orientation ☐
No answer ☐

6. How old are you?

15 - 19 years ☐
20 - 29 years ☐
30 - 39 years ☐
40 - 49 years ☐
50 years or older ☐

7. Where do you live?

City ☐
Town, Village or Hamlet ☐
Rural/Isolated (Camp, Farm, etc.) ☐
On Reserve ☐
Other ☐

(Please specify): ______________________________

8. Do you feel you may need to move, or have you already moved, to be closer to HIV-related health services?

Yes, I feel I will need to move ☐
Yes, I have already moved ☐
Not sure if I may need to move in the future ☐
No need to move ☐
No answer ☐

9. Do you live in:

Private residence (eg., house, apartment) ☐
Hotel room or boarding house ☐
Emergency shelter ☐
Special care or nursing home ☐
Prison or Correctional Facility ☐
Homeless, with no address ☐
Other ☐
(Please specify): ______________________________

10. Which territory or province do you live in now?

Nunavut ☐
Northwest Territories ☐
Yukon ☐
British Columbia ☐
Alberta ☐
Saskatchewan ☐
Newfoundland & Labrador ☐
Manitoba ☐
Ontario ☐
Quebec ☐
New Brunswick ☐
Prince Edward Island ☐
Nova Scotia ☐

11. (a) Did you attend a Residential School?

Yes ☐
No ☐
No answer ☐

If yes, for how long? ____________________ (# of years)

(b) Did your parents, guardians or grandparents attend a Residential School?

	Yes	No	Do not know	No answer
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Guardian(s)	☐	☐	☐	☐
Grandparent(s)	☐	☐	☐	☐

(c) If you answered "yes" to questions (a) or (b) above, do you believe that this Residential School experience has affected your health?

Yes ☐
No ☐
Do not know ☐
No answer ☐

If yes, how or why has it affected your health?______________

12. How do you think you became infected with HIV?

Sexual contact ☐
Blood products or transfusion ☐
Sharing needle for injecting drugs ☐
Sharing other works (fits, pipes, etc.) ☐
Perinatal (born with HIV) ☐
Tattooing, Piercing, etc. ☐
Other ☐

(Please specify): ______________________________

I do not know ☐
No answer ☐

13. What was your last CD4, t-cell count?

Less than 50 ☐
50 to 200 ☐
201 to 300 ☐
301 to 500 ☐
More than 500 ☐
I do not know ☐
No answer ☐

14. What was your last viral load?

Undetected ☐
Less than 5000 ☐
Between 5001 and 10,000 ☐
Between 10,001 and 50,000 ☐
Between 50,001 and 100,000 ☐
More than 100,000 ☐
I do not know ☐
No answer ☐

15. Which of these drugs or treatments do you use? Check each one that you use.

I do not use any drugs or treatment ☐
Anti-retrovirals or HIV medicine given by a doctor ☐
Experimental drugs in a clinical trial ☐
Traditional Aboriginal medicines ☐
Complementary therapy (eg., massage, therapeutic touch) ☐
Alternative medicine (eg., herbal) ☐
Other ☐

(Please specify): ______________________________

PART 2: NEEDS AND SERVICES

INSTRUCTION PAGE

In this part of the survey, we want you to tell us about the services that you need or have used lately (in the last year or so). We want to know if the services meet your needs. If your needs are not met, we want to understand why.

Here is a list of reasons why a service might not meet your needs.

1. I do not trust this service to keep my HIV/AIDS confidential.
2. I do not know where to get this service.
3. I feel this service does not give good care.
4. I do not feel welcome at this service.
5. This service is not covered and it costs too much.
6. This service is too far away and I have no way to get there (no car, bus or cannot afford it).
7. This service does not exist where I live.
8. I feel too sick to use this service.
9. The service is often closed when I need it.
10. The HIV/AIDS care-person is often not there when I need them.
11. I have to wait too long for this service.
12. The service is not in my language.
13. I am worried that others will gossip if they see me use this service.

For this part of the survey, you can put a number from this list into the "Reason" box. Or you may write another reason in your own words. You may write more than one reason: for example, the main (1st) reason and the 2nd reason.

Here is an example:

Chris has gone to the nursing station a few times. The waiting room is always full and it can be an hour or two before he can see a doctor or nurse. Other people waiting ask why Chris is there, and he does not want to tell them. Chris feels the nursing station does not meet his needs very well.

Chris would answer the "NEEDS and SERVICES" part of the survey like this:

Did you need or use this service? Circle NO or YES			If YES, **did the service meet your needs?** Circle if it DID, SOMETIMES, or DID NOT meet your needs.			**REASON** If this service SOMETIMES or DID NOT meet your needs, **why**? You can give more than one reason.
Services				If SOMETIMES or DID NOT ☐ *(go to reason box)*		Use numbers from the list of reasons above or write the reason(s) in your own words.
Nursing Station	NO ☐ *(go to next service)*	[✓ YES ☐ *(go to needs section)*]	**DID** meet my needs	SOMETIMES meets my needs	[✓ DID NOT meet my needs]	11 ("wait too long") People talk about me. (or, Chris can use #13)

16. Traditional Services

Do you need or use traditional services such as Elders, traditional medicines, ceremonies, sharing circles, or a camp / retreat program?

If YES, complete this page. Tell us if your needs are met. If your needs are not met, tell us why.
If NO (you do not need or use any traditional services) skip to #17.

Some REASONS why a service might not meet your needs:

1. Don't trust confidentiality
2. Don't know where to get it
3. Feel it does not give good care
4. Do not feel welcome
5. Not covered; it costs too much
6. Too far away; no way to get there
7. Does not exist where I live
8. Feel too sick
9. Often closed
10. HIV/AIDS care-person is not there when needed
11. Have to wait too long
12. Not in my language
13. Others will gossip if they see me there

Did you need or use this service?			If YES, **did the service meet your needs?** Circle if it DID, SOMETIMES, or DID NOT meet your needs.			**Reason** If this service SOMETIMES or DID NOT meet your needs, **why?** You can give more than one reason.
Traditional Services				If SOMETIMES or DID NOT ☐		Use numbers from the list of reasons above or write the reason(s) in your own words.
Elders	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Traditional Medicines	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Ceremonies	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Sharing Circles or Support Groups	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Camp or Retreat type programs	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Other traditional service (please name it:) ____________	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	

17. Mainstream Medical Services

Do you need or use mainstream medical services such as a doctor, hospital emergency room, nursing station or health centre, dentist, optometrist, pharmacy or a drug plan?

If YES, complete this page. Tell us if your needs are met. If your needs are not met, tell us why.

If NO (you do not need or use any mainstream medical services) skip to #18.

Some REASONS why a service might not meet your needs:

1. Don't trust confidentiality
2. Don't know where to get it
3. Feel it does not give good care
4. Do not feel welcome
5. Not covered; it costs too much
6. Too far away; no way to get there
7. Does not exist where I live
8. Feel too sick
9. Often closed
10. HIV/AIDS care-person is not there when needed
11. Have to wait too long
12. Not in my language
13. Others will gossip if they see me there

Did you need or use this service?			If YES, **did the service meet your needs?** Circle if it DID, SOMETIMES, or DID NOT meet your needs.			**Reason** If this service SOMETIMES or DID NOT meet your needs, **why**? You can give more than one reason.
Medical Services				If SOMETIMES or DID NOT ☐		Use numbers from the list of reasons above or write the reason(s) in your own words.
Doctor	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Hospital Emergency	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Local Health Centre / Nursing Station	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Dentist	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Optician or Eye Doctor	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Pharmacy (prescriptions)	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Drug plan	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Other traditional service (please name it:) ____________	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	

18. Therapy and Diet Services

Do you need or use therapy and diet services such as a chiropractor, physiotherapist, massage therapist, alternative care (for example, homeopathy), marijuana, or a dietitian/nutritionist?

If YES, complete this page. Tell us if your needs are met. If your needs are not met, tell us why.

If NO (you do not need or use any therapy or diet services) skip to #19.

Some REASONS why a service might not meet your needs:

1. Don't trust confidentiality
2. Don't know where to get it
3. Feel it does not give good care
4. Do not feel welcome
5. Not covered; it costs too much
6. Too far away; no way to get there
7. Does not exist where I live
8. Feel too sick
9. Often closed
10. HIV/AIDS care-person is not there when needed
11. Have to wait too long
12. Not in my language
13. Others will gossip if they see me there

Did you need or use this service?			If YES, **did the service meet your needs?** Circle if it DID, SOMETIMES, or DID NOT meet your needs.			**REASON** If this service SOMETIMES or DID NOT meet your needs, **why**? You can give more than one reason.
Therapy & Diet Services				If SOMETIMES or DID NOT ☐		Use numbers from the list of reasons above or write the reason(s) in your own words.
Chiropractor	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Physio-therapist	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Massage Therapist	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Alternative Therapy (ex.Homeopathy)	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Marijuana (Pot for medical use)	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Dietician or Nutritionist	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Other therapy service (please name it:) ____________	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	

19. Social Services

Do you need or use social services such as a social worker, home nurse, hospice care, home care, child care, family planning or parenting skills programs?

If YES, complete this page. Tell us if your needs are met. If your needs are not met, tell us why.

If NO (you do not need or use any social services) skip to #20.

Some REASONS why a service might not meet your needs:

1. Don't trust confidentiality
2. Don't know where to get it
3. Feel it does not give good care
4. Do not feel welcome
5. Not covered; it costs too much
6. Too far away; no way to get there
7. Does not exist where I live
8. Feel too sick
9. Often closed
10. HIV/AIDS care-person is not there when needed
11. Have to wait too long
12. Not in my language
13. Others will gossip if they see me there

Did you need or use this service?			If YES, **did the service meet your needs?** Circle if it DID, SOMETIMES, or DID NOT meet your needs.			**Reason** If this service SOMETIMES or DID NOT meet your needs, **why**? You can give more than one reason.
Social Services				If SOMETIMES or DID NOT ☐		Use numbers from the list of reasons above or write the reason(s) in your own words.
Social Worker	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Home Nursing	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Hospice Care	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Professional Home Care	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Child Care	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Family Planning	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Parenting Skills	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Other social service (please name it:) ______________	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	

20. Addiction and Counselling Services

Do you need or use addiction or counselling services such as addiction treatment centres, harm reduction counselling, needle-exchanges, mental health care, AIDS treatment information, or health education?

If YES, complete this page. Tell us if your needs are met. If your needs are not met, tell us why.

If NO (you do not need or use any counselling or information services) skip to #21.

Some REASONS why a service might not meet your needs:

1. Don't trust confidentiality
2. Don't know where to get it
3. Feel it does not give good care
4. Do not feel welcome
5. Not covered; it costs too much
6. Too far away; no way to get there
7. Does not exist where I live
8. Feel too sick
9. Often closed
10. HIV/AIDS care-person is not there when needed
11. Have to wait too long
12. Not in my language
13. Others will gossip if they see me there

Did you need or use this service?			If YES, **did the service meet your needs?** Circle if it DID, SOMETIMES, or DID NOT meet your needs.			**Reason** If this service SOMETIMES or DID NOT meet your needs, **why**? You can give more than one reason.
Addiction/ Counselling Services				If SOMETIMES or DID NOT ☐		Use numbers from the list of reasons above or write the reason(s) in your own words.
Addiction Treatment & Counselling	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Harm Reduction Information	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Needle Exchange	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Mental Health Care	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
AIDS Treatment Information	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Health Education	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Other addiction / counselling (please name it:) ____________	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	

21. Support Services

Do you need or use support services such as Buddies, Drop-ins, Help-Line, church or spiritual care, grief counselling, financial counselling or legal advice?

If YES, complete this page. Tell us if your needs are met. If your needs are not met, tell us why.

If NO (you do not need or use any support services) skip to #22.

Some REASONS why a service might not meet your needs:

1. Don't trust confidentiality
2. Don't know where to get it
3. Feel it does not give good care
4. Do not feel welcome
5. Not covered; it costs too much
6. Too far away; no way to get there
7. Does not exist where I live
8. Feel too sick
9. Often closed
10. HIV/AIDS care-person is not there when needed
11. Have to wait too long
12. Not in my language
13. Others will gossip if they see me there

Did you need or use this service?			If YES, **did the service meet your needs?** Circle if it DID, SOMETIMES, or DID NOT meet your needs.			**Reason** If this service SOMETIMES or DID NOT meet your needs, **why**? You can give more than one reason.
Support Services				If SOMETIMES or DID NOT ☐		Use numbers from the list of reasons above or write the reason(s) in your own words.
Buddies	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Drop-Ins	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Help-Line	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Church or Spiritual Care	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Grief and Bereavement Counselling	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Financial Counselling	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Legal Advice / Support	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	
Other support service (please name it:) ______	NO ☐	YES ☐	**DID** meet my needs	SOMETIMES meets my needs	DID **NOT** meet my needs	

PART 3: IN YOUR OWN WORDS

22. What is the best way that services can be improved for you, as an Aboriginal person living with HIV or AIDS?

23. Do you have any other comments for us about AIDS care, treatment or support services?

THE END

How to hand in your survey form:

1. When you are finished filling out this survey, put it in the large brown envelope #2.

2. Seal the envelope and write some 'X's across the seals. This tells us that no one else has opened it.

3. Return this envelope and the Consent Form (in the small white envelope #1) to the person who gave you the survey at your agency. They will mail these for you, and they will give you $20 to say...

...Thank you for your participation!

