CANADIAN HIV•AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH•SIDA

CANADIAN ABORIGINAL AIDS NETWORK

HIV/AIDS and Aboriginal People:

Problems of Jurisdiction and Funding

A DISCUSSION PAPER

Second Edition

Health Canada Santé Canada

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Prepared by
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Published by the Canadian HIV/AIDS Legal Network and the Canadian Aboriginal AIDS Network

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Ce document est également disponible en français.

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SUMMARY

Background

In order to stimulate discussion about legal issues relating to HIV/AIDS and Aboriginal communities, the Canadian HIV/AIDS Legal Network and the Canadian Aboriginal AIDS Network are addressing three topics: (1) HIV/AIDS and discrimination; (2) problems of jurisdiction and funding; and (3) testing and confidentiality issues. This Discussion Paper deals with the second topic. A first edition of the papers was based on discussions with key informants who work in the field of Aboriginal people and HIV/AIDS conducted from July to September 1997. In October 1997, draft discussion papers were distributed for comments. The papers were first published in March 1998. Follow-up discussions were conducted and revisions made to the papers in January and February 1999. To the extent possible, the comments received have been reflected and incorporated in this second edition of the Discussion Paper.

Why Is This Discussion Paper Needed?

Statistics about cases of AIDS and the rate of HIV infection in the Aboriginal community suggest that the number of cases of HIV and AIDS are rising dramatically in the Aboriginal population and that the HIV epidemic among Aboriginal people shows no signs of abating. HIV/AIDS

could have a devastating impact on First Nations, Métis, and Inuit communities. Issues rooted in jurisdictional divisions hamper efforts to deal with this HIV/AIDS epidemic.

No group in Canada confronts jurisdictional divisions as much as Aboriginal people. The spread of HIV/AIDS within the Aboriginal community across jurisdictional boundaries has focused attention on the need to reduce the impact of these boundaries on the development and delivery of effective HIV/AIDS programs and services.

What Does the Discussion Paper Contain?

The Discussion Paper examines the issues raised for Aboriginal communities by the relationship between jurisdiction and HIV/AIDS programs and services, based on interviews with individuals working in the field of HIV/AIDS and Aboriginal people, and on research conducted by the author. A number of initiatives designed to overcome or reduce jurisdictional barriers are also discussed.

What Are the Issues?

The Discussion Paper begins with some background on federal and provincial jurisdiction with respect to Aboriginal people, followed by a discussion of jurisdiction, health care, and Aboriginal people.

Consultations conducted for the paper addressed a number of developments in health care that raise concerns for Aboriginal people living with or affected by HIV/AIDS. The Aboriginal community is undergoing a process of transition in health care, culture, and politics. HIV/AIDS issues must be a priority during this process.

The following changes in health care are particularly relevant to HIV/AIDS and Aboriginal communities:

- the devolution of authority over health care to the provinces and territories and the regionalization within provinces and territories of health services; and

- the transfer by the federal government of authority over health services to First Nations and some Inuit communities. This transfer does not respond to the needs of off-reserve and non-status Indians; indeed, it is often detrimental to these groups.

The following issues relating to jurisdiction, HIV/AIDS, and Aboriginal people were raised during the consultation process:

- funding problems, including the adequacy and sources of funding;
- the impact of divisions between federal and provincial/territorial governments on the development and delivery of coordinated and comprehensive HIV/AIDS programs and services for Aboriginal people;
- the impact of interdepartmental barriers on coordination and collaboration; and
- the impact of divisions within the Aboriginal community due to the legacy of imposed definitions and jurisdictional divisions.

What is the Goal of the Discussion Paper?

The paper does not provide definitive answers. In the end, answers to the issues raised must come from within Aboriginal communities. The goal is to provide information and identify problems related to jurisdiction, HIV/AIDS and Aboriginal people. It is hoped that the conclusions contained in the Discussion Paper will stimulate discussion about the issues raised and contribute to the development of solutions to the problems identified.

What Does the Discussion Paper Conclude?

The Discussion Paper contains nine broad conclusions, to the effect that:

- The devolution of authority over certain matters to the provinces, the development of self-government, and the transfer to First Nations of jurisdiction over health services, have a dramatic impact on the lives of Aboriginal people. During this period of transition, HIV/AIDS issues for all Aboriginal people – including status, non-status, on-reserve, off-reserve, Métis, First Nation, and Inuit – need to be considered and addressed. Federal, provincial, and territorial governments should recognize their responsibilities to all Aboriginal people in the implementation of a renewed relationship.
- During the process of regionalization of health services that has been adopted by many provinces and territories, and downsizing in health care, it is important that HIV/AIDS programs and services be uniformly and comprehensively available and that HIV/AIDS issues be a priority for regional health authorities.

- During the process of regionalization, it is also important that the interests of Aboriginal communities be respected and addressed.

- First Nations and Inuit health authorities operating under health transfer initiatives should be encouraged to make HIV/AIDS issues a priority in their communities.

- Although the Canadian Strategy on HIV/AIDS (CSHA), with its focus on Aboriginal communities, is an encouraging development, funding levels for HIV/AIDS programs and services for Aboriginal people were seen to be inadequate by many of those interviewed, particularly in the face of rising rates of infection in the Aboriginal population, the prevalence of risk factors for HIV infection, and the overrepresentation of Aboriginal people in groups at high risk. It is crucial that CSHA funding be used effectively. Part of this will involve an emphasis on training and capacity-building within Aboriginal communities. It is also important to note that funding levels continue to vary, depending on the commitment of provincial and territorial governments to HIV/AIDS initiatives for Aboriginal people.

- Government HIV/AIDS funding agencies should make efforts to reduce the impact of jurisdictional barriers on Aboriginal HIV/AIDS program and service delivery. Aboriginal AIDS organizations should be encouraged to continue to share information and assist each other in accessing funds.

- Initiatives underway to improve collaboration and coordination between federal and provincial/territorial government agencies working in the field of HIV/AIDS, and between departments and branches within government bureaucracies dealing with Aboriginal issues, are encouraged. The value of these initiatives is reinforced by Aboriginal participation in discussion and decision-making.

- Following the example of Ontario and British Columbia, each province and territory should support the development of comprehensive Aboriginal HIV/AIDS strategies. Among other things, such strategies should seek to overcome interprovincial and territorial differences in the availability of culturally appropriate HIV/AIDS programs and services for Aboriginal people.

- The Canadian Aboriginal AIDS Network (CAAN) and its member organizations, along with non-member Aboriginal organizations involved in HIV/AIDS issues, have an important role to play in overcoming jurisdictional problems in the area of Aboriginal people and HIV/AIDS, but require long-term funding in order to continue their work. These organizations should be consulted as to the need for, and design of, a national Aboriginal HIV/AIDS strategy.

HIV/AIDS presents a challenge to federal, provincial, and territorial governments, and to First Nations, Métis, and Inuit governments and organizations: jurisdictional barriers must be overcome, as they frustrate the development of coordinated, collaborative and comprehensive HIV/AIDS programs and services for Aboriginal communities. In addition, the detrimental impact on HIV/AIDS services and other health, social, economic, and cultural services, of the artificial divisions imposed on Aboriginal people must be reduced.

Aboriginal AIDS organizations and Aboriginal people living with or affected by HIV/AIDS are experts in the development of HIV/AIDS programs and services. Governments and organizations should look to them for guidance in designing strategies to reduce the impact of HIV/AIDS on Aboriginal communities.

Next Steps

The revised and updated Discussion Paper is intended to be a resource for Aboriginal and other HIV/AIDS organizations, Aboriginal governments, federal and provincial governments, policymakers, departments and agencies, non-governmental organizations, and others. The Paper will be widely distributed and made available on the Network's website. Articles based on the Paper will be published in the *Canadian HIV/AIDS Policy & Law Newsletter* and submitted for publication in other journals and newsletters. Fact sheets summarizing the Paper's most relevant information have been produced.

Further copies of this Discussion Paper ...

can be retrieved at the website of the Canadian HIV/AIDS Legal Network at <www.aidslaw.ca>.

Copies can also be ordered through the Canadian HIV/AIDS Clearinghouse. For more information, contact:

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INTRODUCTION

In July 1997, the Canadian HIV/AIDS Legal Network (Legal Network) started undertaking a project on legal issues relating to Aboriginal people and HIV/AIDS. Three discussion papers were published in March 1998 on: (1) HIV/AIDS and discrimination; (2) problems of jurisdiction and funding; and (3) testing and confidentiality issues. Funding for the project was initially provided by the HIV/AIDS Policy, Coordination and Programs Division, Health Canada, under the National AIDS Strategy Phase II. This paper deals with the second of the three project topics. [1]

From July to September 1997, discussions with key informants working in the field of HIV/AIDS and Aboriginal people were conducted. In October 1997, draft discussion papers were distributed for comments. The first edition of the discussion papers was published and widely distributed in March 1998. In the fall of 1998, the Legal Network and the Canadian Aboriginal AIDS Network (CAAN) agreed to jointly produce a second, revised edition of the discussion papers and a series of info sheets summarizing the main issues raised in the papers. To this end, in January and February 1999, follow-up discussions were conducted with individuals representing Aboriginal HIV/AIDS organizations and Health Canada. The discussion papers were then revised and this second edition produced. An attempt has been made throughout the paper to reflect and incorporate the comments of those consulted. A list of people interviewed appears in the Appendix to each paper.

[1] Parts of this paper are based on an unpublished paper by Stefan Matiation for 2-Spirited Peoples of the 1st Nations (TPFN) entitled HIV/AIDS and Aboriginal Communities: Problems of Jurisdiction and Discrimination, prepared in connection with the Human Rights Internship Program of the University of Toronto's Faculty of Law. The paper has been reviewed in the *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 3(1): 1.

Background

HIV/AIDS and Aboriginal People

The Laboratory Centre for Disease Control (LCDC) reports that as of 31 December 1997, 255 of the 15,528 AIDS cases in Canada were reported as Aboriginal. Adjusted for reporting delays, the number of Aboriginal AIDS cases was estimated at 332 by the end of 1997, or 33.2 cases per 100,000 Aboriginal people. This number is regarded as underrepresentative of the true number of AIDS cases among Aboriginal people due to delays in reporting, low HIV testing rates, and variations in the completeness of reporting of ethnic status between the provinces.[2] LCDC estimates that "as of the end of 1996, a cumulative total of 50,000 to 54,000 Canadians had been infected with HIV since the onset of the epidemic and that at the end of 1996, 36,000 to 42,000 Canadians were living with HIV infection (including those living with AIDS)."[3] The number of cases of HIV infection among Aboriginal people is largely unknown.

LCDC reports a number of statistics that suggest that "Aboriginal people are infected earlier than non-Aboriginal people, that injection drug use is an important mode of transmission, and that the HIV epidemic among Aboriginal people shows no signs of abating":[4]

- Aboriginal AIDS cases are younger on average than non-Aboriginal AIDS cases (29.8 percent versus 18.6 percent diagnosed at less than 30 years of age).
- Aboriginal AIDS cases are more likely than non-Aboriginal AIDS cases to be attributed to injection drug use (19.0 percent versus 3.2 percent for men, 50.0 percent versus 17.4 percent for women).
- The proportion of AIDS cases attributed to Aboriginal people increased from 2.0 percent before 1989 to more than 10 percent in 1996-97.
- Recent data (1993-97) from British Columbia, Alberta and Saskatchewan shows that Aboriginal people comprise 15, 26, and 43 percent of newly diagnosed HIV-positive cases respectively.

