12.10.2

Housing for Aboriginal People living with HIV/AIDS: A Review of the Relevant Literature

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I. Introduction

People living with HIV/AIDS (PHAs) have increasingly begun to identify housing as one of their most important needs. Housing has become an AIDS issue because PHAs are living longer lives as effective treatments are being developed, care is no longer being delivered by hospitals as it used to be in the 1980s, there is insufficient housing in Canada, and there is limited social housing available for PHAs because of a public fear of AIDS coupled with homophobia.

PHAs often need access to social housing because they can no longer pay for the cost of shelter due to the loss of employment, a reduction in income, or an inability to work due to an HIV/AIDS related illness or need. As well, a significant number of PHAs have not had adequate and affordable housing before being infected with HIV/AIDS.

In response to the housing needs of PHAs, over 20 residences have been developed in Canada for people living with HIV/AIDS.[1] These homes are not designed to be hospitals or institutional-type facilities where people recover from AIDS, but are designed to be safe, supportive, and affordable home-like places where people who cannot afford their own shelter can now live their lives with dignity. In keeping with the early demographics of the AIDS epidemic, these homes have been primarily designed for the use of gay white men.

The situation for Aboriginal people (Indians, Inuit, and Métis) is critical. AIDS is spreading in the Aboriginal community and is projected to reach rates of infection greater than that of the national population. Aboriginal people are already the most disadvantaged when it comes to housing. Aboriginal people experience the worst housing conditions and have the greatest housing backlog in the country. This housing demand is steadily increasing as the Aboriginal population is younger than the general Canadian population and has a birth rate twice as high. Aboriginal people also experience the lowest levels of income, employment, health, and education in Canada.

For Aboriginal people living with HIV/AIDS, this means there are few housing options available to them. Furthermore, the existing stock of housing occupied by Aboriginal people is substandard and not appropriate for people living with compromised immune systems.

Despite recognition of the fact that Aboriginal people are experiencing a serious housing crisis, the funding for various Aboriginal housing programs has either been terminated, drastically reduced, or frozen at inadequate levels that have not changed since 1985.

At present, there is no housing facility anywhere in Canada for Aboriginal people living with HIV/AIDS who cannot afford the cost of their own shelter. The need for an Aboriginal PHA home has been identified by the Royal Commission on Aboriginal Peoples in Urban Centres (1993), the Assembly of First Nations' First Nations Health Commission National Roundtable on HIV/AIDS (1994), the National Aboriginal PHA

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[1] Sharon Manson Willms, Michael V. Hayes, J. David Hulchanski, "Choice, Voice and Dignity: Housing Issues and Options for Persons with HIV Infection in Canada, A National Study", A Report Funded by, National Welfare Grants, Health & Welfare Canada, December 1991, p.29-30

Network (now known as the Canadian Aboriginal AIDS Network (CAAN)), and the Ontario Aboriginal HIV/AIDS Strategy (1995).

1.1 The Purpose of this Study

The Canadian AIDS Society (CAS) has recognized housing to be one of the most significant and growing unmet needs of people living with HIV/AIDS. In response to this growing issue, the Canadian AIDS Society has developed a project on the housing issues of PHAs in Canada from which strategies and solutions can be developed. Included in these studies is this review of the literature relevant to understanding the housing issues and needs of Aboriginal PHAs.

This study is a review of the literature on housing, health, and HIV/AIDS in the Aboriginal community. The primary purpose of this literature review is to summarize and organize the existing literature into a useful format to create an information base from which decisions and strategies for solving the housing needs of Aboriginal PHAs may be met.

1.2 Research Issues

Aboriginal housing issues are complex. The Constitution Act (1982) defines Aboriginal people as people who are Indian, Métis, or Inuit. However, each group is distinct and has different rights to housing that stem from different historical relationships with the Crown. As a result, each Aboriginal group has experienced different Federal housing programs that have been designed to address their specific housing rights and housing needs. This means that Indian, Métis, and Inuit social housing issues have to be examined separately. As well, Aboriginal people of all nations who have moved to Canadian cities have had their individual Aboriginal housing rights change by virtue of leaving their communities and are now subject to a different set of federal and provincial Aboriginal housing programs for urban centres.

Aboriginal AIDS education, prevention, and care programs are equally complex as federal funding for Aboriginal social services are being narrowly confined to Indian reserves and Inuit communities. However, AIDS does not descriminate and moves freely between reserves, northern communities, and urban centres. As a result, a patchwork of inter-jursidictional (federal, provincial, and regional government) AIDS service programming has been developed in some provinces (Alberta, British Columbia, and Manitoba), while in the other provinces, urban and rural Aboriginal groups have had to lobby for funding from governments reluctant to acknowledge responsibility for Aboriginal health care.

Condensing a diverse range of Aboriginal housing rights, housing programs, and housing condition information in one report, where relevant to the care of people living with HIV/AIDS is a complex project.

1.3 Methodology

A first question is, has a study been undertaken on the housing needs of Aboriginal PHAs? The answer appears to be "no".

In order to accomplish the goals of such a study, it is necessary to collect and synthesize:

- statistical information on Aboriginal housing conditions;
- information on the Aboriginal rights to housing and health;
- information on Aboriginal housing programs;
- information on the Aboriginal vision of community health care delivery;
- information on AIDS in the Aboriginal community, and;
- information on mainstream AIDS housing design and experiences.

To begin this study, a letter explaining the research objectives was sent to the organizations most closely related to this study. These organizations were asked to contribute information and literature. Particular assistance has been received from the Canada Mortgage and Housing Corporation (CMHC), the Assembly of First Nations, the Department of Indian Affairs, the Ontario Ministry of Housing, and Pauktuutit.

Existing bibliographies on Aboriginal housing compiled by the CMHC and the Institute for Urban Studies (IUS), and a bibliography on AIDS housing produced by the CMHC were also useful starting points.

Because this is only a review of the literature, and not an original research paper, this study includes a limited amount of information from Aboriginal PHAs, Aboriginal AIDS service organizers, government housing officials, and others contacted during the course of the research.

Statistical information on Aboriginal housing conditions has been obtained from the Department of Indian Affairs (DIA), the Canada Census, and Statistics Canada's 1992 post-censal Aboriginal Peoples Survey (APS).

In terms of the literature, the Aboriginal housing crisis and the jurisdictional issues that frustrate the solution are known. In the last few years, several studies by various groups have brought the Aboriginal housing crisis into sharp focus (Canada 1992, Pauktuutit, AFN 1994, Métis National Council n.d.). As well, in 1990, a Royal Commission was launched to hear and investigate the issues of Aboriginal People in Canada. The Royal Commission's published roundtable discussions represent a useful synthesis of Aboriginal voice on health and urban issues, and have been included in this literature review.

1.4 The structure of this report

In order to understand the various issues that affect the need and administration of housing for Aboriginal people living with HIV/AIDS, this study is broken into a series of sections.

The literature review begins with a general review of Aboriginal social, health, and economic circumstances in Canada (Part A). In order to understand the issue of housing for Aboriginal PHAs, it is then necessary to retrace the history of Aboriginal housing in Canada in order to explain the current Aboriginal housing crisis and the Federal programs developed to address the Aboriginal housing need (Part B). Part C, explains the Aboriginal vision of a holistic health care system for the Aboriginal Community, and Part D explains the impact of AIDS in the Aboriginal community and the Aboriginal response to preventing the spread of the disease in the community disease. From here, it is possible to start understanding decencies in the current housing stock and begin to assess the types of housing needed by Aboriginal PHAs (Part E).