APPENDIX B
FREQUENCY & CROSS-TABULATION TABLES

TABLES 1 - 21: CHARACTERISTICS OF THE APHA PARTICIPANTS

TABLE 1. Aboriginal Identity (Frequency)

	Frequency	Percent	Valid Percent	Cumulative Percent
Inuit	5	2.6	2.6	2.6
Innu	4	2.1	2.1	4.6
Métis	30	15.4	15.4	20.0
First Nation, status	129	66.2	66.2	86.2
First Nation, non-status	19	9.7	9.7	95.9
First Nation, Bill C-31	7	3.6	3.6	99.5
Other	1	.5	.5	100.0
Total	195	100.0	100.0	

TABLE 2A. Geographic Region: Province/Territory (Frequency; Original)

	Frequency	Percent	Valid Percent	Cumulative Percent
Northwest Territories	1	.5	.5	.5
Yukon Territory	8	4.1	4.1	4.6
British Columbia	46	23.6	23.6	28.2
Alberta	34	17.4	17.4	45.6
Saskatchewan	23	11.8	11.8	57.4
Manitoba	30	15.4	15.4	72.8
Ontario	34	17.4	17.4	90.3
Quebec	17	8.7	8.7	99.0
New Brunswick	2	1.0	1.0	100.0
TOTAL	**195**	**100.0**	**100.0**	

TABLE 2B. Geographic Region (Frequency; Re-coded)

	Frequency	Percent	Valid Percent	Cumulative Percent
North	9	4.6	4.6	4.6
Quebec/Atlantic	19	9.7	9.7	14.4
Ontario	34	17.4	17.4	31.8
British Columbia	46	23.6	23.6	55.4
Alberta	34	17.4	17.4	72.8
Saskatchewan	23	11.8	11.8	84.6
Manitoba	30	15.4	15.4	100.0
TOTAL	**195**	**100.0**	**100.0**	

TABLE 3. Settlement Type (Frequency)

	Frequency	Percent	Valid Percent	Cumulative Percent
City	171	87.7	88.6	88.6
Town, Village, Hamlet	10	5.1	5.2	93.8
Rural/Isolated	2	1.0	1.0	94.8
On Reserve	5	2.6	2.6	97.4
Mobile (eg., City & Reserve)	4	2.1	2.1	99.5
Institution (eg., Prison)	1	.5	.5	100.0
TOTAL	**193**	**99.0**	**100.0**	
Missing: NR	2	1.0		
TOTAL	**195**	**100.0**		

TABLE 4A. Need to Move to be Nearer to Services (Frequency; Original)

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes, need to move	32	16.4	18.4	18.4
Yes, have moved	43	22.1	24.7	43.1
Not sure	24	12.3	13.8	56.9
No need to move	75	38.5	43.1	100
TOTAL	**174**	**89.2**	**100**	
Missing NR	21	10.8		
TOTAL	**195**	**100.0**		

TABLE 4B. Need to Move to be Nearer to Services (Frequency; Re-coded)

	Frequency	Percent	Valid Percent	Cumulative Percent
Unsure or Need to Move	56	28.7	32.2	32.2
Have moved	43	22.1	24.7	56.9
No need to move	75	38.5	43.1	100.0
Total	174	89.2	100.0	
Missing: NR	21	10.8		
TOTAL	**195**	**100.0**		

TABLE 5. Housing (Frequency)

	Frequency	Percent	Valid Percent	Cumulative Percent
Private	137	70.3	70.3	70.3
Hotel/Boarding House	20	10.3	10.3	80.5
Shelter/Homeless	26	13.3	13.3	93.8
Care/Nursing Home	2	1.0	1	94.9
Prison/Corrections	4	2.1	2.1	96.9
HIV/AIDS Support Housing	2	1.0	1	97.9
Low Income Housing	2	1	1	99.0
Family/Friends	2	1	1	100
TOTAL	**195**	**100.0**	**100**	

TABLE 6. Age Group (Frequency)

Years	Frequency	Percent	Valid Percent	Cumulative Percent
15-19	1	.5	.5	0.5
20-29	26	13.3	13.4	13.9
30-39	79	40.5	40.7	54.6
40-49	78	40.0	40.2	94.8
50 plus	10	5.1	5.2	100.0
TOTAL	**194**	**99.5**	**100.0**	
Missing NR	1	.5		
TOTAL	**195**	**100.0**		

TABLE 7. Gender (Frequency)

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	113	57.9	58.2	58.2
Female	74	37.9	38.1	96.4
Transgender	4	2.1	2.1	98.5
Inter-sexed	3	1.5	1.5	100.0
TOTAL	**194**	**99.5**	**100.0**	
Missing: NR	1	.5		
TOTAL	**195**	**100.0**		

TABLE 8. Sexual Orientation (Frequency)

	Frequency	Percent	Valid Percent	Cumulative Percent
Heterosexual	102	52.3	54.5	54.5
Homosexual	51	26.2	27.3	81.8
Bisexual	31	15.9	16.6	98.4
Unsure	3	1.5	1.6	100.0
TOTAL	**187**	**95.9**	**100.0**	
Missing NR	8	4.1		
TOTAL	**195**	**100.0**		

TABLE 9. Gender and Sexual Orientation (Cross-tabulation)

	Male	Female	Transgender	Inter-sexed	NR	Total
Heterosexual	40	62				102
Homosexual	45	3	1	2		51
Bisexual	24	7				31
Unsure	2	1				3
NR	2	1	3	1	1	8
TOTAL	**113**	**74**	**4**	**3**	**1**	**195**

TABLE 10. Two-Spirit (Frequency)

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	85	43.6	45.7	45.7
No	78	40.0	41.9	87.6
Do not know	4	2.1	2.2	89.8
Do not understand this term	19	9.7	10.2	100.0
TOTAL	**186**	**95.4**	**100.0**	
Missing: NR	9	4.6		
TOTAL	**195**	**100.0**		

TABLE 11. Transmission Category (Frequency)

	Frequency	Percent	Valid Percent	Cumulative Percent
Sexual contact	92	47.2	52.3	52.3
Blood product/contamination	7	3.6	4	56.3
IDU/Works/Tattoo	52	26.7	29.5	85.8
Sexual contact &/or IDU &/or Blood contamination	25	12.8	14.2	100
TOTAL	**176**	**90.3**	**100.0**	
Missing: Do not know/NR	19	9.7		
TOTAL	**195**	**100.0**		

TABLE 12A. Self-reported Health Status (Frequency; Original)

	Frequency	Percent	Valid Percent	Cumulative Percent
HIV+, no symptoms	68	34.9	35.4	35.4
HIV+, minor problems	93	47.7	48.4	83.9
AIDS, good health	12	6.2	6.3	90.1
AIDS, minor problems	6	3.1	3.1	93.2
AIDS, serious problems	5	2.6	2.6	95.8
Do not know	8	4.1	4.2	100
TOTAL	**192**	**98.5**	**100.0**	
Missing NR	3	1.5		
TOTAL	**195**	**100.0**		

TABLE 12B. Self-reported Health Status (Frequency; Re-coded)

	Frequency	Percent	Valid Percent	Cumulative Percent
HIV+	161	82.6	87.5	87.5
AIDS	23	11.8	12.5	100
TOTAL	**184**	**94.4**	**100**	
Missing: Do not Know/NR	11	5.6		
TOTAL	**195**	**100.0**		

TABLE 13A. CD4 T-Cell Count (Frequency; Original)

	Frequency	Percent	Valid Percent	Cumulative Percent
Less than 50	10	5.1	5.3	5.3
50-200	43	22.1	22.8	28.0
201-300	31	15.9	16.4	44.4
301-500	28	14.4	14.8	59.3
500 or more	21	10.8	11.1	70.4
Do not know	56	28.7	29.6	100.0
TOTAL	**189**	**96.9**	**100.0**	
Missing: NR	6	3.1		
TOTAL	**195**	**100.0**		

TABLE 13B. CD4 T-Cell Count (Frequency; Re-coded)

	Frequency	Percent	Valid Percent	Cumulative Percent
Serious (Under 200)	53	27.2	39.8	39.8
Not Serious (Over 200)	80	41.0	60.2	100
TOTAL	**133**	**68.2**	**100.0**	
Missing: Do not Know/NR	62	31.8		
TOTAL	**195**	**100.0**		

TABLE 14A. Viral Load (Frequency; Original)

	Frequency	Percent	Valid Percent	Cumulative Percent
Undetected	52	26.7	27.4	27.4
Under 5,000	37	19.0	19.5	46.8
5,001-10,000	8	4.1	4.2	51.1
10,001-50,000	9	4.6	4.7	55.8
50,001-100,000	8	4.1	4.2	60.0
Over 100,000	6	3.1	3.2	63.2
Do not know	70	35.9	36.8	100.0
TOTAL	**190**	**97.4**	**100.0**	
Missing: NR	5	2.6		
TOTAL	**195**	**100.0**		

TABLE 14B. Viral Load (Frequency; Re-coded)

	Frequency	Percent	Valid Percent	Cumulative Percent
Serious (Over 10,000)	23	11.8	19.2	19.2
Not Serious (Under 10,000)	97	49.7	80.8	100
TOTAL	**120**	**61.5**	**100**	
Missing: Do not Know/NR	75	38.5		
TOTAL	**195**	**100.0**		

TABLE 15. CD4 T-Cell Count & Viral Load Index (Index)

	Frequency	Percent	Valid Percent	Cumulative Percent
Not Serious (CD4 & Viral)	58	29.7	51.3	51.3
Serious (CD4 or Viral)	47	24.1	41.6	92.9
Very Serious (CD4 & Viral)	8	4.1	7.1	100.0
TOTAL	**113**	**57.9**	**100.0**	
Missing: Do not know/NR	82	42.1		
TOTAL	**195**	**100.0**		

TABLE 16. Drugs, Treatment & Therapy (Multiple Response Frequency)

Responses	Count	Percent of Responses	Percent of Valid Cases
Anti-retrovirals/HIV prescription drugs	91	38.4	48.1
Clinical trial drugs	9	3.8	4.8
Traditional Aboriginal medicines	21	8.9	11.1
Complementary therapy	10	4.2	5.3
Alternative medicine (incl. marijuana)	17	7.2	9
Drug Holiday	3	1.3	1.6
No drugs / treatment	70	29.5	37
No Rx. drugs/Alternative therapies only	12	5.1	6.3
TOTAL RESPONSES	**235**	**100**	**123.3**
(6 missing cases; 189 valid cases)			
Multiple Response Cases			
Use of 2 drugs, treatments or therapies	41	17.5	21.7
Use of 3 drugs, treatments or therapies	7	3.0	3.7
TOTAL	**48**	**20.5**	**25.4**

TABLE 17. APHA Attended Residential School (Frequency)

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	32	16.4	16.7	16.7
No	160	82.1	83.3	100.0
TOTAL	**192**	**98.5**	**100.0**	
Missing: NR	3	1.5		
TOTAL	**195**	**100.0**		

TABLE 18. Years attended Residential School (Frequency; Re-coded)

	Frequency	Percent	Valid Percent	Cumulative Percent
2 years or less	10	5.1	33.3	33.3
3-5 years	7	3.6	23.3	56.7
6-8 years	7	3.6	23.3	80.0
9 years or more	6	3.1	20.0	100.0
TOTAL	**30**	**15.4**	**100.0**	
Missing: NA/NR	165	84.6		
TOTAL	**195**	**100.0**		

TABLE 19. Parent attended Residential School (Index)

	Frequency	Percent	Valid Percent	Cumulative Percent
Neither mother nor father attended	54	27.7	49.1	49.1
One parent attended	16	8.2	14.5	63.6
Both parents attended	40	20.5	36.4	100.0
TOTAL	**110**	**56.4**	**100.0**	
Missing: Do not know/NR	85	43.6		
TOTAL	**195**	**100.0**		

TABLE 20. Parent/Guardian/Grandparent attended Residential School (Index)

	Frequency	Percent	Valid Percent	Cumulative Percent
No grand- &/or parent attended	20	10.3	54.1	54.1
One grand- &/or parent attended	6	3.1	16.2	70.3
Two grand- &/or parents attended	2	1.0	5.4	75.7
Three grand- &/or parents attended	2	1.0	5.4	81.1
Four grand-/parents attended	7	3.6	18.9	100.0
TOTAL	**37**	**19.0**	**100.0**	
Missing: Do not know/NR	158	81.0		
TOTAL	**195**	**100.0**		

TABLE 21. Health Effects of Residential School (Multiple Response Frequency)

Responses	Count	Percent of Responses	Percent of Valid Cases
Poor mental health (psychological/physical abuse)	18	26.1	41.9
Addictions ('generational')	7	10.1	16.3
Low self-esteem	6	8.7	14.0
Unhealthy sexuality/sexual abuse	2	2.9	4.7
High-risk choices/behaviour	9	13.0	20.9
Lack of parenting/skills	7	10.1	16.3
Distrust of institutions (eg., doctor)	1	1.4	2.3
Loss of culture/language/identity	1	1.4	2.3
Family breakdown	3	4.3	7.0
Miscellaneous/Relevance unclear	15	21.7	34.9
TOTAL RESPONSES	**69**	**100.0**	**160.5**
(152 missing cases; 43 valid cases)			

TABLES 22 - 42: TRADITIONAL ABORIGINAL SERVICES

TABLE 22. Summary of Use/Need of Traditional Aboriginal Services (Frequency)

Used and/or Needed Service	One or more Traditional Aboriginal Services	Elders	Traditional Medicine	Ceremonies	Sharing / Healing Circles	Camps / Retreats
Frequency	118	68	59	72	88	52
Percent [n=195]	60.5	34.9	30.3	36.9	45.1	26.7

TABLE 23. Summary of Needs Met by Traditional Aboriginal Services (Frequency; Percent of Valid Respondents)

Did this service meet your needs?	Traditional Aboriginal Category (% Multiple Responses)	Elders [n=65]	Traditional Medicine [n=59]	Ceremonies [n=71]	Sharing/ Healing Circles [n=85]	Camps / Retreats [n=50]
Needs met	64.2	58.5	57.6	71.8	64.7	68.0
Needs sometimes or not met	35.8	41.5	42.4	28.2	35.3	32.0

TABLE 24. Summary of Barriers to Traditional Aboriginal Services (Multiple Response Frequency / Percent Valid Respondents)

Barrier / Reason	Traditional Aboriginal Category [n=61]	Elders [n=34]	Traditional Medicine [n=25]	Ceremonies [n=27]	Sharing/ Healing Circles [n=33]	Camps / Retreats [n=18]
Unknown/Nonexisting	57.4	23.5	24.0	25.9	15.2	50.0
Confidentiality/Privacy issues	16.4	5.9	–	–	24.2	–
Logistical Access Barriers	41.0	29.4	16.0	18.5	15.2	5.6
Inadequate Care/Performance	18.0	14.7	–	14.8	6.1	–
Stigma/Discrimination	13.1	5.9	4.0	7.4	9.1	–
Financial Barriers	1.6	–	4.0	–	–	–
Personal Issues/Barriers	9.8	–	8.0	3.7	6.1	5.6
Service-specific Barriers	8.2	–	16.0	–	3.0	–
Positive Evaluation (unsolicited)	72.1	32.4	28.0	25.9	33.3	44.4

Note: Miscellaneous/Other responses excluded.