LCDC reports that the proportion of women among adult Aboriginal AIDS cases is higher than among adult non-Aboriginal AIDS cases (15.1 percent versus 7.0 percent).[5] In addition, Aboriginal people are overrepresented with respect to many risk factors for HIV/AIDS, including drug and alcohol use, high rates of STDs, teen pregnancies, general poor health conditions, and lower socioeconomic status. Aboriginal people are also overrepresented in groups at high risk for HIV infection, including injection drug users and inmates in provincial and federal prisons.[6]

[2] Laboratory Centre for Disease Control. *Epi Update: HIV/AIDS Epidemiology Among Aboriginal People in Canada*. Ottawa: Health Canada, May 1998.

[3] LCDC. *Epi Update: HIV and AIDS in Canada*. Ottawa: Health Canada, November 1997.

[4] Supra, note 2. Most Aboriginal AIDS cases are male. Of the 213 reported male Aboriginal AIDS cases, men who have sex with men account for 59.2 percent of them.

[5] Ibid.

[6] Ibid. In some cities, 25 to 75 percent of clientele using inner-city services are Aboriginal. Fourteen percent of federal inmates in Canada are Aboriginal, with rates up to 40 percent in provincial or federal prisons in some provinces. STD rates in some regions populated predominantly by Aboriginal people are 5 to 10 times the national average.

The foregoing data, and anecdotal evidence from many of the people consulted, indicate that there is an HIV/AIDS epidemic among Aboriginal people in Canada that could have a devastating impact on First Nations, Métis, and Inuit communities.

Aboriginal People and Canada

The historical relationship between Canada and First Nation and Inuit communities has been characterized largely by oppression, racism, and colonialism. At the time of Confederation in 1867, authority over "Indians" was divided between federal and provincial governments in the same way as were property and control over hospitals. Since then, most Aboriginal people in Canada have lived under an imposed regime of legislated definitions and have been subjected to assimilationist pressures. This historical relationship has made Aboriginal people second-class citizens in Canada in terms of health, economic, and social problems, and has thereby contributed to exacerbating the risk factors for HIV/AIDS.

Lately, there has been a resurgence of Aboriginal culture and community. Throughout this process, Aboriginal people and their leadership have argued forcefully for the recognition of Aboriginal rights, including the right to self-government, and for respect of Aboriginal traditions.

Although this is a period of transition and hope in Aboriginal communities, the legacy of years of oppression and racism remain. Aboriginal people continue to deal with a jurisdictional morass that can frustrate new initiatives and complicate the delivery of services. Jurisdictional issues arise frequently and in many forms for Aboriginal people living with or affected by HIV/AIDS and the organizations trying to assist them. HIV/AIDS does not respect the artificial boundaries that divide the Aboriginal community.

Scope of the Paper

The paper begins with a discussion of the constitutional division of powers as it affects Aboriginal people and the delivery of health services. Jurisdictional barriers have their roots in this division of powers and the way in which legislative authority has been exercised.

The discussion then shifts to consider some of the changes in health care in the last ten years, including regionalization and health transfer policies, and the impact of these changes on the provision of HIV/AIDS-related services to Aboriginal people.

Next, some problems created in the field of HIV/AIDS and Aboriginal people by jurisdictional divisions are identified, including funding problems, service gaps, and problems of coordination and collaboration.

The final section of the paper identifies a number of initiatives currently underway that seek to overcome jurisdictional barriers to the delivery of comprehensive, coordinated, and collaborative HIV/AIDS services and programs for Aboriginal people.

Limitations

Changes over Time

In *HIV Testing and Confidentiality: Final Report*, Ralf Jürgens notes that HIV/AIDS issues may need to be reexamined over time as knowledge about HIV/AIDS increases and the epidemic evolves.[7] It is important to note that the conclusions drawn in this Discussion Paper are far from timeless. Knowledge of the epidemic in the Aboriginal population in Canada is limited by a lack of concrete epidemiological data and a reliance on anecdotal evidence. While anecdotal evidence in this area should not be discounted, as it is generally provided by those who have the best opportunities to monitor the epidemic – namely, front-line workers working with Aboriginal HIV/AIDS organizations, health centres in reserve and urban areas, and others working in the field – it does not mean that there is not much to be learned about the evolution and impact of the epidemic in the Aboriginal population. As knowledge increases, the conclusions drawn in this Discussion Paper may have to be changed and the issues reexamined.

It is also important to note the rapid political and social changes occurring in Aboriginal communities. Many of these changes may also have an impact on the conclusions and comments made in this Discussion Paper and necessitate a reexamination of these issues in the future.

[7] Ralf Jürgens. *HIV Testing and Confidentiality: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1998.

Level of Detail

The Aboriginal population is diverse, consisting of a multitude of cultures, languages, traditions, living circumstances, and experiences. It is impossible in this Discussion Paper to provide the level of detail necessary to account for these differences. In particular, it has been difficult to reflect the circumstances of Inuit and Métis communities. The impact of Nunavut, which comes into being on 1 April 1999, on the lives and health of the predominantly Inuit population in the new territory has not been examined. It is acknowledged that more information concerning Métis people and Inuit and non-status Indians would be useful. It may be appropriate to address the specific issues of these groups in separate papers.

It is also important to bear in mind that the Aboriginal population has also shared in many ways in a common history. Unfortunately, this shared history has not always been positive, involving the ill effects of colonization, racism, and cultural denigration. This shared experience has contributed to the prevalence of risk factors for HIV transmission in the Aboriginal population as a whole.

The Aboriginal population also shares in a capacity to withstand the ravages of colonialism. Although their cultures and traditions have been weakened, and sadly in some cases lost, Aboriginal communities are involved in a cultural and political resurgence: recent developments suggest that the Aboriginal population remains strong and that Aboriginal people are prepared to reassert their cultures and traditions and regain control of their future.

Although this Discussion Paper may not deal specifically with the concerns and experiences of certain groups, the issues raised may nonetheless resonate with the concerns and experiences of such groups. During the preparation of these papers, an attempt has been made to bear in mind the differences and similarities among Aboriginal groups, nations, and communities.

Scope of the Consultations

A third important limitation in this project is the scope of the consultations, which have been limited by time, financial resources, and geography. The discussions have focused on representatives of Aboriginal HIV/AIDS organizations and Health Canada, with additional input where possible. Due to the different circumstances of Aboriginal people across the country, it is important to obtain input from organizations operating in different regions. This has been attempted to the extent possible. However, while some face-to-face meetings were possible, many interviews had to be conducted by telephone.

This project is a small contribution to discussion about legal and ethical issues related to Aboriginal people and HIV/AIDS. It is hoped that discussions will continue among an expanding group of people.

A Note about Terminology

This Discussion Paper adopts the terminology used by the Royal Commission on Aboriginal Peoples:

> The Commission uses the term *Aboriginal people* to refer to the indigenous inhabitants of Canada when we want to refer in a general manner to Inuit and to First Nations and Métis people, without regard to their separate origins and identities.
>
> The term *Aboriginal peoples* refers to organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so-called "racial characteristics." The term includes the Indian, Inuit and Métis peoples of Canada.
>
> *Aboriginal people* (in the singular) means the individuals belonging to the political and cultural entities known as "Aboriginal peoples"....
>
> Our use of the term *Métis* is consistent with our conception of *Aboriginal peoples* as described above. We refer to the Métis as distinct Aboriginal peoples whose early ancestors were of mixed heritage (First Nations, or Inuit in the case of Labrador Métis, and Europeans) and who associate themselves with a culture that is distinctly Métis…
>
> Following accepted practice and as a general rule, the term *Inuit* replaces the term *Eskimo*. As well, the term *First Nation* replaces the term *Indian*…[8]

[8] Royal Commission on Aboriginal Peoples. A Note About Terminology. *Final Report*, Ottawa: Minister of Supply and Services, 1996.

Terms such as Eskimo and Indian continue to be used where such terms are used in quotations from other sources, where the terms are found in legislation or case-law, or in relation to status or non-status Indians, as defined by the *Indian Act*.

Terms such as *Aboriginal community*, *First Nations community*, *Métis community*, or *Inuit community* refer to a group of Aboriginal people residing in a single locality and/or united through shared experiences. Such communities may arise in reserves, remote settlements, or rural or urban areas.

The term *two-spirited* or *two-spirit* is used in this Discussion Paper. The term has a number of meanings within different contexts and Aboriginal traditions. In general terms it means Aboriginal people who identify themselves as gay, lesbian, bisexual, or transgender. The term "two-spirited" or "two-spirit" is preferred because it is more culturally relevant to Aboriginal gay, lesbian, bisexual, and transgender people.

In some Aboriginal traditions, two-spiritedness was regarded as a gift. Two-spirited people were respected and honoured and were visionaries and healers in their communities. The term originates from the recognition of the sacredness in some traditions of people who maintain a balance by housing both the male and female spirits.[9]

[9] "Two-spirited" is defined in the *Ontario Aboriginal HIV/AIDS Strategy*. Toronto: The Strategy, 1996.

JURISDICTION

No other group in Canada has confronted jurisdictional issues or the effects of jurisdictional divisions as much as Aboriginal people. With respect to no other group is the line dividing jurisdictional responsibilities as unclear.

This section begins with a number of examples that reflect the impact that jurisdictional divisions can have on Aboriginal people living with or affected by HIV/AIDS. The rest of the section describes the relationship between federal and provincial legislative powers with respect to Aboriginal people, the relationship between Aboriginal rights and federal and provincial powers and responsibilities, and the development of Aboriginal self-government. This provides some background to the discussion of the impact of jurisdiction on HIV/AIDS programs and services for Aboriginal people.

Examples of Jurisdictional Problems

The following examples drawn from the consultations for this paper reflect some of the ways in which jurisdictional divisions affect Aboriginal people living with or affected by HIV/AIDS:

> An Aboriginal man with AIDS decided to return to his community to die. He required assistance to get around and to avoid health complications. Despite being aware of his intention to return home, the urban AIDS agency that had been assisting the man did not contact health-care workers in his home community in advance of his arrival to discuss his needs.

> Too little funding is available through the Medical Services Branch of Health Canada (MSB) to assist a band to provide effective services. Bands in Atlantic Canada have pooled these funds in order to support the Atlantic First Nations AIDS Task Force. Some other bands misuse HIV/AIDS funding to cover unrelated expenses.

> Many Aboriginal people living with HIV/AIDS do not have access to an Aboriginal AIDS organization. There are no Aboriginal AIDS organizations in a number of cities with significant Aboriginal populations, including Ottawa, Calgary, and Saskatoon. Some Aboriginal AIDS organizations are seriously underfunded.

> There is limited coordination of activities between departments of the federal government, despite the fact that a number of different departments provide services to Aboriginal people. While on-reserve education is provided by Indian and Northern Affairs Canada, HIV/AIDS education funding is administered by various branches of Health Canada.