II. Summary of the Findings and Recommendations

2.1 Findings

The findings of the literature review are:

- Aboriginal people experience the worst housing conditions in Canada, have the greatest backlog of housing, and receive greatly inadequate housing subsidies.
- A large part of the existing stock of Aboriginal housing is inappropriate for people living with HIV/AIDS.
- Aboriginal people experience the lowest levels of employment, income, health, and education in Canada.
- Government funding for Aboriginal housing is complex and plagued with interjurisdictional issues.
- AIDS is in the Aboriginal population and is projected to reach rates of infection greater than that of the general Canadian population.
- HIV/AIDS education, prevention, and care programs for the Aboriginal community must be holistic, culturally appropriate, and delivered by the Aboriginal community.
- A supportive home for Aboriginal PHAs is urgently needed and is one of the greatest gaps in Aboriginal AIDS services.
- There is no existing literature that is relevant or can assist in the design and development of Aboriginal PHA housing.
- Great obstacles exist to the provisioning of appropriate and supportive housing for Aboriginal PHAs, stemming from Federal termination, significant funding cuts, and freezes on Aboriginal Housing programs.
- Jurisdictional issues critically impede the channeling of funding for housing, health, and AIDS care in the Aboriginal community.
- There is a significant lack of real data on the levels of HIV infection in the Aboriginal community.
- There is no data on the housing needs and choices of Aboriginal PHAs.

2.2 Recommendations

It is recommended that a needs assessment be Aboriginally designed and carried out among Aboriginal PHAs to determine their needs, choices, and present socio-economic housing circumstances. This needs assessment is needed to develop information which can assist in the design and development of Aboriginal PHA housing. This information is also needed to inform and influence funders.

It is also recommended that Aboriginal organizations continue to demand an end to federal and provincial jurisdictional divisions in funding and provide appropriate financial support for Aboriginal AIDS care initiatives.

Part A
III. Aboriginal Population, employment, and Health Statistics

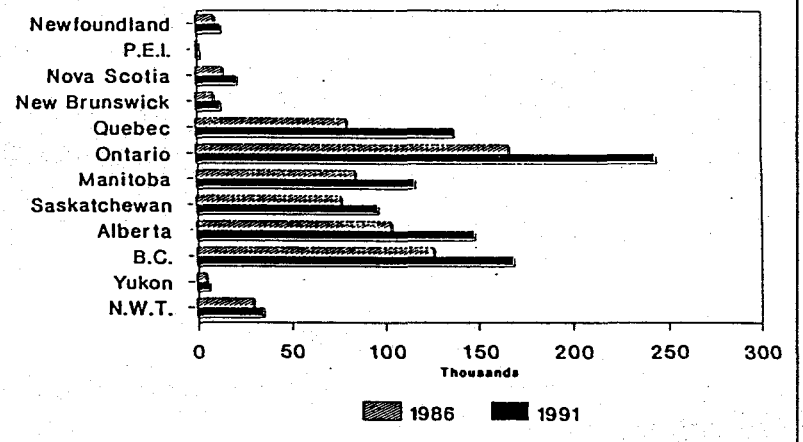
This section on Aboriginal population, employment, and health statistics provides a profile of the general social conditions of Aboriginal people today. This information will help the reader better understand the housing issues of Aboriginal people.

3.1 The Present Aboriginal Population

In the 1991 census, approximately 1 million people identified themselves as an Aboriginal person. This means that 4% of the Canadian population is Aboriginal. The Census has also shown that more Aboriginal people now live in urban centres than on Reserves, Métis settlements and northern communities.[2]

Figure 1

ABORIGINAL POPULATION, 1986 & 1991
PROVINCES AND TERRITORIES



Data Source: 1986, 1991 Census of Canada

From Kastes (1993)

Very significantly, the Aboriginal population is much younger than the general Canadian population and is growing at a greater rate. Fifty percent of all Aboriginal people in Canada are under the age of 25, compared to only 35% of the overall Canadian population. The Aboriginal birth rate stands at 2.72 per 1000 compared to 1.6 for the general Canadian population. However, the age-adjusted mortality rate is 9.7 per 1000 compared to 5.8 per 1000 among Canadians in general.[3]

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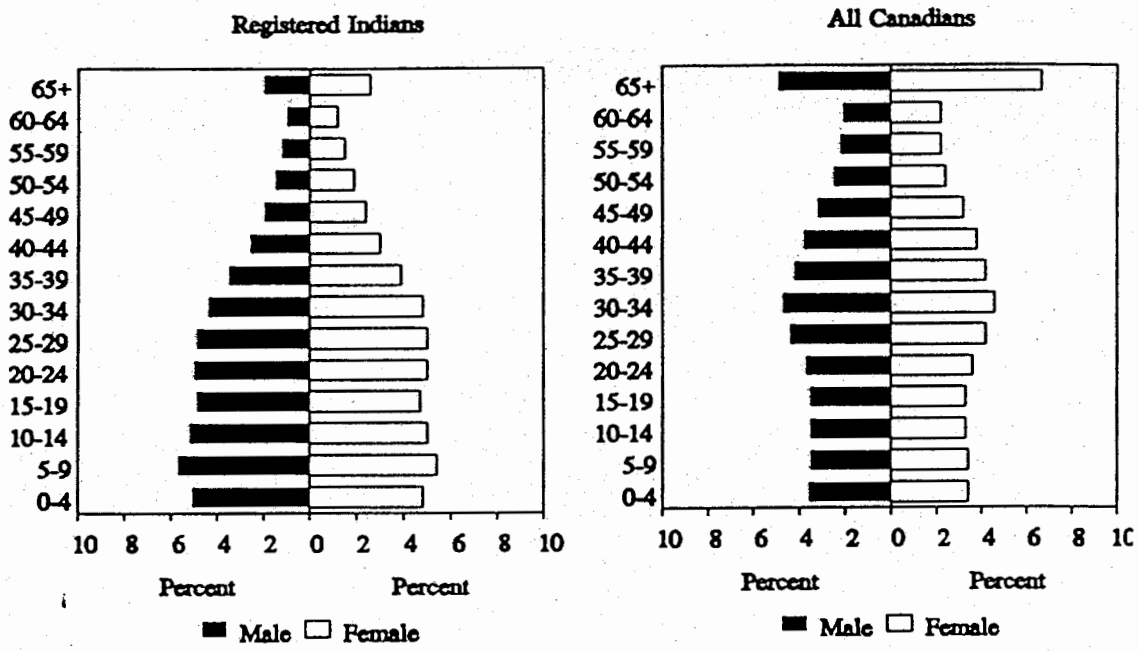
[2] Royal Commission. on Urban Aboriginals, p.11

[3] First Nations Housing Policy Analysis, Draft 6, 07/12/94

Figure 2. Population distribution by age and sex, 1993



from the Department of Indian and Northern Affairs Basic Departmental Data (1994)

3.2 Disparity

Current statistical data provides a profile of an Aboriginal population which has consistently lower levels of formal education, higher unemployment, and lower incomes than the general Canadian population (Census Canada, the APS, DIA Basic Departmental Data 1994, independent studies).