TABLE 25. Traditional Services * Aboriginal Identity (Cross-tabulation)

			Aboriginal Identity (Recoded)				Total
			Inuit; Innu*	Métis	First Nation Status/Bill C-31	First Nation Non-Status	
Traditional Services	No	Count	6	18	44	8	76
		% within Aboriginal Identity	66.7%	60.0%	32.4%	42.1%	39.2%
	Yes	Count	3	12	92	11	118
		% within Aboriginal Identity	33.3%	40.0%	67.6%	57.9%	60.8%
Total		**COUNT**	**9**	**30**	**136**	**19**	**194**
		% within Aboriginal Identity	100.0%	100.0%	100.0%	100.0%	100.0%

* Due to the small sample sizes, Inuit and Innu respondents are combined for statistical analysis purposes; there is no intent to diminish the cultural distinctions between these two Aboriginal peoples.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.039a	3	.012
Likelihood Ratio	10.850	3	.013
Linear-by-Linear Association	5.859	1	.016
N of Valid Cases	194		

a 1 cells (12.5%) have expected count less than 5. The minimum expected count is 3.53.

TABLE 26. Traditional Services * Self-Reported CD4 T-Cell Count (Cross-tabulation)

			CD4 T Cell Count (Re-coded)		Total
			Serious (Under 200)	Not Serious (Over 200)	
Traditional Services	No	Count	25	24	**49**
		% within CD4 T-Cell	47.2%	30.0%	**36.8%**
	Yes	Count	28	56	**84**
		% within CD4 T-Cell	52.8%	70.0%	**63.2%**
Total		**COUNT**	**53**	**80**	**133**
		% within CD4 T-Cell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.039b	1	.044		
Continuity Correctiona	3.335	1	.068		
Likelihood Ratio	4.015	1	.045		
Fisher's Exact Test				.066	.034
Linear-by-Linear Association	4.009	1	.045		
N of Valid Cases	133				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 19.53.

TABLE 27. Use/Need Elder Services * Aboriginal Identity (Cross-tabulation)

			Aboriginal Identity				Total
			Inuit; Innu*	Métis	First Nation, Status & Bill C-31	First Nation, Non Status	
Elders	No	Count	7	25	81	13	**126**
		% within Aboriginal Identity	77.8%	83.3%	59.6%	68.4%	**64.9%**
	Yes	Count	2	5	55	6	**68**
		% within Aboriginal Identity	22.2%	16.7%	40.4%	31.6%	**35.1%**
Total		**COUNT**	**9**	**30**	**136**	**19**	**194**
		% within Aboriginal Identity	100.0%	100.0%	100.0%	100.0%	100.0%

* Due to the small sample sizes, Inuit and Innu respondents are combined for statistical analysis purposes; there is no intent to diminish the cultural distinctions between these two Aboriginal peoples.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.941a	3	.074
Likelihood Ratio	7.531	3	.057
Linear-by-Linear Association	2.781	1	.095
N of Valid Cases	194		

a 1 cells (12.5%) have expected count less than 5. The minimum expected count is 3.15.

TABLE 28. Needs Met by Elder Services * Aboriginal Identity (Cross-tabulation)

			Aboriginal Identity				Total
			Inuit; Innu*	Métis	First Nation, Status & Bill C-31	First Nation, Non Status	
Elder Needs Met	Did meet needs	Count		1	35	2	38
		% within Aboriginal Identity		25.0%	66.0%	33.3%	58.5%
	Sometimes/ Did not meet needs	Count	2	3	18	4	27
		% within Aboriginal Identity	100.0%	75.0%	34.0%	66.7%	41.5%
Total		**COUNT**	**2**	**4**	**53**	**6**	**65**
		% within Aboriginal Identity	100.0%	100.0%	100.0%	100.0%	100.0%

* Due to the small sample sizes, Inuit and Innu respondents are combined for statistical analysis purposes; there is no intent to diminish the cultural distinctions between these two Aboriginal peoples.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.472a	3	.058
Likelihood Ratio	8.179	3	.042
Linear-by-Linear Association	1.064	1	.302
N of Valid Cases	65		

a 6 cells (75.0%) have expected count less than 5. The minimum expected count is .83.

TABLE 29. Needs Met by Elder Services * Region (Cross-tabulation)

			Geographic Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Elder Needs Met	Did meet needs	Count	1	1	4	10	9	5	8	38
		% within Region	50.0%	20.0%	30.8%	66.7%	69.2%	83.3%	72.7%	58.5%
	Sometimes/ Did not meet needs	Count	1	4	9	5	4	1	3	27
		% within Region	50.0%	80.0%	69.2%	33.3%	30.8%	16.7%	27.3%	41.5%
Total		**COUNT**	**2**	**5**	**13**	**15**	**13**	**6**	**11**	**65**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.697a	6	.098
Likelihood Ratio	10.972	6	.089
Linear-by-Linear Association	6.769	1	.009
N of Valid Cases	65		

a 7 cells (50.0%) have expected count less than 5. The minimum expected count is .83.

TABLE 30. Use/Need Traditional Medicines * Aboriginal Identity (Cross-tabulation)

			Aboriginal Identity				Total
			Inuit; Innu*	Métis	First Nation, Status & Bill C-31	First Nation, Non-Status	
Traditional Medicines	No	Count	9	25	85	16	135
		% within Aboriginal Identity	100.0%	83.3%	62.5%	84.2%	69.6%
	Yes	Count		5	51	3	59
		% within Aboriginal Identity		16.7%	37.5%	15.8%	30.4%
Total		**COUNT**	**9**	**30**	**136**	**19**	**194**
		% within Aboriginal Identity	100.0%	100.0%	100.0%	100.0%	100.0%

* Due to the small sample sizes, Inuit and Innu respondents are combined for statistical analysis purposes; there is no intent to diminish the cultural distinctions between these two Aboriginal peoples.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.760a	3	.008
Likelihood Ratio	14.802	3	.002
Linear-by-Linear Association	2.710	1	.100
N of Valid Cases	194		

a 1 cells (12.5%) have expected count less than 5. The minimum expected count is 2.74.

TABLE 31. Use/Need Traditional Medicines * Gender (Cross-tabulation)

			Gender (Male/Female)*		Total
			Male	Female	
Traditional Medicines	No	Count	73	58	131
		% within Gender	64.6%	78.4%	70.1%
	Yes	Count	40	16	56
		% within Gender	35.4%	21.6%	29.9%
Total		**COUNT**	**113**	**74**	**187**
		% within Gender	100.0%	100.0%	100.0%

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 2 (28.6%) participants indicate they need/use traditional medicines; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.046b	1	.044		
Continuity Correctiona	3.415	1	.065		
Likelihood Ratio	4.154	1	.042		
Fisher's Exact Test				.051	.031
Linear-by-Linear Association	4.024	1	.045		
N of Valid Cases	187				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 22.16.

TABLE 32. Needs Met by Traditional Medicines * Gender (Cross-tabulation)

			Gender (Male/Female)*		Total
			Male	Female	
Traditional Medicine Needs Met	Did meet needs	Count	27	6	33
		% within Gender	67.5%	37.5%	58.9%
	Sometimes/Did not meet needs	Count	13	10	23
		% within Gender	32.5%	62.5%	41.1%
Total		**COUNT**	**40**	**16**	**56**
		% within Gender	100.0%	100.0%	100.0%

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 1 participant indicated their needs were not met by traditional medicines; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.250b	1	.039		
Continuity Correctiona	3.101	1	.078		
Likelihood Ratio	4.221	1	.040		
Fisher's Exact Test				.070	.040
Linear-by-Linear Association	4.174	1	.041		
N of Valid Cases	56				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.57.

TABLE 33. Use/Need Traditional Medicines * Viral Load (Cross-tabulation)

			Viral Load		Total
			Serious (Over 10,000)	Not Serious (Under 10,000)	
Traditional Medicine	No	Count	11	68	79
		% within Viral Load	47.8%	70.1%	65.8%
	Yes	Count	12	29	41
		% within Viral Load	52.2%	29.9%	34.2%
Total		**COUNT**	**23**	**97**	**120**
		% within Viral Load	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.102b	1	.043		
Continuity Correctiona	3.171	1	.075		
Likelihood Ratio	3.933	1	.047		
Fisher's Exact Test				.053	.039
Linear-by-Linear Association	4.068	1	.044		
N of Valid Cases	120				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.86.

TABLE 34. Use/Need Traditional Ceremonies * Aboriginal Identity (Cross-tabulation)

			Aboriginal Identity				Total
			Inuit; Innu*	Métis	First Nation, Status & Bill C-31	First Nation, Non-Status	
Ceremony	No	Count	7	26	76	13	122
		% within Aboriginal Identity	77.8%	86.7%	55.9%	68.4%	62.9%
	Yes	Count	2	4	60	6	72
		% within Aboriginal Identity	22.2%	13.3%	44.1%	31.6%	37.1%
Total		COUNT	**9**	**30**	**136**	**19**	**194**
		% within Aboriginal Identity	100.0%	100.0%	100.0%	100.0%	100.0%

* Due to the small sample sizes, Inuit and Innu respondents are combined for statistical analysis purposes; there is no intent to diminish the cultural distinctions between these two Aboriginal peoples.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.232a	3	.011
Likelihood Ratio	12.465	3	.006
Linear-by-Linear Association	4.058	1	.044
N of Valid Cases	194		

a 1 cells (12.5%) have expected count less than 5. The minimum expected count is 3.34.

TABLE 35. Needs Met by Traditional Ceremonies * CD4 T-Cell Count/Viral Load Index (Cross-tabulation)

			CD4 T-Cell Count / Viral Load Index		Total
			Not Serious	Serious - Very Serious	
Ceremony Needs Met	Did meet needs	Count	13	19	32
		% within CD4-Viral Index	59.1%	82.6%	71.1%
	Sometimes /Did not meet needs	Count	9	4	13
		% within CD4-Viral Index	40.9%	17.4%	28.9%
Total		**COUNT**	**22**	**23**	**45**
		% within CD4-Viral Index	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.027b	1	.082		
Continuity Correctiona	1.991	1	.158		
Likelihood Ratio	3.083	1	.079		
Fisher's Exact Test				.108	.079
Linear-by-Linear Association	2.960	1	.085		
N of Valid Cases	45				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.36.

TABLE 36. Use/Need Sharing/Healing Circles * Aboriginal Identity (Cross-tabulation)

			Aboriginal Identity				Total
			Inuit; Innu*	Métis	First Nation, Status & Bill C-31	First Nation, Non-Status	
Sharing/ Healing Circle	No	Count	7	21	69	9	106
		% within Aboriginal Identity	77.8%	70.0%	50.7%	47.4%	54.6%
	Yes	Count	2	9	67	10	88
		% within Aboriginal Identity	22.2%	30.0%	49.3%	52.6%	45.4%
Total		**COUNT**	**9**	**30**	**136**	**19**	**194**
		% within Aboriginal Identity	100.0%	100.0%	100.0%	100.0%	100.0%

* Due to the small sample sizes, Inuit and Innu respondents are combined for statistical analysis purposes; there is no intent to diminish the cultural distinctions between these two Aboriginal peoples.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.042a	3	.110
Likelihood Ratio	6.288	3	.098
Linear-by-Linear Association	5.131	1	.024
N of Valid Cases	194		

a 2 cells (25.0%) have expected count less than 5. The minimum expected count is 4.08.

TABLE 37. Comparison of Traditional Service Use by Aboriginal Identity (Cross-tabulations)

		Inuit [n=5]	Innu [n=4]	Métis [n=30]	First Nation, Status [n=136]	First Nation, Non-Status [n=19]	Total [n=194]*
Traditional Service Category	Count	2	1	12	92	11	118
	% within Aboriginal Identity	40	25	40	67.6	57.9	60.8
Elders	Count	1	1	5	55	6	68
	% within Aboriginal Identity	20	25	16.7	40.4	31.6	35.1
Traditional Medicines	Count	–	–	5	51	3	59
	% within Aboriginal Identity	0	0	16.7	37.5	15.8	30.4
Ceremonies	Count	1	1	4	60	6	72
	% within Aboriginal Identity	20	25	13.3	44.1	31.6	37.1
Sharing / Healing Circles	Count	2	–	9	67	10	88
	% within Aboriginal Identity	40	0	30	49.3	52.6	45.4
Camps / Retreats	Count	1	–	5	42	4	52
	% within Aboriginal Identity	20	0	16.7	30.9	21.1	26.8

* NR = 1

TABLE 38. Use/Need Traditional Camps / Retreats * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec / Atlantic	ON	BC	AB	SK	MB	
Camp / Retreat	No	Count	8	17	23	27	30	16	22	143
		% within Region	88.9%	89.5%	67.6%	58.7%	88.2%	69.6%	73.3%	73.3%
	Yes	Count	1	2	11	19	4	7	8	52
		% within Region	11.1%	10.5%	32.4%	41.3%	11.8%	30.4%	26.7%	26.7%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.275a	6	0.039
Likelihood Ratio	14.231	6	.027
Linear-by-Linear Association	.233	1	.630
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 2.40.