> MSB supports HIV/AIDS-related services for Aboriginal people living on reserve and for Inuit people in Labrador but not for Inuit people in the Northwest Territories. This contributes to HIV/AIDS funding difficulties in the North.

> Despite the high mobility of Aboriginal people and the historic relationship between the federal government and First Nations, the federal government continues to divide and limit most Aboriginal services in accordance with reserve boundaries. There is often a lack of coordination of activities between federal and provincial policy makers to shore up the policy vacuum created by divided jurisdictions. The needs of non-status and Métis people are often ignored.

Aboriginal People and Jurisdiction

"Jurisdiction" means the legal authority of one order of government to legislate with respect to a subject matter. Constitutional law spells out the relationship between the orders of government and the rules of interpretation applicable to the division of powers. Sections 91 and 92 of the *Constitution Act, 1867*[10] distribute the legislative powers of the federal and provincial orders of government in Canada. The process leading toward the development of Aboriginal self-government introduces a third order of government into the constitutional framework.

The issue of jurisdiction with respect to Aboriginal people in Canada is complicated. It does not end with ss 91 and 92 and the rules of constitutional law, but involves the *Royal Proclamation, 1763*,[11] the historical relationship between the Crown and First Nations, treaties and land claims agreements, the *Indian Act*, ss 25 and 35 of the *Constitution Act, 1982*,[12] the concept of fiduciary duty, judicial decisions, and the transition to self-government. It is beyond the scope of this paper to discuss all these matters.[13] Instead, the following section describes the powers and responsibilities of the orders of government with respect to Aboriginal people in order to provide a background to the discussion of the impact of jurisdiction on HIV/AIDS issues.

Federal Legislative Power with Respect to Aboriginal People

Section 91(24) of the *Constitution Act, 1867* provides that the "exclusive Legislative Authority" of the federal government extends to "Indians and Lands reserved for the Indians."[14] Although the term "Indians" has been interpreted to include Inuit[15] and probably includes Métis and non-status Indians,[16] these groups are excluded from the *Indian Act* definition of status Indian. The federal government "has continued to resist arguments that Métis people are included within the scope of section 91(24), despite their inclusion in s. 35 of the Constitution Act, 1982."[17] It has generally been the position of the federal government that it may choose whether to exercise its jurisdiction.[18] Accordingly, with some exceptions, the federal government has focused its activities on status Indians living on reserve and some Inuit communities.

[10] *Constitution Act, 1867* (UK), 30 & 31 Vict c 3.

[11] *Royal Proclamation, 1763*, RSC 1985, App II, No 1.

[12] *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

[13] See Peter Hogg. *Constitutional Law of Canada*, 3d ed. Toronto: Carswell, 1992; and Peter Hogg, Mary Ellen Turpel. Implementing Aboriginal Self-Government: Constitutional and Jurisdictional Issues. *Canadian Bar Review* 1995; 74(2): 187-224, for a more detailed legal analysis of jurisdiction and Aboriginal people. I have relied heavily on Hogg, *Constitutional Law of Canada*, for this section of the paper.

[14] Supra, note 10 at s 91(24). Hogg notes that s 91(24) includes two heads of power: a power over "Indians," which may be exercised over Indians whether or not they have any connection with reserve lands, and a power over "lands reserved for the Indians," which may be exercised in respect of Indians and non-Indians so long as the law relates to lands reserved for the Indians. Lands reserved for the Indians includes Indian reserves and "may extend to all land that is subject to unextinguished aboriginal title." Hogg, supra, note 13 at 27-2.

[15] *Re Eskimos*, [1939] 2 DLR 417 (SCC).

[16] Hogg, supra, note 13 at 27-4.

[17] Supra, note 8, vol 4 at 539.

[18] Ibid at 541. Hogg argues: "The Parliament is, of course, under no obligation to legislate to the full limit of its statutory authority, and, with respect to Indians, it has certainly not done so." See supra, note 13 at 27-4.

Despite the federal policy to limit the use of its legislative powers with respect to Indians and lands reserved for the Indians, Parliament "has taken the broad view that it may legislate for Indians on matters which otherwise lie outside its legislative competence, and on which it could not legislate for non-Indians."[19] For example, although education is a matter of provincial jurisdiction, the *Indian Act* includes provisions respecting the education of status Indians ordinarily resident on reserve.[20]

In short, Parliament has generally exercised the full weight of its constitutional powers over "Indians" while taking a narrow view of its historically based responsibilities to all Aboriginal people, including on-reserve, off-reserve, status, non-status, Métis, and Inuit communities.

Provincial Legislative Power with Respect to Aboriginal People

Provincial laws of general application apply to "Indians and lands reserved for the Indians." A provincial legislature can make a law apply to Aboriginal persons whether they live on or off reserve so long as the law is in relation to a matter falling under a provincial head of power.

Five exceptions to the general rule are:[21]

(1) A provincial law may not single out Indians or reserves for special treatment.

(2) A provincial law cannot affect aboriginal or treaty rights nor can it affect Indian status.

(3) A provincial law that is inconsistent with a federal law such as the *Indian Act* is rendered inoperative by the doctrine of federal paramountcy.[22]

(4) Provincial laws cannot deprive Indians of the right to hunt or fish for food which is protected by the Natural Resources Agreements in Alberta, Saskatchewan and Manitoba.

(5) Provincial and federal laws are subject to s 35 of the Constitution, 1982.

[19] Supra, note 13 at 27-4.

[20] *Indian Act*, RSC 1985, c I-5, ss 114-122.

[21] From supra, note 13 at 27-10 to 27-12.

[22] "Federal paramountcy" is a doctrine of little practical effect. In order for a provincial law to be struck down, the legislation at issue must be directly inconsistent with federal law. A provincial statute establishing one level of minimum wage, for example, is not invalid simply because a federal law imposes a different level, even where the employer is the federal government. Example from Hogg, supra, note 13.

Section 88 of the *Indian Act* adds to the breadth of provincial laws applicable to Indians. In *Dick* v *The Queen*, the Supreme Court of Canada held that s 88 applies to provincial laws that affect Indianness by impairing the status or capacity of Indians. Writing for the majority, Beetz J held that these are the only laws to which s 88 needs to apply because these are the provincial laws that cannot apply of their own force. Beetz J used the example of traffic legislation as provincial laws that apply to Indians of their own force. Provincial hunting laws that impair the status or capacity of Indians might still apply by virtue of s 88, although such laws would be subject to s 35.[23]

Before *Dick*, it was thought that s 88 was simply declarative of the general rule. On the contrary, s 88 expands the body of provincial laws applicable to "Indians and lands reserved for the Indians."

The scope of s 88 is limited by several exceptions similar to those affecting the general rule discussed above: s 88 is subject to the doctrine of federal paramountcy, to the terms of any treaty, to the Natural Resources Agreements, and to s 35.

[23] See Hogg, supra, note 13 at 27-14. See also *Dick* v *The Queen,* [1985] 2 SCR 309. Followed in subsequent cases, including *Derrickson* v *Derrickson*, [1986] 1 SCR 285; *R* v *Francis*, [1988] 1 SCR 1025.

Section 35 and the Fiduciary Relationship

Section 35(1) of the *Constitution Act, 1982* provides that:

> The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.[24]

Treaty rights are rights created by treaties entered into by the Crown with First Nations or bands "and perhaps" rights created by provisions of international treaties.[25] Aboriginal rights are grounded in the traditions of First Nations. Aboriginal rights do not exist because of anything done by the Crown.

A test for identifying Aboriginal rights has recently been articulated by the Supreme Court of Canada in *R* v *Van der Peet* as follows:

> [I]n order to be an aboriginal right an activity must be an element of a tradition, custom or practice integral to the distinctive culture of the aboriginal group claiming the right.[26]

Section 35 protects unextinguished Aboriginal and treaty rights existing in 1982, and treaty rights that may be acquired after 1982. This means that an Aboriginal or treaty right existing before 1982 could only be extinguished by clear and plain language to that effect. Aboriginal and treaty rights existing as of 1982, and treaty rights acquired after 1982, are protected from unjustified curtailment by federal or provincial legislation by s 35.[27] "The effect of s.35 is that aboriginal and treaty rights can only be extinguished in two ways: (1) by (voluntary) surrender and (2) by constitutional amendment."[28]

[24] Supra, note 12 at s 35(1). Section 35 exists outside the Charter and is therefore not subject to the legislative override provided by s 33 (the notwithstanding clause) or to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society," as specified by s 1; nor are the rights effective only against governmental action, as stipulated by s 32. Section 35 rights are not enforceable pursuant to s 24 of the Charter, but can be used as a defence.

[25] Supra, note 13 at 27-8.

[26] [1996] 4 CNLR 177 (SCC), quoted in *R* v *Pamajewan*, [1996] 4 CNLR 164 at 171.

[27] *Sparrow* v *R*, [1990] 1 SCR 1075.

[28] Supra, note 13 at 27-30.

Further, the fiduciary duty of the Crown (the federal Parliament and provincial legislatures) toward Aboriginal people is constitutionally guaranteed.[29] This unique fiduciary duty is grounded in the historic relationship of the Crown and First Nations. This relationship began with the arrival of Europeans to a territory already occupied by self-governing Nations and was subsequently shaped by the *Royal Proclamation, 1763*, which recognized that the Aboriginal people of North America own their lands until voluntarily surrendered.[30] The historical relationship has also been defined by treaties, by the Constitution and by the policies of federal and provincial governments, among other things.

The entrenchment of the fiduciary relationship through the enactment of s 35 limits federal and provincial legislative powers. While the legislative authority of the Crown mandates legislation affecting Aboriginal people, Crown responsibility requires that any infringement upon Aboriginal or treaty rights be stringently justified. In addition, the Supreme Court of Canada has indicated that Aboriginal groups affected by any infringement of Aboriginal or treaty rights must be involved in the decision-making process relating to a proposed infringement.[31]

Aboriginal Governmental Powers

It is the position of the Royal Commission on Aboriginal Peoples (RCAP) that among the Aboriginal rights recognized and affirmed by s 35 is the inherent right to self-government.[32] The government of Canada has adopted this approach in its policy statement on self-government.[33] It is also the federal government's policy that the implementation of self-government will change the nature of the relationship between the federal government and First Nations:

> There is no justifiable basis for the Government to retain fiduciary obligations in relation to subject matters over which it has relinquished its control and over which an Aboriginal government or institution has, correspondingly, assumed control.[34]

[29] Supra, note 13 at 27-29. There is some dispute whether the fiduciary duty is binding upon provincial legislatures. Saying "There's only so much the federal government can do by itself," Georges Erasmus, co-chair of RCAP, called on the provinces to recognize their responsibilities and contribute more to Aboriginal programs and services. This was reported on the same day that the federal government committed $350 million to on-reserve issues and $350 million to a healing fund for people adversely affected by residential schools. While these federal initiatives are laudable, they suggest a federal emphasis on reserve issues. (Reported by the Canadian Press in *Thunder Bay Chronicle-Herald* 7 January 1998.) Erasmus's comments address the policy vacuum experienced by Aboriginal people living off reserve. The reluctance of the federal government to recognize its fiduciary responsibilities toward Aboriginal people living off reserve and the failure of provincial governments to recognize any fiduciary obligations to Aboriginal people contribute to jurisdictional problems for Aboriginal people living with HIV/AIDS.