The 1991 Census showed that only 32% of reserve Indians between the ages of 15 and 64 are employed. Meanwhile, the employment rate for Canadians is 61%. The 1991 Census also showed that close to 80% of Indians on-reserves have incomes below $19,999 compared to 49% of the Canadian population. Only 3% have incomes of $40,000 or more, compared to 18% of the Canadian population.

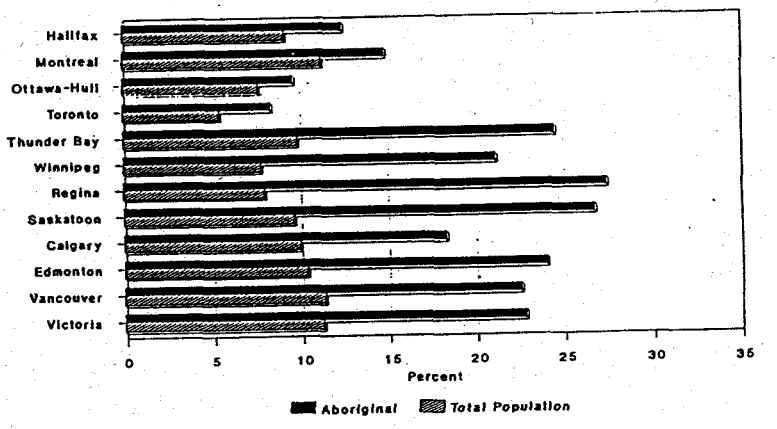
The Inuit experience the highest levels of unemployment in the Aboriginal population with chronic high unemployment rates generally over 60% for the population between the ages of 15 and 64 (Pauktuutit).

It is important to note that although this disparity is national, it also varies from region to region. In particular, it is noted that the greatest disparities between Aboriginal and non-native social well-being are recorded in the Atlantic, prairie provinces, and northern regions of Canada.

Despite these well documented disparities, the AFN notes that, "between 1983 and 1993, government expenditures on a per capita basis on Canadians grew by 21.7%. During this same period, Department of Indian Affairs expenditures towards Native people fell by 3.5%."[4]

figure 3

UNEMPLOYMENT RATE, 1986
SELECTED METROPOLITAN AREAS



Data Source: 1986 Census of Canada
NOTE: Data for population 15+ years.

from Kastes (1993)

3.3 Current Aboriginal Health

Recently, the AFN has reported that roughly 30% of reserve Indians have a chronic health problem. This includes a tuberculosis case load which is three times the national rate, a diabetes rate which is 4 times the national rate, and a disability rate among adults that is 3 times as high as the national rate.[5]

Mortality rates in the Aboriginal community have fallen but continue to exceed those of the national population. For example, the Canadian infant mortality rate is 7.8 deaths per 1000 live births, while the Inuit have an infant mortality rate of 17.7 deaths per 1000 live births. These mortality figures are a significant indicator of community health, and as the Royal Commission on Aboriginal Health reminds us, these high infant mortality rates are, "a powerful reflection of underlying disparities in socio-economic conditions and health care services" in the Aboriginal community.[6]

The National Round table on Aboriginal Health and Social Issues has stated that the "chief characteristic of health conditions in Aboriginal communities is that mortality

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[4] AFN 1994

[5] First Nations Housing Policy, Analysis, First Nations Housing Policy Analysis, Draft 6, 07/12/94, 07/12/94

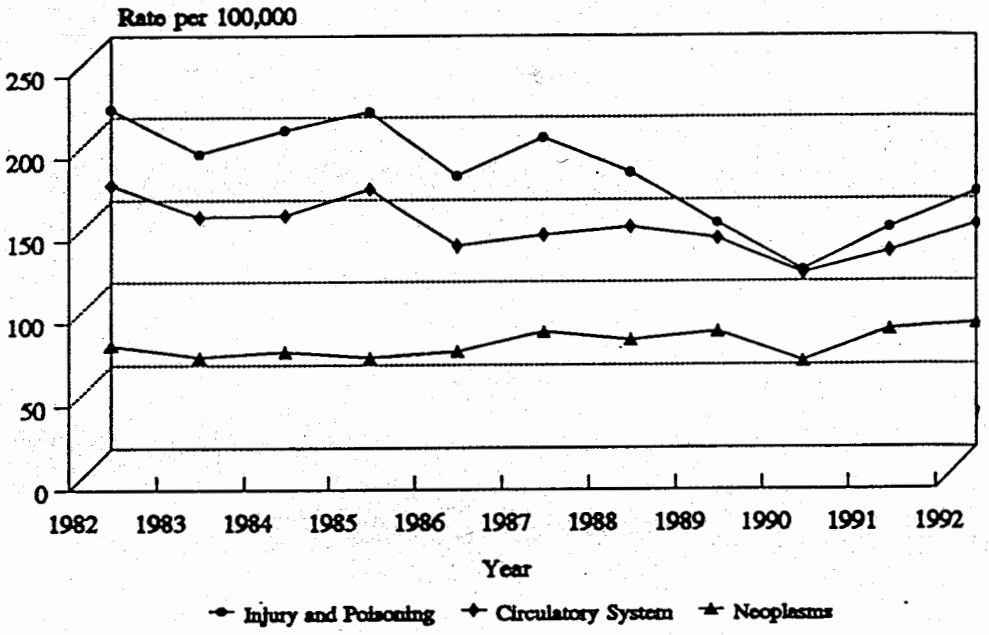
[6] O'Neil, Path to Healing, pp.30-31

and morbidity from both infectious and chronic disease exceeds Canadian averages in most areas".[7]

The AFN has made it clear that much of this excess mortality, high rates of illness, disease, and disability is still linked to poor housing conditions (First Nations Housing Policy, Analysis, First Nations Housing Policy Analysis, Draft 6, 07/12/94). Housing also remains linked to high levels of alcohol abuse, violence, and incarceration. One indicator[8] of cultural and social trauma in the Aboriginal community is a suicide rate that is three times the Canadian average.

Figure 4

Mortality Rates by Major Cause, Registered Indian Population



from the Department of Indian and Northern Affairs Basic Departmental Data (1994)

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[7] Path to Healing, "Report from the Round Table Rapporteur", p.15

[8] Clare Clifton Brant, "Suicide in Canadian Aboriginal Peoples: Causes and Prevention", Path to Healing, p.55

Part B
Aboriginal Housing

This section of the report addresses the current issues and conditions of Aboriginal housing in Canada and outlines existing Aboriginal housing programs. The section begins with a brief historical explanation of the origin of the issues, problems, and programs. Because Aboriginal housing programs are specific to each group of Aboriginal people (Inuit, Métis, and Indian), this section addresses each groups separately. Urban Aboriginal people form a fourth group with separate issues and housing programs and are examined separately.

V. Historical Issues

In Aboriginal issues and research, history is always relevant. History is the source of distinct Aboriginal rights and special status in Canada. History can also be a source of information on Aboriginal traditions prior to the influence of western ideals and forced religious conversion. As well, recent Aboriginal history (1867 to 1967) is one of the most poorly understood histories in Canada.