TABLE 39. Use/Need Traditional Camps / Retreats * Age (Cross-tabulation)

			Age			Total
			15-29 years	30-39 years	40-50+ years	
Camp / Retreat	No	Count	26	56	61	143
		% within Age	96.3%	70.9%	69.3%	73.7%
	Yes	Count	1	23	27	51
		% within Age	3.7%	29.1%	30.7%	26.3%
Total		Count	27	79	88	194
		% within Age	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.309a	2	.016
Likelihood Ratio	11.145	2	0.004
Linear-by-Linear Association	5.319	1	0.021
N of Valid Cases	194		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.10.

TABLE 40. Needs Met by Traditional Camps / Retreats * Age (Cross-tabulation)

			Age			Total
			15-29 years	30-39 years	40-50+ years	
Camp Needs Met	Did meet needs	Count		18	15	33
		% within Age		90.0%	55.6%	67.3%
	Sometimes /Did not meet needs	Count	2	2	12	16
		% within Age	100.0%	10.0%	44.4%	32.7%
Total		**COUNT**	**2**	**20**	**27**	**49**
		% within Age	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.499a	2	.005
Likelihood Ratio	11.807	2	.003
Linear-by-Linear Association	.925	1	.336
N of Valid Cases	49		

a 2 cells (33.3%) have expected count less than 5. The minimum expected count is .65.

TABLE 41. Use/Need Traditional Camps / Retreats * Transmission Category (Cross-tabulation)

			Transmission Category				Total
			Sexual contact	Blood product/ contamination	IDU / Works / Tattoo	Sexual contact &/or IUD &/or Blood product	
Camp / Retreat	No	Count	61	6	45	19	131
		% within Transmission Category	66.3%	85.7%	86.5%	76.0%	74.4%
	Yes	Count	31	1	7	6	45
		% within Transmission Category	33.7%	14.3%	13.5%	24.0%	25.6%
Total		**COUNT**	**92**	**7**	**52**	**25**	**176**
		% within Transmission Category	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.699a	3	.053
Likelihood Ratio	8.151	3	.043
Linear-by-Linear Association	4.548	1	.033
N of Valid Cases	176		

a 1 cells (12.5%) have expected count less than 5. The minimum expected count is 1.79.

TABLE 42. Needs Met by Traditional Camps / Retreats * CD4 T-Cell Count / Viral Load Index (Cross-tabulation)

			CD4 T-Cell / Viral Index		Total
			Not Serious	Serious Very Serious	
Camp Needs Met	Did meet needs	Count	14	13	27
		% within CD4 T-Cell / Viral Index	60.9%	92.9%	73.0%
	Sometimes / Did not meet needs	Count	9	1	10
		% within CD4 T-Cell / Viral Index	39.1%	7.1%	27.0%
Total		**COUNT**	**23**	**14**	**37**
		% within CD4 T-Cell / Viral Index	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.515b	1	.034		
Continuity Correctiona	3.039	1	.081		
Likelihood Ratio	5.187	1	.023		
Fisher's Exact Test				.056	.036
Linear-by-Linear Association	4.393	1	.036		
N of Valid Cases	37				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.78.

TABLES 43 - 58: PRIMARY MEDICAL SERVICES

TABLE 43. Summary of Use/Need of Primary Medical Services

Used and/or Needed Service	One or more Primary Medical Services	Physician	Emergency	Local Health Centre	Pharmacy	Drug Plan
Frequency	172	167	117	84	158	101
Percent [n=195]	88.2	85.6	60.0	43.1	81.0	51.8

TABLE 44. Summary of Needs Met by Primary Medical Services (Percent of Valid Respondents)

Did this service meet your needs?	Primary Medical Category (% Multiple Responses)	Physician [n=158]	Emergency [n=110]	Local Health Centre [n=81]	Pharmacy [n=146]	Drug Plan [n=91]
Needs met	75.1	73.4	65.5	61.7	88.4	80.2
Needs sometimes or not met	24.9	26.6	34.5	38.3	11.6	19.8

TABLE 45. Summary of Barriers to Primary Medical Services
(Multiple Response Frequencies / Percent of Valid Respondents)

Barrier / Reason	Primary Medical Category [n=63]	Physician [n=34]	Emergency [n=28]	Local Health Centre [n=27]	Pharmacy [n=20]	Drug Plan [n=19]
Unknown/Nonexisting	7.9	5.9	–	3.7	–	10.5
Confidentiality/ Privacy issues	23.8	5.9	14.3	18.5	10.0	10.5
Logistical Access Barriers	52.4	26.5	53.6	25.9	10.0	–
Inadequate Care/ Performance	46.0	38.2	25.0	29.6	5.0	–
Stigma/Discrimination	30.2	14.7	25.0	14.8	15.0	–
Financial Barriers	28.6	2.9	–	_	15.0	73.7
Personal Issues/Barriers	6.3	5.9	–	3.7	–	5.3
Service-specific Barriers	12.7	8.8	–	3.7	15.0	5.3
Positive Evaluation (unsolicited)	41.3	29.4	14.3	18.5	30.0	5.3

Note: Miscellaneous/Other responses excluded.

TABLE 46. Use/Need of Primary Medical Services * CD4 T-Cell / Viral Load Index (Cross-tabulation)

			CD4-Viral Index		Total
			Not Serious	Serious - Very Serious	
Primary Medical Services	No	Count	1	7	8
		% within CD4 T-Cell/Viral Index	1.7%	12.7%	7.1%
	Yes	Count	57	48	105
		% within CD4 T-Cell/Viral Index	98.3%	87.3%	92.9%
Total		**COUNT**	**58**	**55**	**113**
		% within CD4 T-Cell/Viral Index	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.195b	1	.023		
Continuity Correctiona	3.657	1	.056		
Likelihood Ratio	5.755	1	.016		
Fisher's Exact Test				.029	.025
Linear-by-Linear Association	5.149	1	.023		
N of Valid Cases	113				

a Computed only for a 2x2 table

b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.89.

TABLE 47. Use/Need of Physician * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec / Atlantic	ON	BC	AB	SK	MB	
Physician	No	Count	4	2	6	3	8	2	3	28
		% within Region	44.4%	10.5%	17.6%	6.5%	23.5%	8.7%	10.0%	14.4%
	Yes	Count	5	17	28	43	26	21	27	167
		% within Region	55.6%	89.5%	82.4%	93.5%	76.5%	91.3%	90.0%	85.6%
Total		Count	9	19	34	46	34	23	30	195
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.837a	6	.046
Likelihood Ratio	11.241	6	.081
Linear-by-Linear Association	1.807	1	.179
N of Valid Cases	195		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is 1.29.

TABLE 48. Use/Need of Physician * CD4 T-Cell / Viral Load Index (Cross-tabulation)

			CD4-Viral Index		Total
			Not Serious	Serious - Very Serious	
Physician	No	Count	3	9	12
		% within CD4-Viral Index	5.2%	16.4%	10.6%
	Yes	Count	55	46	101
		% within CD4-Viral Index	94.8%	83.6%	89.4%
Total		**COUNT**	**58**	**55**	**113**
		% within CD4-Viral Index	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.725b	1	.054		
Continuity Correctiona	2.639	1	.104		
Likelihood Ratio	3.863	1	.049		
Fisher's Exact Test				.069	.051
Linear-by-Linear Association	3.692	1	.055		
N of Valid Cases	113				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.84.

TABLE 49. Use/Need of Emergency * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
Emergency	No	Count	68	4	72
		% within Health Status	42.2%	17.4%	39.1%
	Yes	Count	93	19	112
		% within Health Status	57.8%	82.6%	60.9%
Total		**COUNT**	**161**	**23**	**184**
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.215b	1	.022		
Continuity Correctiona	4.224	1	.040		
Likelihood Ratio	5.763	1	.016		
Fisher's Exact Test				.023	.017
Linear-by-Linear Association	5.187	1	.023		
N of Valid Cases	184				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.00.

TABLE 50. Use/Need of Emergency * Gender (Cross-tabulation)

			Gender (Male/Female)*		Total
			Male	Female	
Emergency	No	Count	51	24	75
		% within Gender	45.1%	32.4%	40.1%
	Yes	Count	62	50	112
		% within Gender	54.9%	67.6%	59.9%
Total		Count	113	74	187
		% within Gender	100.0%	100.0%	100.0%

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 4 (57.1%) participants indicate they need/use emergency services; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.003b	1	.083		
Continuity Correctiona	2.497	1	.114		
Likelihood Ratio	3.036	1	.081		
Fisher's Exact Test				.095	.056
Linear-by-Linear Association	2.987	1	.084		
N of Valid Cases	187				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 29.68.

TABLE 51. Use/Need of Local Health Clinic * Gender (Cross-tabulation)

			Gender (Male/Female)*		Total
			Male	Female	
Local Health Clinic	No	Count	70	36	106
		% within Gender	61.9%	48.6%	56.7%
	Yes	Count	43	38	81
		% within Gender	38.1%	51.4%	43.3%
Total		**COUNT**	**113**	**74**	**187**
		% within Gender	100.0%	100.0%	100.0%

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 2 (28.6%) participants indicate they need/use local health clinics; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig . (1-sided)
Pearson Chi-Square	3.221b	1	.073		
Continuity Correctiona	2.702	1	.100		
Likelihood Ratio	3.216	1	.073		
Fisher's Exact Test				.097	.050
Linear-by-Linear Association	3.203	1	.073		
N of Valid Cases	187				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 32.05.

TABLE 52. Use/Need of Local Health Clinic * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
Local Health Clinic	No	Count	96	9	105
		% within Health Status	59.6%	39.1%	57.1%
	Yes	Count	65	14	79
		% within Health Status	40.4%	60.9%	42.9%
Total		**COUNT**	**161**	**23**	**184**
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.451b	1	.063		
Continuity Correctiona	2.665	1	.103		
Likelihood Ratio	3.416	1	.065		
Fisher's Exact Test				.074	.052
Linear-by-Linear Association	3.432	1	.064		
N of Valid Cases	184				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.88.

TABLE 53. Use/Need of Local Health Clinic * CD4 T-Cell Count (Cross-tabulation)

			CD4 TCell		Total
			Serious (Under 200)	Not Serious (Over 200)	
Local Health Clinic	No	Count	35	41	76
		% within CD4 TCell	66.0%	51.3%	57.1%
	Yes	Count	18	39	57
		% within CD4 TCell	34.0%	48.8%	42.9%
Total		**COUNT**	**53**	**80**	**133**
		% within CD4 TCell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.847b	1	.092		
Continuity Correctiona	2.275	1	.131		
Likelihood Ratio	2.877	1	.090		
Fisher's Exact Test				.109	.065
Linear-by-Linear Association	2.825	1	.093		
N of Valid Cases	133				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 22.71.

TABLE 54. Needs Met by Local Health Clinic * CD4 T-Cell Count (Cross-tabulation)

			CD4 TCell		Total
			Serious (Under 200)	Not Serious (Over 200)	
Local Health Clinic Needs Met	Did meet needs	Count	8	27	35
		% within CD4 TCell	47.1%	71.1%	63.6%
	Sometimes / Did not meet needs	Count	9	11	20
		% within CD4 TCell	52.9%	28.9%	36.4%
Total		**COUNT**	**17**	**38**	**55**
		% within CD4 TCell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.922b	1	.087		
Continuity Correctiona	1.977	1	.160		
Likelihood Ratio	2.867	1	.090		
Fisher's Exact Test				.130	.081
Linear-by-Linear Association	2.869	1	.090		
N of Valid Cases	55				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.18.

TABLE 55. Use/Need of Pharmacy * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Pharmacy	No	Count	3	4	7	5	12	2	4	37
		% within Region	33.3%	21.1%	20.6%	10.9%	35.3%	8.7%	13.3%	19.0%
	Yes	Count	6	15	27	41	22	21	26	158
		% within Region	66.7%	78.9%	79.4%	89.1%	64.7%	91.3%	86.7%	81.0%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.375a	6	.077
Likelihood Ratio	10.966	6	.089
Linear-by-Linear Association	1.035	1	.309
N of Valid Cases	195		

a 3 cells (21.4%) have expected count less than 5. The minimum expected count is 1.71.

TABLE 56. Needs Met by Pharmacy * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Pharmacy Needs Met	Did meet needs	Count	3	12	21	33	21	20	19	129
		% within Region	50.0%	85.7%	87.5%	86.8%	95.5%	100.0%	86.4%	88.4%
	Sometimes/ Did not meet needs	Count	3	2	3	5	1		3	17
		% within Region	50.0%	14.3%	12.5%	13.2%	4.5%		13.6%	11.6%
Total		**COUNT**	**6**	**14**	**24**	**38**	**22**	**20**	**22**	**146**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.575a	6	.050
Likelihood Ratio	11.912	6	.064
Linear-by-Linear Association	3.821	1	.051
N of Valid Cases	146		

a 7 cells (50.0%) have expected count less than 5. The minimum expected count is .70.

TABLE 57. Use/Need of Drug Plan * Geographic Region (Cross-tabulation)b

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Drug Plan	No	Count	7	6	14	24	15	6	22	94
		% within Region	77.8%	31.6%	41.2%	52.2%	44.1%	26.1%	73.3%	48.2%
	Yes	Count	2	13	20	22	19	17	8	101
		% within Region	22.2%	68.4%	58.8%	47.8%	55.9%	73.9%	26.7%	51.8%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.540a	6	.005
Likelihood Ratio	19.231	6	.004
Linear-by-Linear Association	.984	1	.321
N of Valid Cases	195		

a 2 cells (14.3%) have expected count less than 5. The minimum expected count is 4.34.