[30] Supra, note 11.

[31] *Delgamuukw* v *BC*, [1997] 3 SCR 1010.

[32] See RCAP *Final Report*, supra, note 8; and RCAP. *Partners in Confederation*. Ottawa: Minister of Supply and Services, 1993.

[33] *Aboriginal Self-Government: The Government of Canada's Approach to Implementation of the Inherent Right and the Negotiation of Aboriginal Self-Government*. Ottawa: Minister of Public Works and Government Services Canada, 1995.

[34] Ibid at 14.

This view does not seem reflective of mutual recognition, mutual respect, sharing, and mutual responsibility, the fundamental principles of a renewed relationship as described in the RCAP *Final Report*. RCAP discusses the fiduciary relationship in terms of a political and constitutional partnership that involves shared responsibility between the parties. The ideal suggested by RCAP is that this partnership be based on respect and recognition of the mutual vulnerability of the parties, giving rise to mutual obligations in a trust-like relationship.[35] The government's view, as suggested by the above quote, reflects an interpretation of the fiduciary relationship based on notions of guardian and ward.

Evolving Aboriginal governments are negotiating jurisdiction over such subject matters as health, education, and policing. Health transfer agreements, discussed further below, are part of this process.

[35] Supra, note 8, vol 1 at 689.

HEALTH-CARE ISSUES

In its *Final Report*, RCAP states that

> despite the extension of medical and social services (in some form) to every Aboriginal community, and despite large sums spent by Canadian governments to provide services, Aboriginal people still suffer from unacceptable rates of illness and distress.[36]

For most of the twentieth century, Aboriginal people were subjected to Western-style health-care services. Although this system helped lower mortality rates in Aboriginal communities, its benefits did not come without a price: Aboriginal people were often sent, unaccompanied, to distant medical facilities, traditional health-care practices were devalued and often lost, and "Aboriginal people learned that they were not in charge."[37]

> An Inuit woman was removed from her home, a small northern community, to be treated as a young child for tuberculosis in a large southern city. Upon her return she did not speak the language of her parents, having learned only English during her lengthy absence.

More recently, Aboriginal people have begun to play a leading role in the delivery and development of health-care services, and traditional practices are regaining prominence. Nonetheless, the legacy of ill-health remains and contributes to a higher risk for HIV infection among Aboriginal people.

This section describes how jurisdiction relates to the delivery of health-care services to Aboriginal people, particularly in the area of HIV/AIDS, and examines how changes in health care may affect Aboriginal HIV/AIDS programs and services.

[36] Ibid, vol 3 at 119.

[37] Ibid, vol 3 at 114.

Jurisdiction and Health Care

"Health" is an amorphous topic under the Constitution; that is, it is not specifically assigned to one level of government.[38] Health involves criminal aspects, local aspects, labour issues, and national emergency issues as well as Aboriginal aspects. The power to legislate with respect to health issues is divided between provincial and federal governments according to the impact of an issue on the constitutional heads of power. For example, ss 92(16) and 92(7) of the *Constitution Act, 1867* confer on provincial legislatures authority over public health and the provision of health services as a local or private matter and over the establishment and management of hospitals.[39] At the same time, the federal government has exercised authority over the health of Aboriginal people living on reserve under s 91(24).[40]

Through its spending power, the federal Parliament has traditionally exercised a great deal of power outside its explicit area of jurisdiction. In health care, federal governments have been able to influence the health system through conditional federal grants to establish cost-shared programs such as insured health services. In 1996 the current government moved away from this model by replacing Canada Assistance Plan and Established Program Funding transfers with the Canada Health and Social Transfer (CHST) program. "The CHST is the federal contribution to provincial health and social programs."[41]

The new program provides the provinces with an annual federal grant and reduces the role of Parliament in establishing national standards. The CHST imposes conditions, in that the provinces must comply with the *Canada Health Act*, which sets out the federal government's health-care policy, and must not set minimum residency requirements for social assistance. However, the federal transfer is a fixed amount that is not based on a formula reflecting actual health-care costs. "This means that provinces have a greater incentive to control their costs, and the federal government has no interest in controlling or auditing provincial expenditures."[42]

[38] Supra, note 13 at 18-4.

[39] Supra, note 10 at ss 92(7) and 92(16).

[40] Ibid at s 91(24).

[41] Supra, note 13 at 6-11.

[42] Ibid at 6-12.

Health Care and Aboriginal People: An Overview

Federal and provincial governments support an array of services related to Aboriginal health care. Most First Nations and Inuit communities in Canada are assuming more responsibility and control over health services through various forms of transfer agreements. What follows is a brief overview of the major components of Aboriginal health services. Transfer initiatives are discussed below under the heading "Health Transfer."

Reserves and some Inuit communities benefit from targeted health and social service funding from the federal government. The federal government supports the following services for Aboriginal people living on reserve and some Inuit communities, primarily through the Medical Services Branch of Health Canada (MSB):

> (1) Health stations with nurses "working in the expanded role." These stations are generally not overnight facilities but provide fairly extensive outpatient health services. They are generally found in remote communities.
>
> (2) Health centres providing public health services. These facilities are generally found in small communities or more settled areas where more extensive facilities exist nearby.
>
> (3) Community Health Representatives (CHRs) are found in virtually all reserve and some Inuit communities. CHRs are members of the community trained to provide a combination of primary care, public health and health promotion services. The work of CHRs is complimented by the National Native Alcohol and Drug Abuse Program, which supports trained addiction counsellors in most reserve and Inuit communities.[43]

"The federal government also supports some [fifty] residential treatment centres and seven hospitals scattered across the provinces, providing services almost exclusively to First Nations and Inuit patients."[44]

Pursuant to the constitutional division of powers, the provinces are responsible for hospital services and medical professionals working with Aboriginal people. These services are used by First Nations people living on and off reserve.

[43] Personal communication with Judith Ross, Director, Health Programs Support Division, Medical Services Branch, 5 August 1997.

[44] Supra, note 8, vol 3 at 247.

Further, several provincial governments have developed initiatives focused on Aboriginal communities. In Ontario, for example, the Aboriginal Healing and Wellness Policy was announced in June 1994.[45] The Policy supports a number of healing lodges and Aboriginal health centres throughout the province. Services will be provided to Aboriginal people on a status-blind basis.

For the most part, Aboriginal people living off reserve do not benefit from the health services supported by MSB for reserve communities and must rely on provincially funded services. One exception is the Non-Insured Health Benefits program (NIHB), which reimburses Aboriginal residents of Canada who are registered Indians or recognized Inuit or Innu for some medical, dental, and prescription drug expenses. In order to be eligible, these expenses must not be covered by provincial or territorial health insurance, insurance available through employment, or private insurance policies. The program is not available to non-status Indians or Métis people.

HIV/AIDS-Related Funding and Aboriginal People

In 1990, seven years after the human immunodeficiency virus was identified, the federal government committed $112 million to Phase I of the National AIDS Strategy (NAS). Phase II of NAS was approved in 1993 as a five-year initiative involving $211 million, ending in March 1998.

In July 1997, the Minister of Health announced the government's intention to renew a national HIV/AIDS strategy based on a consultation process involving a broad range of national stakeholders. The framework for a new strategy was outlined on 1 December 1997, World AIDS Day. The Canadian Strategy on HIV/AIDS (CSHA) involves a commitment of $42.2 million per year, beginning 1 April 1998.[46]

The following goals for the CSHA have been identified:

- to prevent the spread of AIDS;
- to find and provide effective vaccines, drugs and therapies;
- to find a cure;
- to ensure treatment, care and support for people living with HIV/AIDS, their caregivers, families and friends;
- to minimize the adverse impact of HIV/AIDS on individuals and communities; and
- to minimize the importance of the social the economic factors that increase the individual and collective risk for HIV.[47]

[45] The Policy is discussed in supra, note 8, vol 3 at 251.

[46] Based on Health Canada press release 1997-66, dated 1 December 1997 and on information from the Health Canada website.

[47] *The Canadian Strategy on HIV/AIDS: Moving Forward Together*. Ottawa: Minister of Health, 1998, at 5.

The CSHA identifies Aboriginal communities specifically as a program component of the strategy. The other program components are: prevention; community development and support of national NGOs; care, treatment and support; research; surveillance; international collaboration; legal, ethical and human rights; consultation, evaluation, monitoring and reporting; and correctional services. It is important to note that issues for Aboriginal people cross the boundaries between many of these program components and that Aboriginal isues related to HIV/AIDS will need to be addressed throughout the components of the CSHA.

Under the CSHA, Health Promotion and Programs Branch (HPPB), MSB, and Information Analysis and Connectivity Branch (IACB) receive specific funding for HIV/AIDS issues related to Aboriginal people. Funding for the three branches under the CSHA totals $3.4 million annually, of which $1.5 million is administered by HPPB for non-reserve issues, $1.1 million is administered by MSB for on-reserve issues, and $0.8 million by IACB for HIV/AIDS research that is relevant to Aboriginal communities.[48]

In addition, community-based Aboriginal organizations working with HIV/AIDS issues may apply for funding under the AIDS Community Action Program.[49] ACAP provides project and operational funding for community-based HIV/AIDS initiatives. Aboriginal organizations would apply for funding under ACAP in competition with other community-based organizations. ACAP funding is not available for on-reserve HIV/AIDS projects. Albert McLeod, Executive Director of the Manitoba Aboriginal AIDS Task Force, notes that despite some problems with the program, ACAP, which also existed under NAS Phase II, has been an important source of funds for the development of Aboriginal HIV/AIDS organizations.[50]

The Bureau of HIV/AIDS, STD and TB at the Laboratory Centre for Disease Control, an agency within the Health Protection Branch of Health Canada, has provided funding for the collection of HIV epidemiological and surveillance information among Aboriginal people through: (1) the support of a series of HIV prevalence and incidence studies among Aboriginal people, (2) the hosting of annual Aboriginal HIV/AIDS Epidemiology and Surveillance meetings, (3) the coordination of the Aboriginal Working Group on HIV/AIDS Epidemiology and Surveillance, and (4) the dissemination of its findings.[51]

[48] From email communication with Laura Commanda, 7 February 1999.

[49] Ibid.

[50] Personal communication with Albert McLeod, 24 July 1997.

[51] From the written submission by Mai Nguyen, Research Analyst with the Bureau of HIV/AIDS and STD of LCDC, dated 22 December 1997, in response to the draft discussion paper, and from email communication with Laura Commanda, 7 February 1999.

MSB's mandate is to provide health services to First Nations people living on reserve and to some Inuit communities. An estimated $5.3 million was committed to MSB through Phase I of NAS for HIV/AIDS-related work for First Nations people under the MSB mandate. Another $12 million was committed to MSB to the end of Phase II.[52] The allocation of NAS funds covered contribution amounts for HIV/AIDS activities in First Nations communities, as well as HIV/AIDS program spending expenses at MSB headquarters and MSB regional offices.[53] The $2.5 million per year allocated to MSB under NAS Phase II has now been made a permanent component of the Aboriginal health-care funding in the Branch.