4.1 Gender roles and traditions in the Aboriginal community

In traditional times, puberty was a time to celebrate sexuality and explain the roles and responsibilities of the sexes. Aboriginal people who were gay or lesbian were known as 2-Spirited people and were respected by their communities and assigned special roles as healers, medicine people, and pipe carriers. For example, in the Crow culture, 2-Spirited people were responsible for obtaining the pole that is central to the community's Sun Dance ceremony. Among the Navajo, a family was felt to be doubly blessed if they had a 2-Spirited child. Throughout this pre-contact period, a "gender balance" is known to have existed.

When Europeans began their colonization of North America, they instilled many of their religious and sexual values into Aboriginal cultures. As a result, homophobia entered Aboriginal communities and began to displace 2-Spirited people. As a result, 2-Spirited people have been among the hardest hit by the colonization of the Aboriginal world and Aboriginal value system.

Today, Aboriginal gay and lesbian organizations are seeking to re-establish their traditional roles and become re-integrated into their communities. Because AIDS has disproportionately affected the gay and lesbian population, 2-Spirited people are often at the head of Aboriginal AIDS efforts. This 2-Spirited response to AIDS is consistent with their traditional role as healers in the Aboriginal community. However, fear of AIDS threatens to further alienate 2-Spirited people from their communities.

4.2 Treaties and the Aboriginal Relationship with the Crown

Under British law set in 1763, unsettled Aboriginal land in Canada was recognized to be sovereign. In order for Europeans to acquire Aboriginal land for settlement, the law stated that the Crown (not private persons) must negotiate the Aboriginal surrender of the land through payments and the recognition of special Aboriginal rights and status on the surrendered land. The law also stated that conditions of land surrenders were to be laid down in treaties. This began the treaty making period of Canadian history (roughly 1850 to 1920).

In these treaties, the Aboriginal leadership generally sought the means by which to co-exist with Europeans on the same lands. In order to co-exist, Aboriginal people sought protection of their traditional economies (hunting, fishing, trading) while also seeking assurances of future social and economic development (education, health care, annuities, and housing).

After the 1920s, Aboriginal treaty demands grew increasingly sophisticated and the Crown stopped treating for the balance of the sovereign Aboriginal land in Canada (the B.C. coast and the Arctic). As a result, treaties were not signed with the Indians in British Columbia or the Inuit.

Today, the Canadian Government has a fiduciary responsibility to honour all Aboriginal rights secured by treaty (Constitution Act, 1982) and has an obligation to settle all outstanding Aboriginal claims to land.

4.3 The development of the Aboriginal housing crisis

Until the 1950s, Aboriginal (Indian and Inuit) people did not strictly reside in permanent and dense settlements, but lived all over their traditional land bases in small family units. However, in the 1950s, pressure was mounted by the Federal government to relocate and concentrate all Aboriginal people into "permanent" settlements. For example, in the 1950s, the government began to move the Inuit into permanent communities on the pretense of improving their access to government and social services. In the lower regions of Canada, the government began to force Aboriginal people to reside on the Reserves which the people had protected as "sanctuaries" in their treaties.

As a result of being forced to reside in specific settlements, Aboriginal people were cut off from their resources and traditional pursuits, and poverty began to quickly develop. As well, because reserves in lower Canada and Inuit communities in the North were now becoming more concentrated and more permanent places for people to live, a whole new level of housing and infrastructure (water supply, sewage disposal, etc.) was quickly needed to support these new living conditions. However, because Aboriginal people were deprived of resources, communities were largely unable to build and maintain proper and sufficient housing.

As a result of overcrowding, poor sanitation, and unsafe heating systems, health and social problems began to emerge on reserves and northern communities. This succession of events is clearly supported by a literature which has shown a causal link

between substandard housing and asthma and respiratory disease in the Aboriginal population. Social problems such as alcohol and drug abuse, violence against women, and suicide are also attributed to substandard and inadequate housing (Young 1991, AFN, Dubois 1994, Pauktuutit).

For example, a housing report prepared by Pauktuutit explains that,

> overcrowding, inadequate and unsafe housing conditions, and the lack of basic facilities including running water and indoor plumbing, all contribute to increased incidences of communicable diseases, increased infant mortality and shorter life spans for many Inuit. Overcrowded and inadequate conditions create prime conditions for the spread of contagious diseases including tuberculosis and pneumonia. Between 1989 and 1992, the Northwest Territories recorded 130 cases of pulmonary tuberculosis... In 1991, 500 residents of the Keewatin were afflicted with a form of E. Coli 0157, a deadly strain of bacteria directly related to overcrowding and a lack of plumbing and sewage disposal.

As well, overcrowding and poor housing conditions in Inuit societies has exacerbated problems with poverty and disempowerment and caused social and physical problems in Inuit society. For example, the same study reports:

> Increased rates of substance abuse, family violence and child sexual abuse have been linked by some to dehumanizing housing conditions. Inuit youth commit suicide at a rate ten times the national average.

Thus, in the 1950s, while an economic boom was quickly developing in Canada and was improving the social conditions of most Canadians, an opposite trend of worsening housing conditions, overcrowding, impoverishment, and deteriorating health began to develop on Indian Reserves and Inuit communities across Canada.

(PART B CON'T.)

III INDIAN HOUSING

5.1 Government Involvement in Indian Housing on Reserves

After forcing Indians to locate to reserves, the Federal Government began to recognize the need to promote the development of better housing on Indian Reserves. However, Indian reserves are different from other areas in Canada in that the land can not be mortgaged or alienated. As well, Reserve land is not subject to the same market pressures or stimuli that affects housing supply on public lands. Clearly, very different housing programs would be necessary here.

In the 1950s, the DIA response to Aboriginal housing needs was to hire non-native contractors to build a series of match-box homes on reserves. This construction did not involve Aboriginal input or labour and was highly criticized by Aboriginal people. As a result, limited progress was made through this program. In 1962, a new On-Reserve Housing program was developed to give more control to First Nations. This program involves the granting of subsidies to First Nations to cover a part of the costs of constructing new units and also assisted in rehabilitating old ones. A variety of other programs also exist (see chart 1).

Chart 1 Main Elements of DIAND Housing Program for Status Indians On-Reserve[9]

Title	Type of Program	Assistance
Capital Housing Program	capital contributions (to be used for capital activities only)	provides financial assistance to First Nations for the construction of new houses and the renovation of existing units. New construction subsidies range from $19,000 to $45,000 depending on the locale of the reserve. The subsidies also include transportation and economic components for more remote communities. All new construction must meet at least National Building Code Standards. This program may be augmented by support from the CMHC programs.
O&M Support	contributions	provides financial support to First Nations to offset the cost of program administration, planning as well as to obtain technical assistance, training and inspection services and to undertake demonstration projects.
Ministerial Housing Loan Guarantees	loan guarantee	provides security to private lenders as an alternative to mortgages which are not available on-reserve.
Shelter Allowance	social assistance support	provides shelter allowance to eligible social assistance households to help offset rental charges.