TABLE 58. Use/Need of Drug Plan * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
Drug Plan	No	Count	82	6	88
		% within Health Status	50.9%	26.1%	47.8%
	Yes	Count	79	17	96
		% within Health Status	49.1%	73.9%	52.2%
Total		**COUNT**	**161**	**23**	**184**
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.978b	1	.026		
Continuity Correctiona	4.032	1	.045		
Likelihood Ratio	5.190	1	.023		
Fisher's Exact Test				.028	0.021
Linear-by-Linear Association	4.951	1	.026		
N of Valid Cases	184				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.00.

TABLES 59 - 74: SECONDARY HEALTH SERVICES

TABLE 59. Summary of Use/Need of Secondary Health Services

Used and/or Needed Service	One or more Secondary Health Services	Dentist	Optician	Chiro-practor	Physio-therapist	Dietician	Home Nursing	Home Care
Frequency	149	111	99	28	22	57	14	15
Percent [n=195]	76.4	56.9	50.8	14.4	11.3	29.2	7.2	7.7

Did this service meet your needs?	Secondary Health Category (% Multiple Responses)	Dentist [n=105]	Optician [n=97]	Chiro-practor [n=28]	Physio-therapist [n=19]	Dietician [n=52]	Home Nursing [n=13]	Home Care [n=14]
Needs met	72.9	74.3	84.5	71.4	42.1	67.3	53.8	64.3
Needs sometimes or not met	27.1	25.7	15.5	28.6	57.9	32.7	46.2	35.7

TABLE 61. Summary of Barriers to Secondary Health Services
(Multiple Response Frequencies / Percent of Valid Respondents)

Barrier / Reason	Secondary Health Category [n=52]	Dentist [n=30]	Optician [n=14]	Chiro-practor [n=10]	Physio-therapist [n=10]	Dietician [n=12]	Home Nursing [n=6]	Home Care [n=5]
Unknown/ Nonexisting	11.5	3.3	7.1	10.0	10.0	–	16.7	20.0
Confidentiality/ Privacy issues	9.6	13.3	7.1	–	–	–	–	–
Logistical Access Barriers	30.8	10.0	7.1	20.0	30.0	16.7	33.3	60.0
Inadequate Care/ Performance	21.2	10.0	7.1	10.0	10.0	41.7	–	–
Stigma/ Discrimination	21.2	26.7	7.1	–	–	8.3	16.7	–
Financial Barriers	34.6	16.7	21.4	40.0	20.0	25.0	16.7	–
Personal Issues/ Barriers	15.4	16.7	7.1	–	10.0	8.3	–	–
Service-specific Barriers	1.9	–	7.1	–	–	–	–	–
Positive Evaluation (unsolicited)	30.8	13.3	28.6	20.0	20.0	16.7	16.7	20.0

Note: Miscellaneous/Other responses excluded.

TABLE 62. Use/Need of Secondary Health Services * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Secondary Health Services	No	Count	4	2	5	5	18	5	7	46
		% within Region	44.4%	10.5%	14.7%	10.9%	52.9%	21.7%	23.3%	23.6%
	Yes	Count	5	17	29	41	16	18	23	149
		% within Region	55.6%	89.5%	85.3%	89.1%	47.1%	78.3%	76.7%	76.4%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	25.883a	6	.000
Likelihood Ratio	24.186	6	.000
Linear-by-Linear Association	1.245	1	.264
N of Valid Cases	195		

a 2 cells (14.3%) have expected count less than 5. The minimum expected count is 2.12.

TABLE 63. Use/Need of Secondary Health Services * Age (Cross-tabulation)

			Age			Total
			15-29 years	30-39 years	40-50+ years	
Secondary Medical Services	No	Count	11	20	15	46
		% within Age	40.7%	25.3%	17.0%	23.7%
	Yes	Count	16	59	73	148
		% within Age	59.3%	74.7%	83.0%	76.3%
Total		**COUNT**	**27**	**79**	**88**	**194**
		% within Age	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.603a	2	.037
Likelihood Ratio	6.264	2	.044
Linear-by-Linear Association	6.285	1	.012
N of Valid Cases	194		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.40.

TABLE 64. Use/Need of Dentist * Age (Cross-tabulation)

			Age			Total
			15-29 years	30-39 years	40-50+ years	
Dentist	No	Count	18	33	33	84
		% within Age	66.7%	41.8%	37.5%	43.3%
	Yes	Count	9	46	55	110
		% within Age	33.3%	58.2%	62.5%	56.7%
Total		**COUNT**	**27**	**79**	**88**	**194**
		% within Age	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.286a	2	.026
Likelihood Ratio	7.271	2	.026
Linear-by-Linear Association	5.508	1	.019
N of Valid Cases	194		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.69.

TABLE 65. Needs met by Dentist * Age (Cross-tabulation)

			Age			Total
			15-29 years	30-39 years	40-50+ years	
Dentist Needs Met	Did meet needs	Count	3	34	40	77
		% within Age	33.3%	75.6%	80.0%	74.0%
	Sometimes / Did not meet needs	Count	6	11	10	27
		% within Age	66.7%	24.4%	20.0%	26.0%
Total		**COUNT**	**9**	**45**	**50**	**104**
		% within Age	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.736a	2	.013
Likelihood Ratio	7.561	2	.023
Linear-by-Linear Association	5.310	1	.021
N of Valid Cases	104		

a 1 cells (16.7%) have expected count less than 5. The minimum expected count is 2.34.

TABLE 66. Use/Need of Dentist * CD4 T-Cell Count / Viral Load Index (Cross-tabulation)

			CD4 T-Cell / Viral Index		Total
			Not Serious	Serious - Very Serious	
Dentist	No	Count	15	26	41
		% within CD4 T-Cell/Viral Index	25.9%	47.3%	36.3%
	Yes	Count	43	29	72
		% within CD4 T-Cell/Viral Index	74.1%	52.7%	63.7%
Total		**COUNT**	**58**	**55**	**113**
		% within CD4T-Cell/Viral Index	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.598b	1	.018		
Continuity Correctiona	4.710	1	.030		
Likelihood Ratio	5.648	1	.017		
Fisher's Exact Test				.020	.015
Linear-by-Linear Association	5.548	1	.018		
N of Valid Cases	113				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 19.96.

TABLE 67. Use/Need of Optician * Age (Cross-tabulation)

			Age			Total
			15-29 years	30-39 years	40-50+ years	
Optician	No	Count	20	36	39	95
		% within Age	74.1%	45.6%	44.3%	49.0%
	Yes	Count	7	43	49	99
		% within Age	25.9%	54.4%	55.7%	51.0%
Total		**COUNT**	**27**	**79**	**88**	**194**
		% within Age	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.937a	2	.019
Likelihood Ratio	8.204	2	.017
Linear-by-Linear Association	4.910	1	.027
N of Valid Cases	194		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 13.22.

TABLE 68. Needs met by Optician * CD4 T-Cell Count (Cross-tabulation)

			CD4 T-Cell Count		Total
			Serious (Under 200)	Not Serious (Over 200)	
Optician Needs Met	Did meet needs	Count	21	44	65
		% within CD4 T-Cell	72.4%	91.7%	84.4%
	Sometimes/ Did not meet needs	Count	8	4	12
		% within CD4 T-Cell	27.6%	8.3%	15.6%
Total		**COUNT**	**29**	**48**	**77**
		% within CD4 T-Cell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.094b	1	.024		
Continuity Correctiona	3.735	1	.053		
Likelihood Ratio	4.940	1	.026		
Fisher's Exact Test				.048	.028
Linear-by-Linear Association	5.027	1	.025		
N of Valid Cases	77				

a Computed only for a 2x2 table
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.52.

TABLE 69. Use/Need of Chiropractor * Viral Load (Cross-tabulation)

			Viral Load		Total
			Serious (Over 10,000)	Not Serious (Under 10,000)	
Chiropractor	No	Count	16	85	101
		% within Viral Load	69.6%	87.6%	84.2%
	Yes	Count	7	12	19
		% within Viral Load	30.4%	12.4%	15.8%
Total		**COUNT**	**23**	**97**	**120**
		% within Viral Load	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.552b	1	.033		
Continuity Correctiona	3.298	1	.069		
Likelihood Ratio	3.982	1	.046		
Fisher's Exact Test				1.000	.990
Linear-by-Linear Association	4.514	1	.034		
N of Valid Cases	120				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.64.

TABLE 70. Use/Need of Dietician * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Dietician	No	Count	6	18	19	34	29	14	18	138
		% within Region	66.7%	94.7%	55.9%	73.9%	85.3%	60.9%	60.0%	70.8%
	Yes	Count	3	1	15	12	5	9	12	57
		% within Region	33.3%	5.3%	44.1%	26.1%	14.7%	39.1%	40.0%	29.2%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	15.451a	6	.017
Likelihood Ratio	17.316	6	.008
Linear-by-Linear Association	1.285	1	.257
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 2.63.

TABLE 71. Needs Met by Dietician * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
Dietician Needs Met	Did meet needs	Count	33	2	35
		% within Health Status	71.7%	33.3%	67.3%
	Sometimes / Did not meet needs	Count	13	4	17
		% within Health Status	28.3%	66.7%	32.7%
Total		**COUNT**	**46**	**6**	**52**
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.558b	1	.059		
Continuity Correctiona	2.027	1	.155		
Likelihood Ratio	3.311	1	.069		
Fisher's Exact Test				.081	0.081
Linear-by-Linear Association	3.489	1	.062		
N of Valid Cases	52				

a Computed only for a 2x2 table

b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.96.

TABLE 72. Use/Need of Home Nursing * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
Home Nursing	No	Count	151	19	170
		% within Health Status	93.8%	82.6%	92.4%
	Yes	Count	10	4	14
		% within Health Status	6.2%	17.4%	7.6%
Total		**COUNT**	**161**	**23**	**184**
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.578b	1	.059		
Continuity Correctiona	2.165	1	.141		
Likelihood Ratio	2.836	1	.092		
Fisher's Exact Test				1.000	.982
Linear-by-Linear Association	3.559	1	.059		
N of Valid Cases	184				

a Computed only for a 2x2 table
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 1.75.

TABLE 73. Use/Need of Professional Home Care * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
Home Care	No	Count	151	18	169
		% within Health Status	93.8%	78.3%	91.8%
	Yes	Count	10	5	15
		% within Health Status	6.2%	21.7%	8.2%
Total		**COUNT**	**161**	**23**	**184**
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.481b	1	.011		
Continuity Correctiona	4.573	1	.032		
Likelihood Ratio	4.922	1	.027		
Fisher's Exact Test				1.000	.995
Linear-by-Linear Association	6.445	1	.011		
N of Valid Cases	184				

a Computed only for a 2x2 table
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 1.88.

TABLE 74. Use/Need of Professional Home Care * CD4 T-Cell Count (Cross-tabulation)

			CD4 T-Cell Count		Total
			Serious (Under 200)	Not Serious (Over 200)	
Home Care	No	Count	45	79	124
		% within CD4 T-Cell	84.9%	98.8%	93.2%
	Yes	Count	8	1	9
		% within CD4 T-Cell	15.1%	1.3%	6.8%
Total		**COUNT**	**53**	**80**	**133**
		% within CD4 T-Cell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	9.685b	1	.002		
Continuity Correctiona	7.615	1	.006		
Likelihood Ratio	10.121	1	.001		
Fisher's Exact Test				.003	.003
Linear-by-Linear Association	9.612	1	.002		
N of Valid Cases	133				

a Computed only for a 2x2 table
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.59.

TABLES 75 - 87: ALTERNATIVE/COMPLEMENTARY THERAPIES

TABLE 75. Summary of Use/Need of Alternative/Complementary Therapies

Used and/or Needed Service	One or more Alternative / Complementary Services	Massage	Homeopathy	Marijuana
Frequency	89	32	20	70
Percent [n=195]	45.6	16.4	10.3	35.9

TABLE 76. Summary of Needs Met by Alternative/Complementary Therapies (Percent of Valid Respondents)

Did this service meet your needs?	Alternative / Complementary Category (% Multiple Responses)	Massage [n=31]	Homeopathy [n=17]	Marijuana [n=60]
Needs met	71.3	77.4	70.6	68.3
Needs sometimes or not met	28.7	22.6	29.4	31.7

TABLE 77. Summary of Barriers to Alternative/Complementary Therapies
(Multiple Response Freq./% of Valid Respondents)

Barrier / Reason	Alternative / Complementary Category [n=36]	Massage [n=6]	Homeopathy [n=8]	Marijuana [n=#30]
Unknown/Nonexisting	11.1	16.7	12.5	6.7
Confidentiality/Privacy issues	2.8	–	–	3.3
Logistical Access Barriers	27.8	66.7	25.0	13.3*
Inadequate Care/Performance	–	–	–	–
Stigma/Discrimination	–	–	–	–
Financial Barriers	33.3	50.0	50.0	16.7
Personal Issues/Barriers	2.8	–	–	3.3
Service-specific Barriers	19.4	–	12.5	20.0*
Positive Evaluation (unsolicited)	55.6	16.7	12.5	60.0

* Recoding the 'barriers to marijuana' variable to reflect a combination of illegal access and unknown/unreliable sources, results in 33.3% valid respondents.

Note: Miscellaneous/Other responses excluded.