In addition to federal funding, each province and territory has designated HIV/AIDS funding, some of which is available to community-based organizations. The extent of provincial/territorial funding varies widely across the country. With some exceptions, this funding is not available for on-reserve initiatives.

The Impact of Changes in Health Care and Health Transfer Initiatives

Two components of the litany of changes in health care currently underway in Canada were seen by many people as particularly threatening to the implementation of effective HIV/AIDS programs for Aboriginal people: the regionalization of health services and health transfer initiatives.

Regionalization of Health Care

The introduction by the federal government of the CHST represents a considerable shift in power over the administration of health-care services to the provinces. As discussed above, how the federal contribution to health and social programs is managed by the provinces is no longer of concern to the federal government because the federal contribution is not based on actual costs incurred by the system. So long as the minimal standards of the *Canada Health Act* are satisfied and no residency requirements are imposed, the provinces do not have to account to Parliament. The legislation implementing the CHST goes so far as to specify that the federal government may not impose any additional conditions on the transfer without first consulting provincial governments.[54]

[52] First Nations Health Commission. *Bridging the Gap*. Ottawa: Assembly of First Nations, 1994, at 4.

[53] From written submissions regarding the draft discussion paper submitted on behalf of Health Canada by Isabel Romero, HIV/AIDS Consultation Secretariat, dated 11 December 1997.

[54] Supra, note 13 at 6-13 to 6-14.

The decentralization of authority is also reflected in the regionalization of the administration of health services within a number of provinces and territories. One person consulted for this paper suggested that the regionalization of health services raises jurisdictional issues in a new way; that is, within the provinces and between regional health boards. It is unclear what effect the creation of regional health boards will have on health services for Aboriginal people. At the very least, such a division adds another dimension to an already complex jurisdictional landscape.

It should be noted that devolution in the management of health services has been accompanied by downsizing in health care. A consensus seems to be emerging among provincial governments that establishing regional boards will diminish the overall costs of the health-care system.

Kevin Barlow notes that federal and provincial downsizing and regionalization may result in the disintegration of coordination in HIV/AIDS services and in diminished health-care standards.[55] Denise Lambert, a community educator in Alberta, adds that perpetual reorganizations in health administration are an additional destabilizing element in health care.[56]

Regionalization can have a positive impact on Aboriginal control over health. In a study of a dispute between the Baffin Health Board and the Health Minister of the Northwest Territories, O'Neill suggests that the Baffin Board has the potential to implement health policies and programs that reflect the interests and culture of the largely Inuit community it represents. The study reveals, however, that at least in the early stages of regionalization in the Territories, the Minister of Health was not prepared to devolve real fiscal control and culturally based health planning to the Baffin Board.[57]

Enthusiasm for the benefits of regionalization based on the Baffin Board example must be tempered by the fact that the Board is unique in that it represents a largely Inuit population. Where health boards cover regions with a smaller First Nations or Inuit population, it is less likely that their concerns will be a priority.

The example of health-care changes in Thompson, a town of 15,000 in northern Manitoba with a large Aboriginal population, illustrates how regionalization can be positive. Catherine Spence, Project Coordinator of the Thompson AIDS Project, notes that health-care services in the town are undergoing a variety of changes including hospital restructuring, the creation of a regional health board, and ongoing health transfer agreements with First Nations communities in the Thompson region. The introduction of HIV/AIDS issues into the dialogue respecting these changes through the work of the Thompson AIDS Project and its supporters in the community has made HIV/AIDS a priority.

[55] Personal communication with Kevin Barlow, 23 July 1997.

[56] Personal communication with Denise Lambert, 19 August 1997.

[57] The study is discussed in John D O'Neill. Regional Health Boards and the Democratization of Health Care in the Northwest Territories. *Circumpolar Health 90: Proceedings of the 8th International Congress on Circumpolar Health*. Brian D Postl et al, eds. Winnipeg: University of Manitoba Press, 1991, at 50-53.

Spence suggests that a number of factors have coalesced to create a positive environment for HIV/AIDS discussion, including an influx of medical personnel with HIV experience, the realization by First Nations of the potential impact of HIV on their communities, and a one-year HIV education blitz by local CHRs.[58]

The Thompson example suggests that the existence of an HIV/AIDS project to raise the profile of HIV issues at the right time is helpful in developing positive community responses during a period of transition in health services. As most of the factors identified in Thompson will not be present in every community, however, the approach of the Manitoba Ministry of Health seems appropriate. The Ministry will maintain centralized HIV/AIDS funding administered by a provincial AIDS program coordinator despite the regionalization of health services in the province.[59] As has been suggested by others consulted for this paper, it is difficult to believe that regional health boards will make HIV/AIDS and Aboriginal health issues a priority.

Health Transfer

In 1986, Health Canada introduced the Indian Health Transfer Policy, designed to transfer administrative authority for community health services to First Nations communities in the provinces. First Nations and Inuit communities in the Territories have been involved in a transfer process as well, in the form of the creation of regional health boards. The transfer policy follows on an earlier initiative implemented in the 1970s through the *James Bay and Northern Québec Agreement*, which created health boards representing Cree and Inuit communities in Northern Québec.

The RCAP Commissioners note that health transfer initiatives "promise to provide opportunities for Aboriginal communities to assume greater responsibility for developing health services and programs at the community and regional levels."[60] Many First Nations and Inuit communities have embraced health transfer and most are involved in the process to varying degrees. MSB staff note that transfer takes many forms. Administrative control over specific programs, for example substance abuse or diabetes, may be transferred at different times and different rates.[61]

[58] Personal communication with Catherine Spence, 9 September 1997.

[59] Ibid.

[60] Supra, note 8, vol 3 at 250.

[61] Supra, note 43.

Transfer communities are provided global funding within which they set the priorities ("envelope" funding). There are no national standards, but bands must comply with provincial laws of general application. For example, in Ontario a transfer community must comply with the provisions of the provincial *Health Protection and Promotion Act*. MSB headquarters in Ottawa is not involved in overseeing transfer communities, such communities being dealt with on a regional level. Funding available for transfer is capped to reflect current funding levels.

Aboriginal AIDS organizations and health experts have raised concerns about the envelope system of funding. In response to concerns raised by the MSB HIV/AIDS Focus Group and others, MSB has decided to designate funding for HIV/AIDS instead of including such funding in the health envelope. MSB currently has $2.5 million in designated HIV/AIDS funding outside the CSHA to be allocated to First Nations in accordance with a formula based on a number of factors, including remoteness and population.[62] Despite the fact that funds are designated for HIV/AIDS and First Nations are supposed to use the funds for HIV/AIDS, it is important to bear in mind that, in the end, how health dollars are used by First Nations is up to band councils. Concerns were raised during interviews for this paper that some band councils might not be using the funds as designated.

Despite the scope of change encompassed by transfer agreements, little coordination of information or evaluation of the variety of different initiatives undertaken exists. The Assembly of First Nations (AFN) notes that "independent analysis and internal dialogue between First Nations on [health transfer and self-government] is long overdue."[63]

A number of concerns have been raised about the health transfer policy. It has been suggested that health transfer is "designed to achieve the federal government's goals of reducing spending on health and social services, abdicating legal and fiduciary responsibility for the delivery of health care services to First Nations, denying treaty rights or rights flowing from Aboriginal title, and ultimately, assimilating First Nations."[64]

It would appear that at least the first three goals on this list may well be accomplished through health transfer: federal spending will likely be reduced; it is the government's policy that a transfer of authority to First Nations results in a decline in federal fiduciary responsibilities;[65] and it is government policy that health services are not part of treaty or Aboriginal rights.[66]

[62] Ibid.

[63] First Nations Health Secretariat. *Background Paper for the 18th Annual General Assembly*. Ottawa: Assembly of First Nations, July 1997, at 4. A lack of internal dialogue may reflect the breakdown in relations between some First Nations and the AFN over the last few years. It has been suggested that this results from a "divide and conquer" policy on the part of the federal government.

[64] Dara Culhane Speck. The Indian Health Transfer Policy: A Step in the Right Direction or Revenge of the Hidden Agenda? *Native Studies Review* 1989; 5(1): 187.

[65] Supra, note 33 at 12.

[66] Supra, note 8, vol 3 at 251. Here RCAP describes the Manitoba Framework Agreement on Health as being stalled on the issue of the treaty right to health.

Concerns have also been raised that transfer to First Nations increases the policy vacuum experienced by Aboriginal people living off reserve.[67] One person consulted for this paper argued that transfer initiatives that ignore off-reserve problems will increase divisions between on- and off-reserve Aboriginal people. This is particularly important for Aboriginal people living with HIV/AIDS, as most presently live in cities. It appears to be the policy of the federal government that unless an Aboriginal person is a status Indian living on a reserve, s/he is not an Indian for the purposes of most programs and funding directed to Aboriginal people. Noelle Spotton, Clinic Director at Aboriginal Legal Services in Toronto, suggests that this problem is occurring with increasing frequency and is in keeping with the divisive assimilationist policies practised since the enactment of the first *Indian Act*.[68]

Further, transfer of program administration to bands will reduce the portability of health rights, to the limited extent that such rights are recognized by the federal government. Downloading of the NIHB program particularly raises concerns for off-reserve Aboriginal people generally, and Aboriginal people with HIV/AIDS in particular.[69]

Aboriginal people working in the field of HIV/AIDS are concerned about the impact of transfer initiatives on HIV/AIDS services for Aboriginal people. Art Zoccole, Project Coordinator of the B.C. Aboriginal HIV/AIDS Task Force, notes that there is concern that HIV issues will end up at the bottom of the list of band priorities due to homophobia and AIDSphobia, the extent of social and health problems confronting many communities, and limited resources.[70]

Despite arguments against transfer, the RCAP Commissioners state that they are "singularly impressed with the extent to which health programs in communities that have participated in transfer initiatives increasingly reflect Aboriginal priorities."[71] The experience of the Swampy Cree Tribal Council, one of the first transfer communities, is enlightening:

> [W]e entered the transfer process – but with our eyes wide open. We saw transfer as a way to achieve some of our objectives and we felt we could look after ourselves in dealing with government. We still feel that way.[72]

> [W]e suggest that health transfer be recognized for what it is. It is not a solution to all the health problems we face in the communities. It is only administrative control. Once that fact is accepted, we can get on with pursuing other objectives to resolve our health needs in other ways.[73]

[67] RCAP calls jurisdiction the number one problem for Aboriginal people living in urban centres. See RCAP. *Aboriginal Peoples in Urban Centres: Report of the National Round Table on Urban Aboriginal Issues*. Ottawa: Minister of Supply and Services Canada, 1993, at 17.

[68] Written communication from Noelle Spotton in response to request for comments, 19 December 1997.

[69] *Report on the Future Management of the Non-Insured Health Benefits Program. Vol 1*. Ottawa: Assembly of First Nations, 1996, para 5(d) at 57.