The Assembly of First Nations maintains that Aboriginal people have a right to housing secured through treaties with the crown. However, the Federal government has not recognized housing to be a treaty right. It is the Department of Indian Affairs' (DIA) position that the government has entered the Reserve housing sector because of "the legal framework of the Indian Act" and because "the limited economic opportunities of Indians

[9] Reproduced from the Department of Indian and Northern Affairs, Basic Departmental Data, 1994

on reserves makes the construction and maintenance of housing on reserves difficult without active and significant involvement on the part of the federal government".[10]

Statistical information and studies on reserve housing conditions from 1965 to 1985 found housing conditions on reserves improved, but noted that the bulk of housing on reserves and infrastructure had remained substandard. These studies concluded that a great deal more progress and funding was necessary before reserve housing conditions would match standards enjoyed by mainstream Canadians. For example, in 1985, a national survey of reserve housing conditions found that 47% of the homes failed to meet basic standards, 36% were seriously overcrowded, and 38% lacked some or all basic amenities.[11]

5.2 Current Indian Reserve Housing Conditions

The 1991 Census found that Indian Reserves have among the worst housing conditions in Canada (based on amenities and housing conditions). Specifically, the census found that 38.8% of Reserve dwellings require major repairs, while only 8.2% of dwellings in the general Canadian population are in need of major repairs. The census also found that 39.2% of Reserve dwellings were not adequately meeting the needs of the occupants.

Many more statistics are available, but the short answer is that the On-Reserve housing program is failing. A major problem with the current program is that the base budget for funding the program was set in 1983. Except for increases in basic funding to accommodate those who regained their Indian status under the provisions of Bill C-31, the DIA budget has not increased since 1983. This means that basic subsidies have not been adjusted for inflation for over 10 years and are now worth half their original value. As a result, the subsidies provided through the program are not enough to build a house and communities have had to find other sources of funding in order to complete each unit.

The lack of adequate funding has meant a drop in the number of units being constructed and renovated on Reserve each year.[12] The AFN states,

> On-reserve housing conditions, despite the investment of $2.8 billion in federal capital funding and the construction of 31,000 new houses since 1982, continue to be among the worst in Canada. Under the current policy, dwellings on-reserve last approximately half as long as those off-reserve, and the gap between need and the supply has increased steadily... Close to 11,000 have inadequate sewage treatment and 6,000 have inadequate water supplies. Unless corrective measures are taken by the year 2005, over 60% of the 114,000 projected households on-reserve will not be adequately housed and the backlog of required homes will grow to over 74,000 housing units.[13]

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[10] Indian and Northern Affairs Canada, Information sheet No. 6, Indian Housing, July 1991.

[11] Ekos, 1985

[12] First Nations Housing Policy Analysis, Draft 6, 07/12/94

[13] First Nations Housing Policy Analysis, Draft 6, 07/12/94

(PART B CON'T.)

IV Inuit

6.1 Inuit Housing Overview

The Arctic is the most difficult and most expensive place in Canada to construct new homes. The Northwest Territory Housing Corporation (NWTHC) has estimated that the cost for constructing a home in the territory is 3 times that of similar home in southern Canada. As well, the costs of heating fuel and maintenance in the North are extremely high. There is a housing market in the arctic but it is described as 'extremely limited' and it can not produce a sufficient number of homes.

Today, there is a serious housing crisis in Inuit communities. The small housing market that does exist in the arctic is inaccessible to the Inuit because they experience chronic unemployment in the wage earning sector of the regional economy and thus cannot afford the high costs involved in the purchase and maintenance of a private home. In order to live in permanent settlements, the Inuit have had to look toward social housing. However, because the Inuit have not signed treaties with the Crown, the Inuit do not have special funding arrangements with the federal government. As well, because the Inuit do not live on reserves, they must compete with non-Aboriginal Canadians for social housing in the Arctic.

6.2 Government Involvement in Inuit Housing

The Federal government has become involved in social housing in the north due to the high cost of construction and the absence of a viable housing market in the region which could produce a sufficient number of affordable homes.

6.3 Current Inuit Housing Programs

The Inuit live in 3 provincial/territorial jurisdictions in the Arctic – the Northwest Territories (NWT), Nunavik (northern Québec), and Labrador. Provincial/territorial housing programs vary for each region, as does federal assistance for each region. As a result, Inuit housing conditions and access to social housing vary in each region. In order to understand Inuit housing conditions, it is necessary then to examine the government housing programs in each region. For a breakdown, see Chart 2.

In the NWT, federal housing programs provide most of the housing in the territory, and there is no Inuit specific housing program. The Northwest Territories Housing Corporation (NWTHC) administers both GNWT and CMHC housing programs which generally fall into 2 categories (Assisted Rental and Home Ownership Programs).

In Nunavik, the DIA is responsible for Inuit social housing and funds programs that are coordinated by the Société d'habitation du Québec (SHQ). A new housing delivery

system for the region has been anticipated since 1975 as part of the James Bay and Northern Quebec Agreement, but to date, no such housing agreement has been reached.

Housing in Labrador is administered by the Newfoundland and Labrador Housing Corporation (NLHC), which is funded by CMHC and the province. Social housing is provided by NLHC, the Torngat Regional Housing Association (TRHA), and the Melville Native Housing Association (MNHA).

Priority in the allocation of social housing in all 3 regions is based on an elaborate point rating system.

Chart 3 Inuit Housing Programs[14]

Type of Program by Region	Title of program, or Name of Housing Delivery Organization	Comments
NWT		
Rental Assistance	Public Housing Program Modernization & Improvement Program Fire Damage/Replacement Program Weber Retrofit Program	Assisted Rental Programs have been developed for rental accommodation with subsidized rents, and are assessed to the tenant's income. These programs form the majority of the programs accessible to Inuit. These programs have been seriously cutback by the 1993 federal cuts in social housing.
Home Ownership	Lease to Purchase Program Owner Build Program Alternative Housing Program Maintenance Program and Subsidy Sale of Access Material Packages Interim Financing Program Home Improvement Program Information and Counselling Service Direct Lending Forgivable Loans above Core Need Income	Access to Home Ownership Programs are for families who can afford the expenses of operating a home. Inuit, and especially Inuit women have limited access to these programs because of their under employment in wage incomes. These programs have been seriously cutback by the 1993 federal cuts in social housing.
Nunavik	Société d'Habitation du Québec (SHQ)	The SHQ Aboriginal housing division is funded by the CMHC. The SHQ coordinates federal (CMHC and DIAND) financial arrangements and is responsible for the design and implementation of the regions housing programs. 1993 CMHC funding cutbacks may result in a failure to meet a commitment to provide 199 new Inuit social housing units.
Labrador	Newfoundland and Labrador Housing Corporation (NLHC)	The NLHC administers funding from the CMHC and the provincial government. NLHC gives priority in public housing to victims of violence
	Torngat Regional Housing Association (TRHA)	The TRHA estimates that in order to meet the current demand for housing, $6.5 million is required to build 100 homes and another $1 million is required for repairs.
	Melville Native Housing Association	A delivery agency for Native housing in Labrador.

[14] Inuit Housing Program information taken from, "Inuit Women: The Housing Crisis and Violence" prepared for the CMHC by Pauktuutit Inuit Women's Association.

6.4 Current Inuit Housing Conditions

As stated, the Inuit are experiencing a serious housing crisis. Typically, government housing made available to the Inuit has been inadequate and not appropriately designed for extended Inuit families and the domestic activities of an Inuit household (i.e., the homes did not provide a place for carcass preparation, or an outdoor storage area, etc.). Finally, the amount of housing provided has been insufficient.