TABLE 78. Use/Need of Alternative/Complementary Therapies * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Alternative / Complementary Therapies	No	Count	3	12	15	21	28	16	11	106
		% within Region	33.3%	63.2%	44.1%	45.7%	82.4%	69.6%	36.7%	54.4%
	Yes	Count	6	7	19	25	6	7	19	89
		% within Region	66.7%	36.8%	55.9%	54.3%	17.6%	30.4%	63.3%	45.6%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.708a	6	.001
Likelihood Ratio	22.910	6	.001
Linear-by-Linear Association	.293	1	.588
N of Valid Cases	195		

a 2 cells (14.3%) have expected count less than 5. The minimum expected count is 4.11.

TABLE 79. Use/Need of Alternative/Complementary Therapies * Viral Load (Cross-tabulation)

			Viral Load		Total
			Serious (Over 10,000)	Not Serious (Under 10,000)	
Alternative / Complementary Therapies	No	Count	7	53	60
		% within Viral Load	30.4%	54.6%	50.0%
	Yes	Count	16	44	60
		% within Viral Load	69.6%	45.4%	50.0%
Total		**COUNT**	**23**	**97**	**120**
		% within Viral Load	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.357b	1	.037		
Continuity Correctiona	3.442	1	.064		
Likelihood Ratio	4.454	1	.035		
Fisher's Exact Test				.062	.031
Linear-by-Linear Association	4.320	1	.038		
N of Valid Cases	120				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.50.

TABLE 80. Use/Need of Massage Therapy * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Massage Therapy	No	Count	5	17	26	37	32	22	24	163
		% within Region	55.6%	89.5%	76.5%	80.4%	94.1%	95.7%	80.0%	83.6%
	Yes	Count	4	2	8	9	2	1	6	32
		% within Region	44.4%	10.5%	23.5%	19.6%	5.9%	4.3%	20.0%	16.4%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.695a	6	.048
Likelihood Ratio	12.907	6	.045
Linear-by-Linear Association	2.409	1	.121
N of Valid Cases	195		

a 4 cells (28.6%) have expected count less than 5. The minimum expected count is 1.48.

TABLE 81. Use/Need of Massage Therapy * Viral Load (Cross-tabulation)

			Viral Load		Total
			Serious (Over 10,000)	Not Serious (Under 10,000)	
Massage Therapy	No	Count	14	83	97
		% within Viral Load	60.9%	85.6%	80.8%
	Yes	Count	9	14	23
		% within Viral Load	39.1%	14.4%	19.2%
Total		**COUNT**	**23**	**97**	**120**
		% within Viral Load	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.320b	1	.007		
Continuity Correctiona	5.812	1	.016		
Likelihood Ratio	6.409	1	.011		
Fisher's Exact Test				1.000	.998
Linear-by-Linear Association	7.259	1	.007		
N of Valid Cases	120				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.41.

TABLE 82. Use/Need of Homeopathic Therapy * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Homeopathic Therapy	No	Count	6	18	27	43	33	21	27	175
		% within Region	66.7%	94.7%	79.4%	93.5%	97.1%	91.3%	90.0%	89.7%
	Yes	Count	3	1	7	3	1	2	3	20
		% within Region	33.3%	5.3%	20.6%	6.5%	2.9%	8.7%	10.0%	10.3%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.402a	6	.054
Likelihood Ratio	10.800	6	.095
Linear-by-Linear Association	2.452	1	.117
N of Valid Cases	195		

a 7 cells (50.0%) have expected count less than 5. The minimum expected count is .92.

TABLE 83. Use/Need of Marijuana for Medical Purposes * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Marijuana	No	Count	7	12	18	25	30	18	15	125
		% within Region	77.8%	63.2%	52.9%	54.3%	88.2%	78.3%	50.0%	64.1%
	Yes	Count	2	7	16	21	4	5	15	70
		% within Region	22.2%	36.8%	47.1%	45.7%	11.8%	21.7%	50.0%	35.9%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.683a	6	.007
Likelihood Ratio	19.317	6	.004
Linear-by-Linear Association	.048	1	.827
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 3.23.

TABLE 84. Use/Need of Marijuana for Medical Purposes * Gender (Cross-tabulation)

			Gender (Male/Female)*		Total
			Male	Female	
Marijuana	No	Count	66	54	120
		% within Gender	58.4%	73.0%	64.2%
	Yes	Count	47	20	67
		% within Gender	41.6%	27.0%	35.8%
Total		**COUNT**	**113**	**74**	**187**
		% within Gender	100.0%	100.0%	100.0%

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 3 (42.9%) participants indicate they need/use marijuana for medical purposes; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.126b	1	.042		
Continuity Correctiona	3.517	1	.061		
Likelihood Ratio	4.204	1	.040		
Fisher's Exact Test				.044	.030
Linear-by-Linear Association	4.104	1	.043		
N of Valid Cases	187				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 26.51.

TABLE 85. Needs Met by Marijuana for Medical Purposes * Gender (Cross-tabulation)

			Gender (Male/Female)*		Total
			Male	Female	
Marijuana Needs Met	Did meet needs	Count	25	15	40
		% within Gender	61.0%	88.2%	69.0%
	Sometimes/ Did not meet needs	Count	16	2	18
		% within Gender	39.0%	11.8%	31.0%
Total		Count	41	17	58
		% within Gender	100.0%	100.0%	100.0%

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 1 participant indicates their needs were not met by marijuana for medical purposes; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.172b	1	.041		
Continuity Correctiona	2.996	1	.083		
Likelihood Ratio	4.686	1	.030		
Fisher's Exact Test				.061	.037
Linear-by-Linear Association	4.100	1	.043		
N of Valid Cases	58				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.28.

TABLE 86. Use/Need of Marijuana for Medical Purposes * Viral Load (Cross-tabulation)

			Viral Load		Total
			Serious (Over 10,000)	Not Serious (Under 10,000)	
Marijuana	No	Count	9	63	72
		% within Viral Load	39.1%	64.9%	60.0%
	Yes	Count	14	34	48
		% within Viral Load	60.9%	35.1%	40.0%
Total		**COUNT**	**23**	**97**	**120**
		% within Viral Load	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.164b	1	.023		
Continuity Correctiona	4.144	1	.042		
Likelihood Ratio	5.067	1	.024		
Fisher's Exact Test				.033	.022
Linear-by-Linear Association	5.121	1	.024		
N of Valid Cases	120				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.20.

TABLE 87. Needs Met by Marijuana for Medical Purposes * CD4 T-Cell Count (Cross-tabulation)

			CD4 T-Cell Counts		Total
			Serious (Under 200)	Not Serious (Over 200)	
Marijuana Needs Met	Did meet needs	Count	12	20	32
		% within CD4 T-Cell	52.2%	80.0%	66.7%
	Sometimes/ Did not meet needs	Count	11	5	16
		% within CD4 T-Cell	47.8%	20.0%	33.3%
Total		**COUNT**	**23**	**25**	**48**
		% within CD4 T-Cell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.174b	1	.041		
Continuity Correctiona	3.016	1	.082		
Likelihood Ratio	4.244	1	.039		
Fisher's Exact Test				.066	.041
Linear-by-Linear Association	4.087	1	.043		
N of Valid Cases	48				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.67.

TABLES 88 - 98: SOCIAL AND FAMILY SERVICES

TABLE 88. Summary of Use/Need of Social and Family Services

Used and/or Needed Service	One or more Social & Family Services	Social Worker	Child Care	Family Planning	Parenting Skills
Frequency	121	114	15	14	18
Percent [n=195]	62.1	58.8	7.7	7.2	9.2

TABLE 89. Summary of Needs Met by Social and Family Services (Percent of Valid Respondents)

Did this service meet your needs?	Social & Family Category (% Multiple Responses)	Social Worker [n=109]	Child Care [n=13]	Family Planning [n=13]	Parenting Skills [n=15]
Needs met	60.7	58.7	69.2	53.8	73.3
Needs sometimes/ not met	39.3	41.3	30.8	46.2	26.7

TABLE 90. Summary of Barriers to Social and Family Services
(Multiple Response Frequencies / Percent of Valid Respondents)

Barrier / Reason	Social & Family Category [n=40]	Social Worker [n=33]	Child Care [n=5]	Family Planning [n=4]	Parenting Skills [n=2]
Unknown/Nonexisting	–	–	–	–	–
Confidentiality/Privacy issues	37.5	33.3	40.0	25.0	50.0
Logistical Access Barriers	17.5	18.2	20.0	–	–
Inadequate Care/Performance	15.0	18.2	–	–	–
Stigma/Discrimination	30.0	33.3	–	25.0	–
Financial Barriers	5.0	–	40.0	–	–
Personal Issues/Barriers	2.5	3.0	–	–	–
Service-specific Barriers	15.0	18.2	–	–	–
Positive Evaluation (unsolicited)	20.0	18.2	–	25.0	50.0

Note: Miscellaneous/Other responses excluded.

TABLE 91. Social and Family Services * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Social & Family Services	No	Count	2	12	19	11	16	9	5	74
		% within Region	22.2%	63.2%	55.9%	23.9%	47.1%	39.1%	16.7%	37.9%
	Yes	Count	7	7	15	35	18	14	25	121
		% within Region	77.8%	36.8%	44.1%	76.1%	52.9%	60.9%	83.3%	62.1%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.547a	6	.001
Likelihood Ratio	22.236	6	.001
Linear-by-Linear Association	5.466	1	.019
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 3.42.

TABLE 92. Social and Family Services * CD4 T-Cell Count (Cross-tabulation)

			CD4 TCell		Total
			Serious (Under 200)	Not Serious (Over 200)	
Social & Family Services	No	Count	12	31	43
		% within CD4 T-Cell	22.6%	38.8%	32.3%
	Yes	Count	41	49	90
		% within CD4 T-Cell	77.4%	61.3%	67.7%
Total		**COUNT**	**53**	**80**	**133**
		% within CD4 T-Cell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.781b	1	.052		
Continuity Correctiona	3.081	1	.079		
Likelihood Ratio	3.885	1	.049		
Fisher's Exact Test				.060	.038
Linear-by-Linear Association	3.753	1	.053		
N of Valid Cases	133				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 17.14.

TABLE 93. Social Worker * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Social Worker	No	Count	3	12	19	13	16	9	9	81
		% within Region	33.3%	63.2%	55.9%	28.3%	47.1%	39.1%	30.0%	41.5%
	Yes	Count	6	7	15	33	18	14	21	114
		% within Region	66.7%	36.8%	44.1%	71.7%	52.9%	60.9%	70.0%	58.5%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.253[a]	6	.057
Likelihood Ratio	12.354	6	.055
Linear-by-Linear Association	3.066	1	.080
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 3.74.

TABLE 94. Social Worker * CD4 T-Cell Count (Cross-tabulation)

			CD4 T-Cell Count		Total
			Serious (Under 200)	Not Serious (Over 200)	
Social Worker	No	Count	15	35	50
		% within CD4 T-Cell	28.3%	43.8%	37.6%
	Yes	Count	38	45	83
		% within CD4 T-Cell	71.7%	56.3%	62.4%
Total		**COUNT**	**53**	**80**	**133**
		% within CD4 T-Cell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.243b	1	.072		
Continuity Correctiona	2.618	1	.106		
Likelihood Ratio	3.300	1	.069		
Fisher's Exact Test				.099	.052
Linear-by-Linear Association	3.218	1	.073		
N of Valid Cases	133				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 19.92.

TABLE 95. Child Care * Gender (Cross-tabulation)

			Gender			Total
			Male	Female	Trans-gender; Trans-sexual; Inter-sexed	
Child Care	No	Count	112	61	6	179
		% within Gender	99.1%	82.4%	85.7%	92.3%
	Yes	Count	1	13	1	15
		% within Gender	.9%	17.6%	14.3%	7.7%
Total		**COUNT**	**113**	**74**	**7**	**194**
		% within Gender	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	17.882a	2	.000
Likelihood Ratio	19.629	2	.000
Linear-by-Linear Association	15.088	1	.000
N of Valid Cases	194		

a 1 cells (16.7%) have expected count less than 5. The minimum expected count is .54.

TABLE 96. Child Care * Age [Re-coded] (Cross-tabulation)

			Age		Total
			Under 30	30 and over	
Child Care	No	Count	22	157	179
		% within Age	81.5%	94.0%	92.3%
	Yes	Count	5	10	15
		% within Age	18.5%	6.0%	7.7%
Total		**COUNT**	**27**	**167**	**194**
		% within Age	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.115b	1	.024		
Continuity Correctiona	3.510	1	.061		
Likelihood Ratio	4.031	1	.045		
Fisher's Exact Test				1.000	.991
Linear-by-Linear Association	5.089	1	.024		
N of Valid Cases	194				

a Computed only for a 2x2 table
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 2.09.

TABLE 97. Family Planning Programs * Gender (Cross-tabulation)

			Gender			Total
			Male	Female	Trans-gender; Trans-sexual; Inter-sexed	
Family Planning	No	Count	112	62	6	180
		% within Gender	99.1%	83.8%	85.7%	92.8%
	Yes	Count	1	12	1	14
		% within Gender	.9%	16.2%	14.3%	7.2%
Total		**COUNT**	**113**	**74**	**7**	**194**
		% within Gender	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	16.239a	2	.000
Likelihood Ratio	17.784	2	.000
Linear-by-Linear Association	14.004	1	.000
N of Valid Cases	194		

a 1 cells (16.7%) have expected count less than 5. The minimum expected count is .51.

TABLE 98. Parenting Skills Programs * Gender (Cross-tabulation)

			Gender			Total
			Male	Female	Trans-gender; Trans-sexual; Inter-sexed	
Parenting Skills	No	Count	110	60	6	176
		% within Gender	97.3%	81.1%	85.7%	90.7%
	Yes	Count	3	14	1	18
		% within Gender	2.7%	18.9%	14.3%	9.3%
Total		**COUNT**	**113**	**74**	**7**	**194**
		% within Gender	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.269a	2	.001
Likelihood Ratio	14.645	2	.001
Linear-by-Linear Association	11.687	1	.001
N of Valid Cases	194		

a 1 cells (16.7%) have expected count less than 5. The minimum expected count is .65.