[70] Personal communication with Art Zoccole, 10 August 1997. Medical expenses for Aboriginal people living with or affected by HIV/AIDS in more remote areas would likely be particularly high. The amount of money set aside for HIV for Aboriginal people is not based on an evaluation of the minimum required for an effective HIV/AIDS program.

[71] Supra, note 8, vol 3 at 250.

[72] G Connell et al. Implementing Primary Health Care Through Community Control: The Experience of the Swampy Cree Tribal Council. *Circumpolar Health 90*, supra, note 57 at 44.

[73] Ibid at 46.

Although health transfer represents an opportunity for First Nations governments to achieve self-determination and control in health care, the concerns of Aboriginal HIV/AIDS experts should not be ignored. Despite the inconsistency with self-government, one Aboriginal person working in the HIV/AIDS field supports non-discretionary funding for HIV/AIDS work as a component of the health transfer process. This person went on to say that the best scenario would be one in which First Nations deal with HIV in a holistic and caring fashion in accordance with Aboriginal traditions.

PROBLEMS CREATED BY JURISDICTIONAL DIVISIONS

In addition to the concerns raised by those consulted regarding ongoing jurisdictional realignment of health-care services in Canada, a number of specific problems with jurisdictional divisions can be gleaned from the consultations and from other sources. These are: (1) funding problems, and (2) barriers to coordination and collaboration.

Funding Problems

Some of the problems experienced by Aboriginal organizations in the area of funding for HIV/AIDS services are similar to those experienced by other organizations working in the same field. Many organizations are underfunded and certain groups receive a disproportionately low share of funding. One Aboriginal person consulted for this paper suggested that Aboriginal HIV/AIDS funding often emerges as an afterthought or it is based on needs and policies developed for non-Aboriginal groups.

Complicating the provision of HIV/AIDS services is the history of oppression and racism experienced by Aboriginal people since European contact. "There is no lack of data describing the disproportionate burden of illness suffered by the Aboriginal peoples."[74] It is within the context of poor health and cultural upheaval that an analysis of the impact of jurisdictional divisions on the provision of HIV/AIDS services for Aboriginal people must be approached.

[74] John D O'Neill, Brian D Postl. Community Healing and Aboriginal Self-Government: Is the Circle Closing? *Aboriginal Self-Government in Canada*. John Hylton (ed). Saskatoon: Purich Publishing, 1994, at 67. See also RCAP. *The Path to Healing*. Ottawa: Minister of Supply and Services Canada, 1993.

Adequacy of Funding

The adequacy of funding for HIV/AIDS services for Aboriginal people varies substantially across the country. Funding levels often depend on the participation of provincial governments in the support of Aboriginal services and on the availability of Aboriginal AIDS experts to lobby for support. The variability of funding levels to support Aboriginal programs may be seen in a comparison of the situations in Ontario and in some of the Maritime provinces.

The government of Ontario has supported Aboriginal HIV/AIDS initiatives through the establishment of the Aboriginal Health Office and the development of such projects as the Ontario Aboriginal HIV/AIDS Strategy. Further, the province has not allowed jurisdictional distinctions to undermine the seriousness of AIDS issues. The provincial AIDS Bureau accepts proposals from on- and off-reserve sources and supports the Ontario Aboriginal HIV/AIDS Strategy. Currently, the Ontario Aboriginal HIV/AIDS Strategy employs a Provincial Coordinator and an equivalent of 6.5 full-time workers throughout the province. In addition, the AIDS Bureau funds an AIDS Educator in each of the four Political Territorial Organizations on reserve.[75]

The current government has so far maintained funding levels for HIV/AIDS work. In contrast, the governments in Nova Scotia and New Brunswick do not contribute any funding for projects designed specifically for Aboriginal people.

Due to the extent of health and social problems affecting Aboriginal people, LaVerne Monette, Provincial Coordinator of the Ontario Aboriginal HIV/AIDS Strategy, notes that there will probably never be enough funding to overcome all of the risk factors for HIV/AIDS among Aboriginal people.[76] Certainly, resources need to be used effectively and efficiently. One person interviewed for this paper suggested that more education and the galvanization of leadership support for HIV/AIDS initiatives, within both Aboriginal and non-Aboriginal sectors, would help ensure effective use of HIV/AIDS resources.

[75] Written submission from Darcy Albert on behalf of TPFN, dated 13 November 1997, in response to the draft discussion paper. It should be noted that it was not the present government of Ontario that implemented these initiatives.

[76] Personal communication with LaVerne Monette, 16 July 1997.

The implementation of the CSHA, with its focus on Aboriginal communities, is an important step in creating an adequate base of funding for Aboriginal HIV/AIDS initiatives. LaVerne Monette expressed some concern, however, that the CSHA funding may be encouraging a sense in the HIV/AIDS field that Aboriginal HIV/AIDS issues have been adequately addressed.[77] This may lead to complacency. Epidemiological data and anecdotal evidence concerning the rate of HIV infection in the Aboriginal community, and the prevalence of risk factors and overrepresentation of Aboriginal people among high-risk groups, suggest that such an attitude would be dangerous. The injection of directed funding to Aboriginal communities in the CSHA is long overdue. Now it is crucial that this funding be used. Duane Etienne, of the Assembly of First Nations, suggests that part of this effectiveness will come from a focus on training and capacity building within the Aboriginal community.[78]

The experience of a number of First Nations that have implemented community-based health-care initiatives supports the view that "any community has the power to heal itself":

> We sometimes fail to recognize our own strengths and the resources we have in our own communities ... if we allow ourselves vision and the ability to listen and care, we will find these strengths in ourselves and others.[79]

It has been suggested that the government has a problem in justifying high expenditures for HIV/AIDS because more people die of other diseases. Further, some argue that the Canadian public is not prepared to accept increased funding for Aboriginal people. When RCAP released its final report, the government and media deflected attention away from the document by concentrating on the funding issue. In response to such views, Kevin Barlow notes that mainstream society does not appreciate the extent of the poor health conditions experienced by First Nations people and Inuit. With regard to funding HIV/AIDS services for Aboriginal people, Barlow emphasizes that ignoring HIV now will result in a more rapid spread of the virus and increased costs in the future.[80] Support for health care makes good financial and ethical sense and is, above all, necessary.

The commitment made by the federal government to Aboriginal HIV/AIDS issues in the CSHA is encouraging, but it is only a beginning.

[77] Personal communication with LaVerne Monette, 19 January 1999.

[78] Personal communication with Duane Etienne, 10 February 1999.

[79] Heather Clayton. Indian Health and Community Development: Notes for an Address. *Circumpolar Health 90*, supra, note 57 at 42.

[80] Personal communication with Kevin Barlow, 8 August 1997.

Sources of Funding

When this Discussion Paper was first published in March 1998, it was reported that there were a number of sources of HIV/AIDS funding for Aboriginal people:

(1) Aboriginal AIDS organizations can apply for provincial funding, but the level of funding available varies widely between provinces. Some provinces take the position that no Aboriginal-specific programs need to be supported by the province because Aboriginal programs fall under federal jurisdiction or because mainstream programs and facilities are available to Aboriginal people.

(2) As discussed earlier, MSB does not provide services to Aboriginal people living off reserve. Off-reserve Aboriginal organizations can apply to ACAP for project funding, but must do so in competition with mainstream HIV/AIDS organizations.

(3) Many off-reserve Aboriginal AIDS organizations receive no core funding to sustain their activities and must rely exclusively on project funding from ACAP.

Catherine Spence notes that the Thompson AIDS Project began its work on a volunteer basis and reverted to volunteer status during the time between a grant for a needs assessment and approval of a one-year community development budget.[81]

The fact that funding for HIV/AIDS services and programs comes from a variety of sources has hindered the development of community-driven AIDS organizations, particularly during the early stages of growth. Before a new organization could be firmly entrenched, time and effort was lost in the pursuit of appropriate contacts and funds rather than productively engaged in the work for which the organization was designed.[82]

[81] Supra, note 58.

[82] Art Zoccole, Project Coordinator of the B.C. Aboriginal HIV/AIDS Task Force, reported in a personal communication of 17 July 1997 that many organizations in British Columbia had yet to take advantage of ACAP funds. One organization, Healing Our Spirit, has had some success with corporate funding (personal communication with Catherine Blackstock, Executive Director, Healing Our Spirit B.C. First Nations AIDS Society, 18 September 1997).

Other concerns about sources of funding raised by those consulted for this paper in 1997 included the following:

> There was a perception that personal relationships between fund decision-makers and organizations or individuals influenced which projects were supported.
>
> Aboriginal AIDS workers often had expertise in social work and counselling but not in administration, proposal writing, and fundraising.
>
> Funding is a big problem in Northern and remote communities. Travel budgets in an area like Baffin Island can make projects involving travel between communities virtually impossible to support financially.
>
> Funding priorities and formulas are often based on the interests of mainstream AIDS organizations and do not reflect Aboriginal issues.

The CSHA has had or will have an impact in this area. A clear picture as to whether the aforementioned issues remain relevant and to what extent since March 1998 was not established during the follow-up discussions conducted in January and February 1999, partly due to time constraints and partly because organizations have not had the opportunity to properly address the impact of the CSHA.

It is clear that initiatives often continue to be confined by the source of funding. An ACAP-funded project is restricted to off-reserve activities, while an MSB project only extends to reserve residents. The Aboriginal community of Canada is highly mobile; people travel frequently back and forth between reserve or rural communities and the city as well as between cities. Artificial boundaries between HIV/AIDS programs are detrimental to the development of comprehensive, culturally appropriate health services. It is also clear that there is increasingly a recognition within Health Canada of these facts and of the need to overcome jurisdictional barriers.

Finally, despite the CSHA, funding levels for Aboriginal HIV/AIDS initiatives continue to vary among provinces and territories.

Barriers to Coordination and Collaboration

Divisions between Federal and Provincial Governments

The jurisdictional divisions between federal and provincial governments have been described earlier and mentioned throughout the paper.

In its report on the National Round Table on Urban Aboriginal Issues, RCAP heard many submissions identifying jurisdiction as one of the most pervasive issues for Aboriginal people. Jurisdictional divisions between provincial and federal governments give rise to a policy vacuum in which many Aboriginal people find no culturally appropriate services.

> Presenters at the round table reported frequently that applications for services result in their being shuffled from one level of government to another and served by none. Lobbying to upgrade provincial services for Aboriginal people often meets the response that the federal government is trying to off-load its responsibilities to the provinces.[83]

Territoriality issues between provincial and federal governments can seriously hamper the coordination of efforts at controlling the spread of HIV/AIDS among Aboriginal people. One person consulted for this paper suggested that long-term solutions to jurisdictional divisions will require individuals at a high level within each government to show leadership and vision to initiate coordination. Another person suggested that, in the end, jurisdictional divisions are entrenched in the Constitution and will always be a barrier to effective programs for Aboriginal people.