The existing stock of homes are quickly deteriorating and a growing Inuit population has meant that severe overcrowding, and inadequate and unsafe housing conditions have become commonplace for many Inuit families. A Pauktuutit report has stated that overcrowding is widely considered among the Inuit to be "the most serious problem they face". In particular, the health and well-being of Inuit women is threatened by inadequate housing which exacerbates social problems, promotes assault and other abuses, and yet does not provide alternative places for the abused to live away from the abuser.

The 1991 census found that 18.3% of Inuit households are in need of major repair and that 32.9% of Inuit homes were not adequately meeting the needs of the occupants. The census also found that the Inuit have the highest average level of crowding in Canada, at 0.8 persons per room (twice that of the Canadian average). The Aboriginal People's Survey of 1992 also found that 57% of Inuit households do not have adequate living space.

In terms of regions, in the NWT, Pauktuutit reports,

> According to the 1992 NWTHC Needs assessment, over 3,584 new housing units are required to meet the demands for housing at 1992 levels. Considering the rapid growth of the Inuit population and the poor condition of much if the current social housing stock, it is safe to assume that the housing crisis will worsen substantially at the present level of funding.[15]

The Inuit in Labrador are generally considered to have the worst housing conditions of all Inuit. These Inuit communities have not experienced the same progress achieved by Inuit in the other regions due to complicated jurisdictional issues arising from Newfoundland and Labradors terms of entrance into Confederation. It is difficult to quantitatively describe the Inuit housing conditions in Labrador because the government does not undertake systematic needs assessment in the region. However, qualitative information shows a substantial demand for housing and a highly insufficient supply, compounded by a high population increase in the region. As well, overcrowding and substandard housing are chronic, and people have been known to wait on waiting lists for 13-14 years (Pauktuutit). Overall, Pauktuutit states that government officials concede that Inuit in Labrador live in "Third World" conditions.

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[15] Pauktuutit, p.6

(PART B CON'T.)

VII. The Métis

7.1 The Métis

Métis people are a separate Aboriginal Nation who live in rural and urban areas in Canada and are represented by the Métis National Council. In rural areas, Métis people have historically formed self-determining Métis settlements and communities.

7.2 Government Involvement in Métis housing

The Federal government has not acknowledged any special responsibilities for Métis housing. In 1974, Métis people were responsible for successfully lobbying the creation of the Rural and Native Housing (RNH) which became available to all rural Aboriginal people, but specifically reflects the needs of Métis people who live outside of urban centres but do not live on reserves.

7.3 Métis Housing Programs

Métis people have access to the RNH and Urban Native Housing Program (see Chart 3). The RNH Program is designed to address the shelter needs of rural low-income off-reserve native and non-native households. However, the CMHC's budget for the RNH program was capped in the 1993 federal budget and new commitments have been stopped.

Métis organizations have also developed their own Métis housing programs through the CMHC. For example, in Alberta, a Métis Urban Housing Corporation was formed by the Métis Nation of Alberta to provide housing in the province's urban centres for low and moderate income Métis and Aboriginal families. In terms of rural areas, the Manitoba Métis Federation (MMF) is currently the only Métis group involved in rural property management (Métis National Council, n.d.).

7.4 Current Métis Housing Conditions

Housing needs vary greatly within the Métis Nation. However, the Métis communities as a whole are experiencing a housing crisis similar to the other Aboriginal sectors. The 1991 census found that 16.8% of Métis homes needed major repairs (over twice that of the general Canadian population) and in 1994, the CMHC placed over 44% of rural Native households (primarily Métis) in core housing need.[16] There is also an established need for more Métis access to rental accommodation in urban centres (Métis National Council, n.d.).

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[16] The State of Canada's Housing, p.v

(PART B CON'T.)

VIII. Urban Aboriginal People

8.1 Aboriginal urbanization

In the 1960s, a large number of Aboriginal people (Indian, Inuit, Métis) began to migrate from reserves to urban centres. This process of Aboriginal urbanization is well documented by studies conducted during this period.

The studies from the period have shown that Aboriginal men migrated to urban centres primarily for employment and education, and not due to any dissatisfaction or disruptions on reserves (McCaskill 1981, Clatworthy 1980). Aboriginal women, however, did report dissatisfaction and concerns over abuse as a motive for leaving reserves (Peters 1992). 2-Spirited people were not surveyed at that time, but report to have left their communities due to intolerance, homophobia, and in order to find educational and economic opportunities (Deschamps, Zoccole).

Because the Federal government has pursued a policy of confining treaty rights to Indian reserves and Inuit settlements since the first part of the 20th century, a process began to develop in the 1960s, wherein, at the time an Aboriginal or Inuit person left their reserve or northern community, they also left the jurisdiction where social services and benefits are provided by the Federal Department of Indian Affairs.[17]

To complicated the loss of Federal social services and assistance, studies have found that Aboriginal people leaving their communities and migrating to urban centres do not find a better life in the cities, but only find "racial prejudice, discrimination, and denial of education, job training, employment and housing."[18] In a recent review of the urban Aboriginal literature, Kastes (1993) has noted that, "the literature is consistent in finding that Aboriginal people migrating to urban centres are, for the most part, not breaking out of the cycle of poverty".[19]

8.2 Assimilation

Early studies of Aboriginal urbanization argued that given time, Aboriginal people would adapt to cities and ultimately assimilate. However, studies done 10 years after the first wave of urban migration found that assimilation was not occurring (McCaskill 1981, Clatworthy 1982).

These studies have shown that Aboriginal people are forming separate communities in urban centres with their own distinct cultural values (McCaskill 1981, Clatworthy 1982, Frideres 1988, Peters 1987). Indeed, Peters (1987) challenged the

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[17] To this day, the DIA has only made allowances for some education and health benefits to be granted off-reserves. As well, Métis and all other people who are not defined as Indians under the Indian Act receive no services under federal legislation.

[18] JNCAAEP, p.31

[19] Kastes, p.78

assumption that urban Aboriginals live disorganized lives as a result of cultural and community break-down and carefully documents a new system of coping strategies reflective of Aboriginal culture and values.

The literature also notes that Aboriginal service organizations and programming (i.e., Friendship Centres, health clinics, child care, street patrols, cultural centres, etc.) are stemming any further effects of assimilation and are successfully promoting the development of a vital urban aboriginal community serviced and supported by its own organizations and grounded in its own values and traditions.

As a result of narrowly defined federal jurisdictions on Aboriginal rights to social services, urban Aboriginals have become a separate community cut off from most DIA services and benefits. Yet, the communities are not entirely separate, as Aboriginal people continue to move back and forth between their urban and rural homes. A 1979 survey showed that 85% of Aboriginal people in Toronto and 72% of Aboriginal people in Winnipeg regularly move between their homes in the city and the reserve.[20] The numbers have apparently remained the same.

8.3 Urban Aboriginal Housing Experiences

In terms of housing, leaving reserves and northern communities clearly did not lead to markedly improved housing conditions in urban centres (Krotz 1980, Kastes 1993). Most studies conducted during the period from 1975 to 1985, found that adequate and affordable housing was identified by Aboriginal respondents as their greatest and most under-met need in urban centres (Manitoba Indian Brotherhood 1971, Stanbury 1975, Gurstein 1977, Saskatoon 1979, Krotz 1980, Maidman 1981, City of Calgary 1984).