TABLES 99 - 100: SUBSTANCE USE SERVICES

TABLE 99. Summary of Use/Need of Substance Use Services

Used and/or Needed Service	One or more Substance Use Services	Addiction Treatment	Harm Reduction	Needle Exchange
Frequency	118	92	63	64
Percent [n=195]	60.5	47.2	32.3	32.8

TABLE 100. Summary of Needs Met by Substance Use Services (Percent of Valid Respondents)

Did this service meet your needs?	Substance Use Category (% Multiple Responses)	Addiction Treatment [n=83]	Harm Reduction [n=58]	Needle Exchange [n=63]
Needs met	73.5	61.4	75.9	87.3
Needs sometimes or not met	26.5	38.6	24.1	12.7

TABLE 101. Summary of Barriers to Substance Use Services
(Multiple Response Frequencies / Percent of Valid Respondents)

Barrier / Reason	Substance Use Category [n=43]	Addiction Treatment [n=31]	Harm Reduction [n=13]	Needle Exchange [n=9]
Unknown/Nonexisting	14.0	9.7	–	–
Confidentiality/Privacy issues	14.0	16.1	–	11.1
Logistical Access Barriers	25.6	19.4	15.4	33.3
Inadequate Care/Performance	20.9	9.7	38.5	11.1
Stigma/Discrimination	4.7	3.2	–	11.1
Financial Barriers	2.3	3.2	–	–
Personal Issues/Barriers	11.6	9.7	15.4	–
Service-specific Barriers	9.3	9.7	7.7	–
Positive Evaluation (unsolicited)	25.6	19.4	15.4	33.3

Note: Miscellaneous/Other responses excluded.

TABLE 102. Substance Use Services * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Substance Use Services	No	Count	1	8	20	13	16	10	9	77
		% within Region	11.1%	42.1%	58.8%	28.3%	47.1%	43.5%	30.0%	39.5%
	Yes	Count	8	11	14	33	18	13	21	118
		% within Region	88.9%	57.9%	41.2%	71.7%	52.9%	56.5%	70.0%	60.5%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.933a	6	.044
Likelihood Ratio	13.492	6	.036
Linear-by-Linear Association	.121	1	.728
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 3.55.

TABLE 103. Substance Use Services * Transmission Category (Cross-tabulation)

			Transmission Category				Total
			Sexual contact	Blood product/ contamination	IDU/ Works/ Tattoo	Sexual contact &/or IDU &/or Blood product	
Substance Use Services	No	Count	49	3	9	5	66
		% within Transmission Category	53.3%	42.9%	17.3%	20.0%	37.5%
	Yes	Count	43	4	43	20	110
		% within Transmission Category	46.7%	57.1%	82.7%	80.0%	62.5%
Total		**COUNT**	**92**	**7**	**52**	**25**	**176**
		% within Transmission Category	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	22.149a	3	.000
Likelihood Ratio	23.226	3	.000
Linear-by-Linear Association	19.851	1	.000
N of Valid Cases	176		

a 2 cells (25.0%) have expected count less than 5. The minimum expected count is 2.63.

TABLE 104. Addiction Treatment * Transmission Category (Cross-tabulation)

			Transmission Category				Total
			Sexual contact	Blood product/ contamination	IDU/ Works/ Tattoo	Sexual contact &/or IDU &/or Blood product	
Addiction Treatment	No	Count	56	4	18	11	89
		% within Transmission Category	60.9%	57.1%	34.6%	44.0%	50.6%
	Yes	Count	36	3	34	14	87
		% within Transmission Category	39.1%	42.9%	65.4%	56.0%	49.4%
Total		**COUNT**	**92**	**7**	**52**	**25**	**176**
		% within Transmission Category	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.752a	3	.021
Likelihood Ratio	9.868	3	.020
Linear-by-Linear Association	7.245	1	.007
N of Valid Cases	176		

a 2 cells (25.0%) have expected count less than 5. The minimum expected count is 3.46.

TABLE 105. Harm Reduction Programs * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Harm Reduction	No	Count	4	15	25	32	28	12	16	132
		% within Region	44.4%	78.9%	73.5%	69.6%	82.4%	52.2%	53.3%	67.7%
	Yes	Count	5	4	9	14	6	11	14	63
		% within Region	55.6%	21.1%	26.5%	30.4%	17.6%	47.8%	46.7%	32.3%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.631a	6	.049
Likelihood Ratio	12.635	6	.049
Linear-by-Linear Association	1.839	1	.175
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 2.91.

TABLE 106. Harm Reduction Programs * Transmission Category (Cross-tabulation)

			Transmission Category				Total
			Sexual contact	Blood product/ contamination	IDU/ Works/ Tattoo	Sexual contact &/or IDU &/or Blood product	
Harm Reduction	No	Count	71	6	31	10	118
		% within Transmission Category	77.2%	85.7%	59.6%	40.0%	67.0%
	Yes	Count	21	1	21	15	58
		% within Transmission Category	22.8%	14.3%	40.4%	60.0%	33.0%
Total		**COUNT**	**92**	**7**	**52**	**25**	**176**
		% within Transmission Category	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.952a	3	.002
Likelihood Ratio	14.734	3	.002
Linear-by-Linear Association	13.184	1	.000
N of Valid Cases	176		

a 2 cells (25.0%) have expected count less than 5. The minimum expected count is 2.31.

TABLE 107. Harm Reduction Programs * CD4 T-Cell Count / Viral Load Index (Cross-tabulation)

			CD4-Viral Index		Total
			Not Serious	Serious - Very Serious	
Harm Reduction	No	Count	47	33	80
		% within CD4 T-Cell/ Viral Index	81.0%	60.0%	70.8%
	Yes	Count	11	22	33
		% within CD4 T-Cell/ Viral Index	19.0%	40.0%	29.2%
Total		**COUNT**	**58**	**55**	**113**
		% within CD4 T-Cell/ Viral Index	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.041b	1	.014		
Continuity Correctiona	5.067	1	.024		
Likelihood Ratio	6.121	1	.013		
Fisher's Exact Test				.022	.012
Linear-by-Linear Association	5.988	1	.014		
N of Valid Cases	113				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 16.06.

TABLE 108. Harm Reduction Programs * CD4 T-Cell Count (Cross-tabulation)

Crosstab

			CD4 TCell Count		Total
			Serious (Under 200)	Not Serious (Over 200)	
Harm Reduction	No	Count	29	62	91
		% within CD4 T-Cell	54.7%	77.5%	68.4%
	Yes	Count	24	18	42
		% within CD4 T-Cell	45.3%	22.5%	31.6%
Total		Count	53	80	133
		% within CD4 T-Cell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.659b	1	.006		
Continuity Correctiona	6.640	1	.010		
Likelihood Ratio	7.585	1	.006		
Fisher's Exact Test				.008	.005
Linear-by-Linear Association	7.601	1	.006		
N of Valid Cases	133				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 16.74.

TABLE 109. Needs Met by Harm Reduction Programs * CD4 T-Cell Count / Viral Load Index (Cross-tabulation)

			CD4 T-Cell/Viral Index		Total
			Not Serious	Serious - Very Serious	
Harm Reduction Needs Met	Did meet needs	Count	11	15	26
		% within CD4 T-Cell/ Viral Index	100.0%	68.2%	78.8%
	Sometimes/ Did not meet needs	Count		7	7
		% within CD4 T-Cell/ Viral Index		31.8%	21.2%
Total		Count	11	22	33
		% within CD4 T-Cell/ Viral Index	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.442b	1	.035		
Continuity Correctiona	2.742	1	.098		
Likelihood Ratio	6.584	1	.010		
Fisher's Exact Test				.067	.040
Linear-by-Linear Association	4.308	1	.038		
N of Valid Cases	33				

a Computed only for a 2x2 table

b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.33.

TABLE 110. Needle Exchange Programs * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Needle Exchange	No	Count	2	16	28	29	20	12	24	131
		% within Region	22.2%	84.2%	82.4%	63.0%	58.8%	52.2%	80.0%	67.2%
	Yes	Count	7	3	6	17	14	11	6	64
		% within Region	77.8%	15.8%	17.6%	37.0%	41.2%	47.8%	20.0%	32.8%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	20.319a	6	.002
Likelihood Ratio	20.497	6	.002
Linear-by-Linear Association	.043	1	.836
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 2.95.

TABLE 111. Needle Exchange Programs * Transmission Category (Cross-tabulation)

			Transmission Category				Total
			Sexual contact	Blood product/ contamination	IDU/ Works/ Tattoo	Sexual contact &/or IDU &/or Blood product	
Needle Exchange	No	Count	79	5	24	10	118
		% within Transmission Category	85.9%	71.4%	46.2%	40.0%	67.0%
	Yes	Count	13	2	28	15	58
		% within Transmission Category	14.1%	28.6%	53.8%	60.0%	33.0%
Total		**COUNT**	**92**	**7**	**52**	**25**	**176**
		% within Transmission Category	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.364a	3	.000
Likelihood Ratio	34.364	3	.000
Linear-by-Linear Association	32.154	1	.000
N of Valid Cases	176		

a 2 cells (25.0%) have expected count less than 5. The minimum expected count is 2.31.

TABLES 112 - 124: COMMUNITY AND AIDS SERVICE ORGANIZATION (ASO) SERVICES

TABLE 112. Summary of Use/Need of Community and AIDS Service Organization (ASO) Services

Used and/or Needed Service	One or more Community & ASO Services	AIDS Treatment Information	Health Education	Hospice Care	Buddies	Drop -Ins	Crisis/ Help-Lines
Frequency	157	108	68	11	72	114	24
Percent [n=195]	80.5	55.4	34.9	5.6	36.9	58.5	12.3

TABLE 113. Summary of Needs Met by Community and AIDS Service Organization (ASO) Services (Percent of Valid Respondents)

Did this service meet your needs?	Community & ASO Category (% Multiple Responses)	AIDS Treatment Information [n=100]	Health Education [n=60]	Hospice Care [n=10]	Buddies [n=67]	Drop -Ins [n=104]	Crisis/ Help-Lines [n=21]
Needs met	74.9	76.0	85.0	70.0	67.2	72.1	81.0
Needs sometimes or not met	25.1	24.0	15.0	30.0	32.8	27.9	19.0

TABLE 114. Summary of Barriers to Community and AIDS Service Organization (ASO) Services (Multiple Response Frequencies / Percent of Valid Respondents)

Barrier / Reason	Community & ASO Category [n=50]	AIDS Treatment Information [n=26]	Health Education [n=8]	Hospice Care [n=4]	Buddies [n=22]	Drop Ins [n=23]	Crisis/ Help-Lines [n=3]
Unknown/Nonexisting	22.0	3.8	50.0	50.0	4.5	8.7	33.3
Confidentiality/ Privacy issues	24.0	7.7	–	–	27.3	13.0	33.3
Logistical Access Barriers	24.0	11.5	12.5	–	13.6	21.7	–
Inadequate Care/ Performance	10.0	3.8	25.0	–	–	8.7	–
Stigma/Discrimination	8.0	3.8	–	25.0	4.5	4.3	–
Financial Barriers	2.0	–	–	25.0	–	–	–
Personal Issues/Barriers	10.0	3.8	–	–	–	17.4	–
Service-specific Barriers	10.0	19.2	–	–	–	–	–
Positive Evaluation (unsolicited)	66.0	38.5	25.0	–	54.5	39.1	–

Note: Miscellaneous/Other responses excluded.

TABLE 115. Community and ASO Services * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Community & ASO Servcies	No	Count		3	10	4	14	5	2	38
		% within Region		15.8%	29.4%	8.7%	41.2%	21.7%	6.7%	19.5%
	Yes	Count	9	16	24	42	20	18	28	157
		% within Region	100.0%	84.2%	70.6%	91.3%	58.8%	78.3%	93.3%	80.5%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.304a	6	.002
Likelihood Ratio	22.553	6	.001
Linear-by-Linear Association	.000	1	.986
N of Valid Cases	195		

a 3 cells (21.4%) have expected count less than 5. The minimum expected count is 1.75.

TABLE 116. Community and ASO Services * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
Community & ASO Servcies	No	Count	34	1	35
		% within Health Status	21.1%	4.3%	19.0%
	Yes	Count	127	22	149
		% within Health Status	78.9%	95.7%	81.0%
Total		**COUNT**	**161**	**23**	**184**
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.674b	1	.055		
Continuity Correctiona	2.666	1	.102		
Likelihood Ratio	4.823	1	.028		
Fisher's Exact Test				.084	.040
Linear-by-Linear Association	3.654	1	.056		
N of Valid Cases	184				

a Computed only for a 2x2 table
b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.38.

TABLE 117. AIDS Treatment Information * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
AIDS Treatment Information	No	Count	5	9	17	13	25	10	8	87
		% within Region	55.6%	47.4%	50.0%	28.3%	73.5%	43.5%	26.7%	44.6%
	Yes	Count	4	10	17	33	9	13	22	108
		% within Region	44.4%	52.6%	50.0%	71.7%	26.5%	56.5%	73.3%	55.4%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.299a	6	.002
Likelihood Ratio	21.912	6	.001
Linear-by-Linear Association	1.153	1	.283
N of Valid Cases	195		

a 2 cells (14.3%) have expected count less than 5. The minimum expected count is 4.02.

TABLE 118. AIDS Treatment Information * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
AIDS Treatment Information	No	Count	74	6	80
		% within Health Status	46.0%	26.1%	43.5%
	Yes	Count	87	17	104
		% within Health Status	54.0%	73.9%	56.5%
Total		Count	161	23	184
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.235b	1	.072		
Continuity Correctiona	2.477	1	.116		
Likelihood Ratio	3.394	1	.065		
Fisher's Exact Test				.077	.056
Linear-by-Linear Association	3.218	1	.073		
N of Valid Cases	184				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.00.