Although this may be true, federal departments and provincial ministries involved in HIV/AIDS issues and Aboriginal governments must take seriously calls for coordination by Aboriginal people working in the field. RCAP supports "cooperative, coordinated action by the government of Canada, the provinces and territories, and Aboriginal nations," and recommends that governments should institute a framework for discussion of Aboriginal issues, with a view to establishing collaborative measures to resolve problems.[84]

If governments in Canada do take RCAP's recommendations seriously, it is important that HIV/AIDS issues be on the agenda for discussion. It would be encouraging if a strategy to collaborate across jurisdictions to deal with HIV/AIDS issues for Aboriginal people emerged as a "test" initiative of the ability of federal, provincial, territorial, and Aboriginal governments to cooperate.

[83] Supra, note 67 at 5.

[84] Supra, note 8, vol 5 at 10-11. See RCAP's Recommendation 5.1.1.

Interdepartmental Barriers

A number of departments in the federal government have responsibilities that relate to Aboriginal people and HIV/AIDS: MSB and other services in Health Canada, Indian and Northern Affairs Canada, and Correctional Services Canada all have important roles in a coordinated HIV/AIDS strategy. One Aboriginal person consulted for this paper argued that the federal government relies too heavily on Health Canada to set the agenda and to respond in the area of HIV/AIDS. Aboriginal people favour a holistic approach to health problems. Such an approach is facilitated by interdepartmental coordination.

Barriers to interdepartmental coordination identified during the consultation process include the following:

- There are barriers within departments. For example, one person suggested there is a perception within Health Canada that it is hard to get clarity and resolution in files dealing with Aboriginal issues. Further, it was suggested that it often seems difficult to get action at the political and interjurisdictional level.

- Interdepartmental coordination depends a lot on the working relationships between individuals. Personnel changes can therefore destabilize evolving connections. Once a working relationship takes hold between individuals working in different departments, efforts at coordination can still be stymied by a breakdown in the relationship at a higher level of bureaucracy.

- Departments other than Health Canada may not perceive the importance of their role in HIV/AIDS issues.

Divisions among Aboriginal People

The imposition of legislated definitions has created divisions among Aboriginal people. For example, since 1985 First Nations people have been defined pursuant to the *Indian Act* as status, non-status, and Bill C-31 ("reinstated") Indians. Bill C-31 Indians are further defined depending on whether they regained status under s 6(1) or 6(2) of the *Indian Act*.

Jurisdictional distinctions divide the Aboriginal community against itself in many ways: reserve governments are divided against organizations representing off-reserve Aboriginal people, while the various representatives of off-reserve people compete among themselves for the leadership of the large off-reserve constituency. In addition, Métis organizations fight for the recognition of Métis people, and Inuit organizations seek action on problems in the North.

The competition between on- and off-reserve organizations that arises due to jurisdictional distinctions is compounded by the fact that the funding allocated to a First Nation is often dependent on the population of the reserve. A number of people interviewed expressed concern that it is not uncommon for a band to include members of the community living off reserve in its assessment of need for funding purposes, but to restrict the provision of services to those band members who are ordinarily resident on the reserve.

The off-reserve Aboriginal community also contains diverse interests. Off-reserve people are represented by a number of sometimes cooperative, but often competing, organizations.[85] For example, there is no single organization representing the interests of the large Aboriginal population living in Toronto. A number of broad-based organizations such as the Native Canadian Centre of Toronto and the Ontario Federation of Indian Friendship Centres as well as more narrowly focused groups like TPFN are driven to compete both for funding and for participation in decision-making, sometimes at the expense of their collective strength.

Clearly, the Aboriginal community is not homogeneous; it consists of a rich diversity of cultures and traditions. Mary Ellen Turpel notes that the term "Indian" as defined by the federal government in the Indian Act is an alien one, "a term of the colonizers." Turpel argues that the word "Indian" denies and effaces the diversity of Aboriginal peoples who have been "Indianized" "or classified by the government for administrative purposes" and "racialized" "as minorities."[86]

An important aspect of the revitalization of Aboriginal communities involves the reawakening of cultural traditions and the expression of self-definitions by First Nations people, Métis, and Inuit. Self-naming is an important part of the healing process. For Aboriginal gay and lesbian people, self-naming involves a rejection of the disparaging terms for homosexuality imposed by Western culture in favour of the concept of two-spiritedness, which captures traditional views about sexuality.[87]

Aboriginal people are casting off false definitions and stereotypes that have been imposed on them. They have resurrected practices that were forced underground by racism and the law. It is time to respect the diversity of Aboriginal cultures and allow self-naming without a loss of services. It is also important to recognize the links between individuals living in cities and those living on the reserve. Inappropriate jurisdictional distinctions efface diversity and divide community.

[85] For an example that went to trial, see *Re Native Women's Association of Canada and the Queen* (1992), 95 DLR (4th) 106. NWAC argued that the interests of Aboriginal women were not represented by the Assembly of First Nations and that NWAC should have a seat at the table for the constitutional negotiations that ended in the Charlottetown Accord.

[86] Mary Ellen Turpel. Patriarchy and Paternalism: The Legacy of the Canadian State for First Nations Women. *Canadian Journal of Women and the Law* 1993; 6: 173 at 178.

[87] Based on notes taken at a workshop delivered by Terry Tafoya, Native American storyteller and psychologist, Bereavement and Multiple Loss, presented by the AIDS Committee of Toronto HIV Mental Health Group, 3 June 1994. Traditionally, two-spirited people occupied important roles and revered positions in Aboriginal communities as health-care workers, teachers and shamans. "Two-spirited" is a term that refers to vision, respect and social roles, not just sexuality. For more on two-spiritedness, see Susan Beaver. We Are Part of a Tradition: Report to RCAP by TPFN, 25 June 1992; and Will Roscoe (ed). *Living the Spirit: A Gay American Indian Anthology*. New York: St Martin's Press, 1988.

OVERCOMING JURISDICTIONAL BARRIERS

The need for coordination of Aboriginal HIV/AIDS programs and services has been repeatedly identified by First Nations and other Aboriginal communities and organizations. One person consulted for this paper argued that Aboriginal people living with or affected by HIV/AIDS should not have to spend their time solving jurisdictional issues.

There is an increasing recognition within federal departments working on HIV/AIDS issues that jurisdictional barriers diminish the effectiveness of HIV/AIDS programs.[88] It was suggested by one person during consultations for the paper that although the need for coordination has been recognized for some time, HIV/AIDS issues have served to solidify support for coordination and increase the urgency around such initiatives.

[88] See, for example, Indian and Northern Health Services Directorate. *Interjurisdictional Coordination on HIV/AIDS and Aboriginal Populations: Issues and Approaches*. Ottawa: Minister of Public Works and Government Services Canada, 1995.

A number of initiatives that seek to improve the coordination of HIV/AIDS programs and services for Aboriginal people are discussed below.

Working Groups

One approach is to promote coordination through working groups. A description of some such initiatives follows.

Two initiatives under NAS Phase II were the Departmental Aboriginal AIDS Committee (DAAC) and the MSB HIV/AIDS Focus Group. The purpose of DAAC is to share information about HIV/AIDS projects for Aboriginal people and to develop coordinated approaches where possible. DAAC involves representatives from MSB, HPPB, and LCDC as well as an MSB field person and ACAP regional representative. Meeting every six to eight weeks, the group attempts to generate interdepartmental discussion and action. In the end, however, each branch within Health Canada is independent and continues to work on its own.[89] The group does not include any non-governmental representatives.

The MSB HIV/AIDS Focus Group consists of representatives of fifteen Aboriginal organizations, including some Aboriginal AIDS organizations and health centres, and regional and national representatives of MSB. The group discusses HIV/AIDS issues affecting Aboriginal people within the MSB mandate and can have some influence on MSB policymaking.

Initiatives under the CSHA include the National Aboriginal Reference Group on HIV/AIDS, which was created to help focus the CSHA on issues within the Aboriginal population that need the most attention. Representation on the group includes the national Aboriginal organizations, Aboriginal people with HIV/AIDS, Aboriginal HIV/AIDS organizations, and the federal government. Aboriginal representatives also participate in the Ministerial Council on HIV/AIDS, which advises the Minister of Health on aspects of HIV/AIDS that have a national scope.[90]

Examples of initiatives at the provincial level are the HIV/AIDS coordinating committees of Alberta, British Columbia, and Manitoba. Alberta's Committee on HIV/AIDS (formerly known as the Multi-Agency Committee on Aboriginal AIDS) includes representatives of provincial, federal, and municipal government organizations, First Nations and other Aboriginal organizations, and non-governmental organizations concerned with HIV/AIDS in Aboriginal populations. The Committee focuses on all Aboriginal populations in Alberta.[91]

[89] Information from personal communication with Health Canada staff, 5 August 1997.

[90] Supra, note 48.

[91] See supra, note 88 at 5-7 and supra, note 52 at 15.

The BC Aboriginal AIDS Focus Group and the Manitoba Regional HIV/AIDS Steering Committee are somewhat more limited in focus than the Alberta Committee. The function of the BC Focus Group is to promote information sharing and advice to MSB. The Manitoba Steering Committee includes representatives of off-reserve interests but is also focused on the MSB mandate.[92]

Although these examples suggest that the need to form partnerships is being recognized, it is important to note the limitations in these groups. The first group involves the exchange of information and a degree of policy and program coordination but is an internal partnership only; the second includes Aboriginal representatives but only deals with issues within the MSB mandate; the mandate of two of the three provincial committees is also limited in scope.

Suspicion about government partnership initiatives was expressed by some of those consulted. One person suggested such initiatives are window dressing and do not make much difference to policy and funding decisions. The AFN has been critical of Health Canada for involving Aboriginal representatives in consultations, only to proceed with decision-making unilaterally.[93]

Finally, Art Zoccole emphasizes the difficulty Aboriginal HIV/AIDS workers and organizations face in trying to ensure that the interests of Aboriginal people are adequately represented on the many boards and committees that continue to develop around HIV/AIDS initiatives.[94] In many cases, too few people are being asked to do too much. This lends further weight to the argument that capacity building and training within the Aboriginal community should be a focus of directed funding within the CSHA for Aboriginal communities.

Interdepartmental and multi-agency partnership initiatives should involve Aboriginal people in decision-making in a substantive way, and include consideration of HIV/AIDS issues on a multi-jurisdictional level.

[92] See supra, note 88 at 5-7.

[93] See AFN reports, supra, notes 63 and 69.

[94] Personal communication with Art Zoccole, 22 January 1999. The argument for capacity building was also made by Duane Etienne in a personal communication, 10 February 1999.

Aboriginal HIV/AIDS Strategies

A second approach to reducing the impact of jurisdictional barriers is through Aboriginal HIV/AIDS strategies. Currently, two provinces have or are developing such strategies: Ontario and British Columbia.

After a number of years of discussion and planning, in 1994 the first comprehensive strategy to deal with issues related to HIV/AIDS and Aboriginal people was implemented. The Ontario Aboriginal HIV/AIDS Strategy (Ontario Strategy) is a joint initiative between the Aboriginal community and the Ontario Ministry of Health and is an improvement in coordination of HIV/AIDS programs and services based on the following goal:

> To design, develop and deliver a comprehensive plan for an effective and accessible continuum of physical, mental, emotional and spiritual care, support, training and education for Aboriginal individuals, families and communities living with and/or affected by HIV/AIDS directly or indirectly, regardless of residency.[95]

The focus of the Ontario Strategy is on Aboriginal community-based design, development and delivery of services and programs that are Aboriginal-directed. The promotion of networking, coordination and sharing of information and resources is one of the principles of the initiative.[96]

One shortfall of the Ontario Strategy is that it did not succeed in uniting on- and off-reserve interests. During the planning stages, representatives of reserve communities refused to join in the design of a multi-jurisdictional strategy. As a result, the mandate of Ontario Strategy workers does not extend to reserve communities.