As a result of poverty and non-assistance from Federal programs and services, Aboriginal people in urban centres have been forced to take up the worst dwellings in urban cores. The result has been that Aboriginal settlement in urban centres has not been based on the formation of ethnic enclaves, but the development of a scattered site settlement based on the location of the cheapest dwellings in the city. Quite clearly, Aboriginal people have had a limited choice in where they live in cities (Krotz 1980).

Between 1960 and 1992, no nation-wide study was conducted on the housing conditions of urban Aboriginal people. Part of the reason for this is, there is no way to identify urban Aboriginal people. However, during this period, several case studies were conducted on urban Aboriginal housing conditions in selected urban centres (Stanbury 1975, Clatworthy 1982, Clatworthy and Hull 1983, Chu 1991). Each study concluded that urban Aboriginal people represented one of the most poorly housed segments of Canadian society. For example, in a 1984 study of Aboriginal households in Winnipeg, Peters concluded that, "Natives live in the poorest housing conditions in the city. While less than one quarter of the inner city is in poor condition, one half of native households lived in poor housing".[21] In 1987, Clatworthy and Stevens found that one third of urban native households were not paying affordable rents and that urban "Indian households are

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[20] John A. Price, "Native people, Urban Migration", in Hurtig, The Canadian Encyclopedia, p. 1461

[21] Peters, 1984, p.32

also much more likely than non-Indian households to acquire housing which is in need of major repairs, lacks basic facilities or is too small to accommodate their space needs".[22]

Much of the disparity that these case studies documented between Aboriginal and general urban households is attributed to racial discrimination, low employment, welfare dependency, and low income levels. For example, Chu concluded in 1991 that, "Urban Native housing problems are intricate, interdependent and inter-related, but the problems can be reduced to major factors: systemic poverty and racism".

8.4 Urban Housing programs

There have been two types of urban housing programs designed to increase the number of adequate and affordable housing available to urban Aboriginal people.

The Indian Off-Reserve Housing Program was set up in 1966 by the CMHC and the DIA, and was available across Canada. The program provided loans, mortgage assistance, and grants for furnishings, to stable and upwardly mobile Status Indians. The program was not designed to help non-status Indians or Métis people, and the program also failed to assist the majority of Status Indians (Krotz 1980, AFN). The program was terminated by the Federal government in 1985.

The alternative to the Indian Off-Reserve Program has been Aboriginally operated urban housing programs that offer rental housing to Aboriginal people. The first program began in Winnipeg (Kinew) in 1970, and similar projects were developed in many other urban centres during the mid-1970s. The projects were funded by grants from the CMHC and the provinces, and used Aboriginal labour and skills to salvage old homes and then rent them to Aboriginal people and families based on the applicant's ability to pay, with a government subsidy making up the difference. These programs were more broadly based, available to all Aboriginal people, and designed to help those in the greatest need. A significant problem with these programs was that they could not keep up with demand and huge waiting lists were generated. In 1975, the policies that supported these programs were changed and no new projects were developed. These original housing programs continue, but remain too few to house the number of urban Aboriginal people still in need of housing.

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[22] Clatworthy and Steven 1987, pp. xxii-xxiii

Chart 2 Main Elements of Principle CMHC Housing Programs for urban Aboriginal People[23]		
Title	**Type of Program**	**Assistance**
On and off-reserve:		
Residential Rehabilitation Assistance Program	loan, forgivable up to a maximum	Up to 1995: max loan $25,000, max. forgiveness $5,000 to $8,250 depending on zone. 1995 max loan: $18,000 to $27,000, maximum forgiveness $18,000 to $27,000 depending on zone. **Off-Reserve expires 1995.**
Native Cadré Program	training	On-the-job training (usually within CMHC) in all aspects of housing administration and delivery for Aboriginal nominees of Aboriginal groups and provinces (6 months minimum)
Off-Reserve:		
Rural and Native Housing Program	Long term subsidy. Rental, lease to purchase, and self build ownership have been funded	To reduce payments/rent to geared-to-income levels. Further reductions in payments for self build ownership based on Labour contributed. **Commitments ended 1993.**
Urban Native Housing Program	Long term subsidy. Projects owned by Native groups	To bridge the gap between project operating costs, and revenues based on rent-geared to income. **New commitments ended 1993.**
Emergency Repair Program	Grant for urgent repairs for continued safe habitation	Maximum grant $4,635 - $8,242 depending on zone. **Expires 1995.**

8.5 Current Urban Aboriginal Housing Needs

The 1991 census found 27% of non-reserve Aboriginal households to be in the area of core housing need. At 27%, this number is well above the non-native core housing need of 15.9%. As well, the number of non-reserve Aboriginal households in need of major repair was found to be almost twice as high as that for the general Canadian population. Statistics Canada's Research Program and Statistical Services Division has also compared non-native to Aboriginal household need and found that although affordability was the greatest Aboriginal need, that suitability and adequacy were much more important to Aboriginals than non-natives. This is probably because Aboriginal people have less choice in where they live. In 1993, the Royal Commission reported that "participants were blunt about the need for adequate and appropriate housing for Aboriginal people in urban centres".[24]

In urban centres, the bottom line is that, accessible, adequate, and affordable housing for urban Aboriginal people has not been achieved. All sources of funding have been cancelled and no new sources of funding for Aboriginal housing projects exist. As

[23] Reproduced from the Department of Indian and Northern Affairs, Basic Departmental Data, 1994

[24] The Royal Commission on Urban Aboriginals, p.23

Chu (1991) states, "if housing is a social right in a democratic society ... the majority of urban Natives are deprived of this social right in housing in every respect".

Figure 5

1991 Canada Census

Statistics on Aboriginal housing conditions, periods of construction, and bathrooms, broken down by Aboriginal groups[25]

	Canada's Total Dwellings	Total Aboriginal Dwellings	North American Indian	North American Indian On-Reserve	North American Indian Off-Reserve	Métis	Inuit
Number of dwellings	10,018,265	239,240	177,250	39,870	137,580	65,005	9,655
Dwellings in need of repair							
Major repairs	8.2	19.6	20.8	38.8	15.6	16.8	18.3
Minor repairs	23.6	29.5	29.4	28.7	29.6	30.3	24.2
Regular maintenance	68.2	50.9	49.8	32.5	54.8	52.9	57.4
Dwellings where needs were not adequately met	.....	21	21.7	39.2	16.7	18.6	32.9
bathrooms	99.4%	91.2%	90.3%	83.4%	92.3%	93.4	96.3%

.... figures not available

[25] Reproduced from Statistics Canada, "The Daily", March 25, 1994

(PART B CON'T.)

IX. Funding

9.1 Current Funding Levels for Aboriginal Housing Programs

As explained above, the Federal government's responsibility for Aboriginal housing has been carried out by the Department of Indian Affairs (DIA) and the Canada Mortgage and Housing Corporation (CMHC).