TABLE 119. Health Education Programs * Geographic Region (Cross-tabulation)

Crosstab

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Health Education	No	Count	7	13	21	28	29	16	13	127
		% within Region	77.8%	68.4%	61.8%	60.9%	85.3%	69.6%	43.3%	65.1%
	Yes	Count	2	6	13	18	5	7	17	68
		% within Region	22.2%	31.6%	38.2%	39.1%	14.7%	30.4%	56.7%	34.9%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.823a	6	.032
Likelihood Ratio	14.432	6	.025
Linear-by-Linear Association	1.583	1	.208
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 3.14.

TABLE 120. Health Education Programs * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
Health Education	No	Count	109	11	120
		% within Health Status	67.7%	47.8%	65.2%
	Yes	Count	52	12	64
		% within Health Status	32.3%	52.2%	34.8%
Total		**COUNT**	**161**	**23**	**184**
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.505b	1	.061		
Continuity Correctiona	2.683	1	.101		
Likelihood Ratio	3.351	1	.067		
Fisher's Exact Test				.099	.053
Linear-by-Linear Association	3.486	1	.062		
N of Valid Cases	184				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.00.

TABLE 121. Buddy Programs * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Buddies	No	Count	4	10	26	22	30	14	17	123
		% within Region	44.4%	52.6%	76.5%	47.8%	88.2%	60.9%	56.7%	63.1%
	Yes	Count	5	9	8	24	4	9	13	72
		% within Region	55.6%	47.4%	23.5%	52.2%	11.8%	39.1%	43.3%	36.9%
Total		**COUNT**	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	19.262a	6	.004
Likelihood Ratio	20.924	6	.002
Linear-by-Linear Association	.294	1	.588
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 3.32.

TABLE 122. Needs Met by Buddy Programs * Geographic Region (Cross-tabulation)

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Buddies Needs Met	Did meet needs	Count	3	7	7	14	1	3	10	45
		% within Region	75.0%	77.8%	100.0%	66.7%	20.0%	37.5%	76.9%	67.2%
	Sometimes /Did not meet needs	Count	1	2		7	4	5	3	22
		% within Region	25.0%	22.2%		33.3%	80.0%	62.5%	23.1%	32.8%
Total		**COUNT**	**4**	**9**	**7**	**21**	**5**	**8**	**13**	**67**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.792a	6	.046
Likelihood Ratio	14.422	6	.025
Linear-by-Linear Association	1.416	1	.234
N of Valid Cases	67		

a 9 cells (64.3%) have expected count less than 5. The minimum expected count is 1.31.

TABLE 123. Drop-In Programs * Geographic Region (Cross-tabulation)

Crosstab

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Drop-Ins	No	Count	1	11	15	18	17	12	7	81
		% within Region	11.1%	57.9%	44.1%	39.1%	50.0%	52.2%	23.3%	41.5%
	Yes	Count	8	8	19	28	17	11	23	114
		% within Region	88.9%	42.1%	55.9%	60.9%	50.0%	47.8%	76.7%	58.5%
Total		COUNT	**9**	**19**	**34**	**46**	**34**	**23**	**30**	**195**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.896a	6	.064
Likelihood Ratio	12.761	6	.047
Linear-by-Linear Association	.410	1	.522
N of Valid Cases	195		

a 1 cells (7.1%) have expected count less than 5. The minimum expected count is 3.74.

TABLE 124. Needs Met by Drop-In Programs * Geographic Region (Cross-tabulation)

Crosstab

			Region							Total
			North	Quebec/ Atlantic	ON	BC	AB	SK	MB	
Drop-In Needs Met	Did meet needs	Count	3	5	17	18	10	8	14	75
		% within Region	37.5%	62.5%	100.0%	75.0%	66.7%	72.7%	66.7%	72.1%
	Sometimes /Did not meet needs	Count	5	3		6	5	3	7	29
		% within Region	62.5%	37.5%		25.0%	33.3%	27.3%	33.3%	27.9%
Total		**COUNT**	**8**	**8**	**17**	**24**	**15**	**11**	**21**	**104**
		% within Region	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12.341a	6	.055
Likelihood Ratio	16.225	6	.013
Linear-by-Linear Association	.014	1	.907
N of Valid Cases	104		

a 5 cells (35.7%) have expected count less than 5. The minimum expected count is 2.23.

TABLES 125 - 131: MENTAL HEALTH AND COUNSELLING SERVICES

TABLE 125. Summary of Use/Need of Mental Health and Counselling Services

Used and/or Needed Service	One or more Mental Health & Counselling Services	Mental Health Care	Spiritual / Religious Counselling	Grief Counselling	Financial Counselling	Legal Support / Counselling
Frequency	106	50	67	30	20	35
Percent [n=195]	54.4	25.6	34.4	15.4	10.3	17.9

TABLE 126. Summary of Needs Met by Mental Health and Counselling Services (Percent of Valid Respondents)

Did this service meet your needs?	Mental Health & Counselling Category (% Multiple Responses)	Mental Health Care [n=46]	Spiritual / Religious Counselling [n=61]	Grief Counselling [n=29]	Financial Counselling [n=22]	Legal Support / Counselling [n=30]
Needs met	62.8	52.2	72.1	58.6	50.0	73.3
Needs sometimes or not met	37.2	47.8	27.9	41.4	50.0	26.7

TABLE 127. Summary of Barriers to Mental Health and Counselling Services
(Multiple Response Frequencies / Percent of Valid Respondents)

Barrier / Reason	Mental Health & Counselling Category [n=38]	Mental Health Care [n=18]	Spiritual / Religious Counselling [n=15]	Grief Counselling [n=8]	Financial Counselling [n=7]	Legal Support/ Counselling [n=7]
Unknown/ Nonexisting	26.3	5.6	13.3	37.5	42.9	14.3
Confidentiality/Privacy	13.2	5.6	20.0	–	–	14.3
Logistical Access Barriers	13.2	22.2	–	12.5	–	–
Inadequate Care/ Performance	18.4	22.2*	–	–	–	42.9
Stigma/Discrimination	7.9	–	13.3	12.5	–	–
Financial Barriers	7.9	5.6	–	–	–	28.6
Personal Issues/Barriers	10.5	–	13.3	25.0	–	–
Service-specific Barriers	13.2	22.2*	–	–	14.3	–
Positive Evaluation (unsolicited)	31.6	11.1	46.7	12.5	28.6	–

* Recoding the 'barriers to mental health care' variable to reflect a combination of poor care and service-specific barriers such as "does not help resolve problems" results in 38.9% valid respondents.

Note: Miscellaneous/Other responses excluded.

TABLE 128. Needs Met by Mental Health * Age (Cross-tabulation)

			Age			Total
			15-29 years	30-39 years	40-50+ years	
Mental Health Needs Met	Did meet needs	Count		14	10	24
		% within Age		66.7%	52.6%	52.2%
	Sometimes/ Did not meet needs	Count	6	7	9	22
		% within Age	100.0%	33.3%	47.4%	47.8%
Total		**COUNT**	**6**	**21**	**19**	**46**
		% within Age	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.315a	2	.016
Likelihood Ratio	10.662	2	.005
Linear-by-Linear Association	1.903	1	.168
N of Valid Cases	46		

a 2 cells (33.3%) have expected count less than 5. The minimum expected count is 2.87.

TABLE 129. Needs Met by Mental Health * CD4 T-Cell Count (Cross-tabulation)

			CD4 T-Cell Count		Total
			Serious (Under 200)	Not Serious (Over 200)	
Mental Health Needs Met	Did meet needs	Count	10	9	19
		% within CD4 T-Cell	90.9%	42.9%	59.4%
	Sometimes/ Did not meet needs	Count	1	12	13
		% within CD4 T-Cell	9.1%	57.1%	40.6%
Total		**COUNT**	**11**	**21**	**32**
		% within CD4 T-Cell	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.910b	1	.009		
Continuity Correctiona	5.062	1	.024		
Likelihood Ratio	7.846	1	.005		
Fisher's Exact Test				.011	.010
Linear-by-Linear Association	6.694	1	.010		
N of Valid Cases	32				

a Computed only for a 2x2 table

b 1 cells (25.0%) have expected count less than 5. The minimum expected count is 4.47.

TABLE 130. Needs Met by Financial Counselling * Transmission Category (Cross-tabulation)

			Transmission Category			Total
			Sexual contact	IDU/ Works/ Tattoo	Sexual contact &/or IDU &/or Blood product	
Financial Needs Met	Did meet needs	Count	4	6	1	11
		% within Transmission Category	33.3%	100.0%	33.3%	52.4%
	Sometimes/ Did not meet needs	Count	8		2	10
		% within Transmission Category	66.7%		66.7%	47.6%
Total		**COUNT**	**12**	**6**	**3**	**21**
		% within Transmission Category	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.636a	2	.022
Likelihood Ratio	9.969	2	.007
Linear-by-Linear Association	2.036	1	.154
N of Valid Cases	21		

a 4 cells (66.7%) have expected count less than 5. The minimum expected count is 1.43.

TABLE 131. Needs Met by Financial Counselling * Self-Reported Health Status (Cross-tabulation)

			Health Status		Total
			HIV+	AIDS	
Financial Needs Met	Did meet needs	Count	11		11
		% within Health Status	61.1%		52.4%
	Sometimes/ Did not meet needs	Count	7	3	10
		% within Health Status	38.9%	100.0%	47.6%
Total		Count	18	3	21
		% within Health Status	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.850b	1	0.05		
Continuity Correctiona	1.790	1	0.181		
Likelihood Ratio	5.008	1	0.025		
Fisher's Exact Test				.090	.090
Linear-by-Linear Association	3.667	1	.056		
N of Valid Cases	21				

a Computed only for a 2x2 table

b 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.43.

TABLE 132. "Best ways to improve services for APHAs" (Multiple Response Frequency)

Category label	Code	Count	Pct of Responses	Pct of Cases
More/sustainable support services	1	56	12.8	34.4
More/better information	2	34	7.8	20.9
On-Reserve/Rural support services	3	15	3.4	9.2
Traditional support services	4	18	4.1	11.0
Aboriginal workers/service	5	43	9.8	26.4
Emotional, mental spiritual support	6	21	4.8	12.9
Public education & awareness	7	25	5.7	15.3
Funding for support services	8	16	3.7	9.8
Better HIV/AIDS medical treatment services	9	25	5.7	15.3
Women-specific services	10	7	1.6	4.3
Travel/transport assistance	11	10	2.3	6.1
Home outreach services	12	11	2.5	6.7
Housing & hospice services	13	13	3.0	8.0
Hours of service	14	8	1.8	4.9
On-line & phone-line assistance	15	6	1.4	3.7
Enhance privacy & confidentiality	16	9	2.1	5.5
Client-based & PHA front-line service	17	13	3.0	8.0
Income security	18	16	3.7	9.8
Children-specific services	19	6	1.4	3.7
Find a cure for AIDS	20	5	1.1	3.1
Keep up the good work!	21	50	11.4	30.7
Recognize diversity	22	14	3.2	8.6
Address stigma & discrimination	23	17	3.9	10.4
TOTAL RESPONSES		**438**	**100.0**	**268.7**

32 missing cases; 163 valid cases

TABLES 133 - 135: CHAPTER 3

TABLE 133. Transmission Category * Gender (Cross-tabulation)

			Gender			Total
			Male	Female	Trans-gender; Trans-sexual; Inter-sexed	
Transmission Category	Sexual contact	Count	53	35	3	91
		% within Gender	48.2%	47.9%	42.9%	47.9%
	Blood product/ contamination	Count	4	3		7
		% within Gender	3.6%	4.1%		3.7%
	IDU/Works	Count	30	19	2	51
		% within Gender	27.3%	26.0%	28.6%	26.8%
	Tattooing	Count		1		1
		% within Gender		1.4%		.5%
	Blood contamination & IDU	Count	2			2
		% within Gender	1.8%			1.1%
	Sexual contact & Blood contamination	Count		1		1
		% within Gender		1.4%		.5%
	Sexual contact & IDU/Tattoo	Count	9	11	2	22
		% within Gender	8.2%	15.1%	28.6%	11.6%
	Do not know	Count	12	3		15
		% within Gender	10.9%	4.1%		7.9%
Total		**COUNT**	**110**	**73**	7	**190**
		% within Gender	100.0%	100.0%	100.0%	100.0%

Note: Chi-Square Tests do not yield significant results.

TABLE 134. Need to or have Moved * Gender (Cross-tabulation)

			Gender			Total
			Male	Female	Trans-gender; Trans-sexual; Inter-sexed	
Need to or have moved	Yes, need to move	Count	15	15	2	32
		% within Gender	14.7%	22.7%	40.0%	18.5%
	Yes, have moved	Count	27	15	1	43
		% within Gender	26.5%	22.7%	20.0%	24.9%
	Not sure	Count	15	9		24
		% within Gender	14.7%	13.6%		13.9%
	No need to move	Count	45	27	2	74
		% within Gender	44.1%	40.9%	40.0%	42.8%
Total		Count	102	66	5	173
		% within Gender	100.0%	100.0%	100.0%	100.0%

Note: Chi-Square Tests do not yield significant results.

TABLE 135. Stigma as a Barrier to Services * Gender (Summary of Cross-tabulations; Number of respondents)

	Traditional Aboriginal [n=8]	Primary Medical [n=19]	Secondary Health [n=11]	Social/ Family [n=12]	Substance Use [n=2]	Community /ASO [n=4]	Mental Health /Counselling [n=3]
Male	7	11	8	8	2	3	3
Female	1	8	3	4	0	1	0

Note: Zero (0) responses from trans-gender, trans-sexual, or inter-sexed APHAs.

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