The newest strategy is currently at the implementation stage in British Columbia. The BC Aboriginal HIV/AIDS Strategy (BC Strategy) seeks to overcome the jurisdictional barriers that weaken the Ontario Strategy and establish a long term framework for HIV work involving Aboriginal communities. One objective of the BC Strategy is to "[i]dentify and address program and service overlap, duplication and gaps to develop means of better utilizing all resources and encourage the building of teams and partnerships."[97] There is a strong commitment to make the BC Strategy an Aboriginal-designed strategy that is relevant to Aboriginal people wherever they live in the province.

[95] *Ontario Aboriginal HIV/AIDS Strategy*, supra, note 9 at 33.

[96] Ibid, Principle 6 at 34.

[97] BC Aboriginal HIV/AIDS Task Force. *Workplan 1997-98*, by Art Zoccole, July 1997, at 3.

The report of the BC Aboriginal HIV/AIDS Task Force, outlining the BC Strategy, was released 1 February 1999. Called "The Red Road – Pathways to Wholeness," the report notes that Aboriginal communities and individuals often cannot afford to volunteer their services and expertise to take advantage of federal funding for HIV/AIDS initiatives because they are too busy trying to survive. Among its recommendations, the report calls for drug-law changes to reduce the spread of HIV among injection drug users, for a freeze on plans to transfer responsibility for HIV/AIDS programs to regional health boards in BC because Aboriginal people are not adequately represented on the boards, and for special programs to address the risks created by the large number of Aboriginal people in prisons.[98]

In 1995 the Aboriginal HIV/AIDS Project (the Alberta Project) was initiated in Alberta. The Project was able to attract the support of representatives of both on- and off-reserve communities. Significantly, the Chiefs of Alberta signed a resolution in support of the general principles of the initiative, one of which is increased involvement of community leaders.[99]

The purpose of the Alberta Project was to "develop a program plan for the collaborative delivery of HIV/AIDS prevention services to [A]boriginal peoples across Alberta."[100] Further, the Alberta Project encouraged and assisted Aboriginal communities to collaborate with one another and with HIV/AIDS agencies and other health agencies in developing programs. The three project coordinators represented the Alberta regional office of MSB, Alberta Health, and the Aboriginal community.

The Alberta Project was in operation until March 1998 and has not resulted in the implementation of a longer-term strategy. Constant changes in Alberta Health and a narrow-minded approach to HIV/AIDS issues by the Alberta government have detracted from the advances made by the Project.[101]

Developments in other provinces and territories vary. For example, in Manitoba an implementation advisory committee for the Manitoba Provincial AIDS Strategy, which includes an Aboriginal component, has been established. Progress has, however, been slow – an initial meeting of the group had not been established by the end of January 1999. The Strategy was initially produced in 1996 but there has since been no action aside from the establishment of the committee. The Manitoba AIDS Coalition gave the provincial government an "F" grade with respect to the Strategy in a report card issued on World AIDS Day, 1998.[102]

[98] Based on personal communication with Art Zoccole, 14 January 1999, and report by Paul Wilcocks in *Globe & Mail*, 1 February 1999.

[99] Personal communication with Marion Perrin, Regional Nurse Epidemiologist with MSB and a Project Coordinator of the Alberta Aboriginal HIV/AIDS Strategy, 28 July 1997.

[100] Project for the Development of a Collaborative Strategy to Prevent the Spread of HIV Among Aboriginal Peoples in Alberta. Fax received from Marion Perrin, 31 July 1997.

[101] The Government of Alberta decided in 1997 not to complete a provincial AIDS strategy that had been in the works, and disbanded its AIDS unit within Alberta Health, leaving HIV/AIDS work to be done in piecemeal fashion on an ad hoc basis.

[102] Personal communication with Albert McLeod, 22 January 1999, and Manitoba AIDS Coalition, Report Card to the Government of Manitoba, December 1998.

Canadian Aboriginal AIDS Network

Another initiative that seeks to improve coordination of efforts around HIV/AIDS in Aboriginal communities is the Canadian Aboriginal AIDS Network (CAAN), a national organization with a membership that includes Aboriginal AIDS organizations, other non-governmental AIDS organizations with a significant Aboriginal component, Aboriginal people living with HIV/AIDS and others involved in HIV/AIDS work with Aboriginal people.

CAAN's focus is broad: it acts as a national voice on HIV/AIDS issues affecting Inuit, Métis, and status and non-status First Nations people, regardless of place of residence. The Network attempts to strengthen the capacity of Aboriginal organizations and communities to respond to HIV/AIDS by coordinating activities, lobbying federal, provincial and Aboriginal governments and departments, and promoting the significance of HIV/AIDS issues for Aboriginal people.

The precursor to CAAN was the National Aboriginal PHA Network, an organization for Aboriginal people with HIV/AIDS founded in 1994 that has since merged with CAAN. Some funding was received by CAAN after 1994 for specific projects, including a joint project with the Canadian AIDS Society. Finally, CAAN incorporated as a nonprofit organization in the spring of 1997 and opened its office in Ottawa in July of that year.

In recognition of the important role played by CAAN and the extent of the work that needs to be undertaken, CAAN presently receives core funding through the CSHA.[103]

[103] Information about CAAN based on personal communication with Kevin Barlow, 23 July 1997, and on personal communication with Albert McLeod, 22 January 1999.

CONCLUSIONS

No group in Canada deals with jurisdictional divisions as much as Aboriginal people. The spread of HIV/AIDS in Aboriginal communities across jurisdictional boundaries has focused attention on the need to reduce the impact of these boundaries on the development and delivery of HIV/AIDS programs and services. This paper seeks to draw attention to the ways in which jurisdiction affects HIV/AIDS programs and services for Aboriginal people.

Based on the research and consultations conducted during the process of this paper, a number of conclusions have been drawn:

1. Federal and provincial governments must recognize and affirm their responsibilities derived from the historical relationship between Canada and First Nations, Métis people, and Inuit. These responsibilities are owed to all Aboriginal people, whether on or off reserve, status or non-status, Métis or Inuit, and include responsibilities in the area of health care and HIV/AIDS. The commitment made to Aboriginal HIV/AIDS issues by the federal government in the CSHA is encouraging.

This is a time of transition and renewal for Aboriginal communities. The following changes are significant:

(a) The devolution of authority over certain matters to the provinces.

(b) The development of self-government giving rise to a third order of government with its own powers and responsibilities.

(c) The transfer of jurisdiction over health issues to Aboriginal communities.

During this period of transition, issues related to HIV/AIDS and Aboriginal people must be addressed. Aboriginal AIDS organizations and Aboriginal people living with or affected by HIV/AIDS should be given opportunities to participate in the process of renewal.

2. Regionalization of health-care authority has been adopted by many provinces and territories in Canada as part of cost-cutting efforts. During this process, it is important that HIV/AIDS services be uniformly and comprehensively available and that HIV/AIDS issues be a priority for regional health authorities. A mechanism to ensure coordination of HIV/AIDS programs and services should be part of any regionalization scheme. In addition, the interests of Aboriginal people must be adequately represented and respected in the developing regional authorities.

3. Regional programs and services within provincial and territorial jurisdictions must reflect and respect the needs and traditions of Aboriginal people.

4. In many ways, health transfer has been positive for First Nations communities; the process has increased Aboriginal control over health care and has facilitated the development of programs and services based on Aboriginal needs and traditions. However, many people consulted for this paper also expressed concern about the impact of health transfer on HIV/AIDS issues. These issues must be a priority in the health transfer process. Aboriginal AIDS organizations and Aboriginal people living with or affected by HIV/AIDS must be consulted as to how this can be accomplished. Further, health transfer initiatives should not result in a reduction in culturally appropriate programs and services for Aboriginal people living off reserve.

5. Despite the implementation of the CSHA, the funding available for HIV/AIDS programs and services for Aboriginal people continues to be seen as inadequate by many of those interviewed, particularly in the face of rising rates of infection, and of care, treatment, and support costs. Funding levels must reflect an assessment of the actual costs of administering and delivering programs and services and must be based on long-term consistent objectives and a recognition of rising costs. The funding that is available must also be used effectively, as required and requested by Aboriginal communities. Training and capacity building within the Aboriginal population should be a focus within initiatives under the CSHA. Further, the announcement of a focus on Aboriginal communities within the CSHA does not mean that Aboriginal HIV/AIDS issues have been resolved.

6. Although the inclusion of Aboriginal communities among the listed program components of the CSHA is encouraging, it is long overdue and only a beginning. Levels of funding for Aboriginal HIV/AIDS initiatives continue to vary widely across provincial and territorial boundaries. The provinces and territories must work together and with the federal government to reduce differences in the level of support for Aboriginal HIV/AIDS programs and services.

7. Funding for Aboriginal AIDS initiatives is available from a variety of sources, and Aboriginal AIDS organizations and service providers must share information and assist each other in locating funds. Further, government agencies and departments must continue to coordinate their activities and services to reduce the impact of jurisdictional barriers on Aboriginal HIV/AIDS program and service delivery.

8. Jurisdictional problems have contributed to divisions between provincial and federal governments, interdepartmental barriers, and divisions between Aboriginal people. A number of initiatives are underway that focus on improving collaboration and coordination, reducing service gaps, and increasing efficiency: interdepartmental working groups, national focus groups, and provincial coordinating committees are all important developments in the response to HIV/AIDS. These initiatives are reinforced by substantive Aboriginal participation in discussion and decision-making. Networking and information sharing between these groups is essential to the development of a coordinated response to HIV/AIDS in Aboriginal communities.

9. Another important initiative in the coordination of efforts are the provincial Aboriginal HIV/AIDS strategies. Following the example of Ontario and British Columbia, with the support and participation of the Aboriginal community, each province and territory should develop a comprehensive Aboriginal HIV/AIDS strategy. Such strategies must be based on principles of Aboriginal design and control. Further, such strategies should seek to overcome interprovincial/territorial differences in the availability of culturally appropriate HIV/AIDS programs and services for Aboriginal people, while respecting the distinctive needs and traditions of the First Nations, Métis, and Inuit within the scope of each strategy.

10. CAAN and its member organizations, as well as non-member Aboriginal HIV/AIDS organizations, should be consulted as to the need for and design of a national Aboriginal HIV/AIDS strategy.

HIV/AIDS presents a challenge to federal, provincial, territorial, and First Nations and Inuit governments: to overcome jurisdictional barriers that frustrate the development of coordinated health services for Aboriginal people. Aboriginal AIDS organizations and Aboriginal people living with or affected by HIV/AIDS are experts in the development and delivery of HIV/AIDS programs and services for Aboriginal people. It is to them that governments should look for guidance in developing sustainable, comprehensive, and collaborative responses to HIV.

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APPENDIX

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