In 1993, the Federal Budget eliminated subsidy commitments to social housing and stopped increasing funding to Canada Mortgage and Housing Corporation (CMHC) programs. As a result, in 1993, the CMHC ceased making new commitments for off-reserve social housing programs (i.e., RNH), and the off-reserve Residential Rehabilitation Assistance Program (RRAP) expires this year (1995). These cuts have severely affected social housing programs for the Inuit, urban, and rural Aboriginal people. For example, in the arctic, the Federal government has stopped contributing money to the governments of the NWT, Québec and Newfoundland and Labrador for the construction of the new social housing units. Because the Inuit represent the majority of people in the region and occupy 90% of the existing stock of social housing as well as the bulk of those waiting for new homes, these cuts particularly affect them

New initiatives for government funding of off-reserve Aboriginal housing has been shifted to the provinces. However, the provinces have no mandate or responsibility to provide Aboriginal housing (jurisdictional issue) and are very reluctant to build housing for Aboriginal people.

While most reserve housing programs continue, the principal funding for On-Reserve housing programs has not changed since 1985. As a result, present funding is not sufficient to build new homes. Housing backlog on reserves has become acute.

9.2 New Possibilities

Since 1985, various Aboriginal organizations (Inuit, the AFN, the Métis National Council) have been agitating for a new housing program with greater Aboriginal control and greater funding and these groups have rigorously protested the 1993 Federal Budget cuts.

In 1992, a House of Commons Standing Committee on Aboriginal Affairs was struck to investigate the issues of Aboriginal housing in Canada. The Report that found existing Aboriginal housing conditions to be substandard and government inaction on the subject to be deplorable. The Standing Committee report called for an end to government inaction in the area of Aboriginal housing, called for increased Aboriginal control over housing policy and funding, and called for an end to jurisdictional issues in funding.

It would appear that recently, new Aboriginal housing policy is being developed by the CMHC, the DIA, and representatives from the Aboriginal community. Recommendations for this new policy development are expected to go to Cabinet this summer. The DIA could not comment on the contents of this policy due to its secrecy, but have told me that the current proposal, "stress local control and program flexibility to ensure the most effective use of limited federal resources, combined with local resources, to support improvements in housing, as well as providing opportunities for job creation, training and economic development".[26]

It may be that new funding sources will emerge from this new program. Information on this program should become public this summer.

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[26] pers. comm. from Chantale Guimond, Housing Officer, Indian Programming and Funding Allocations Directorate, May 30, 1995

X. A Summary of the Data and Issues

It is clear that adequate and affordable housing has been one of the greatest and yet un-met needs of Aboriginal people living in both urban centres, on reserves, in Métis settlements, and in Inuit communities. The absence of suitable Aboriginal housing stems from a denial of Aboriginal access to resources, the absence of a regular housing market, and as a result of limited housing programs, the curtailment of funding, and narrowly defined government recognition of Aboriginal rights.

The lack of sufficient, affordable, and appropriate housing has impacted on community health and promoted social problems in the Aboriginal community.

Studies are unanimous in that federal housing assistance programs have not succeeded in increasing the number of affordable and appropriate housing units in Aboriginal communities. As well, the existing stock of homes is deteriorating and a growing Aboriginal population means existing conditions of overcrowding and poor housing will be further exacerbated. A very significant housing crisis exists in the Aboriginal community (Inuit, Métis, and Indian) and will continue to worsen

Part C

XI. Aboriginal Control over Social Services and Support

This section on Aboriginal control over social services and support has been included in this report because it is important to emphasize that Aboriginal people have distinct rights to separate social services in Canada. It is also important to explain the Aboriginal vision of the delivery of social services to their community. An understanding of these rights and vision is critical to understanding some of the unique issues in the delivery of AIDS care residences for Aboriginal people.

11.1 The Urban Aboriginal Example

The Royal Commission and other studies have clearly documented the fact that Aboriginal people want to survive as a distinctive people (in urban centres, rural areas, Inuit communities, and on Indian reserves). In order to survive and build a strong and healthy community, Aboriginal people are calling for control over the delivery of health and social services.

Urban Aboriginal people have been among the most vocal in arguing their right to survive as a people and promote their community's health, self-esteem, culture, identity, and languages. Control over social services in the urban environment is necessary to realizing this vision. The Royal Commission on Urban Aboriginal people has supported this vision by stating that Aboriginal people "have a human right and, it can be argued, a constitutional right to survive as peoples, wherever in this land they choose to live".[27]

However, urban Aboriginal service organizations face a tremendous challenge. The urban Aboriginal community is not only disadvantaged by inadequate and unaffordable housing, but is constantly affected by high unemployment, low incomes, discrimination, alcohol and substance abuse, sexual and physical violence, physical exploitation, diminished self-esteem, and culture shock.

The greatest obstacle to the urban Aboriginal community's vision of developing a sophisticated system of Aboriginal health and social services is jurisdictional problems. The Aboriginal right to social services stems from treaties between Aboriginal nations and the Crown. In these treaties, Aboriginal people sought protection of their economies and lifestyles from white resource users and secured distinct rights, benefits, and status in Canada in exchange for the surrender of sovereignty over their land. In these treaties, Aboriginal negotiators had sought ways by which Europeans and Aboriginals could co-exist in Canada as independent peoples living on the same lands. Treaty rights were thus

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[27] Royal Commission on Urban Aboriginal people, p.4

intended to apply to Aboriginal people living anywhere on lands pursuant to a treaty, but since the turn of the century, the DIA has pursued a wrongful policy of confining Aboriginal rights and social services to the areas of Reserves proper. This has been an unjust and inequitable exercise of power on the part of the Federal government.

As a result of confining Aboriginal rights and social services to reserves and Inuit communities, urban and rural Aboriginal people have been left in what the Royal Commission has called a "policy vacuum" in which they do not qualify for federal assistance and there is no mandate on the part of the provinces or municipalities to provide special funding or services to Aboriginal people living within their jurisdictions. For years, Aboriginal applications for service provisions in the urban setting have been pushed from one level of government to the other, and served by none.

The literature has in fact identified jurisdictional issues as the foremost impediment to the delivery of effective Aboriginal housing, health services, and AIDS education, prevention, and care programs in the urban environment.

Population statistics differ, but show that 50 to 70% of the Aboriginal population lives off reserves. While the urban half of the Aboriginal population has the similar disparities in health, income, and educational achievement, it does not have the same access to health and social services.

In the NWT, the transfer of funding for Aboriginal education and health care from the Federal government to the Government of the North West Territories has led to additional jurisdictional problems for this Aboriginal population. In this case, Aboriginal people can not control the allocation of health dollars and are unable to apply for additional funding from other areas.

11.2 The Rationale for Culturally Appropriate Services

Many government departments and funders do not recognize Aboriginal social services as legitimate and sometimes think they are a duplication of services. However, these programs are legitimate and necessary as studies show that cultural barriers exist to the delivery of health and social services to Aboriginal people.

In a study of Aboriginal use of city social services, the City of Calgary (1984) found that Aboriginal people significantly underuse the city's social services based on attitudinal (distrust) and institutional (did not understand, long wait, not helpful) characteristics.

In jumping ahead to AIDS services, the ARA study found that AIDS services are less accessible to non-whites.[28] A Vancouver study found that Aboriginal people with AIDS access health care and social services later and at a more acute level of AIDS related illness than non-natives (St. Paul's Study). Finally, most delegates to the National Roundtable on HIV/AIDS noted the inability of mainstream AIDS service organizations (ASOs) to effectively meet the needs of Aboriginal PHAs.

In short, it is now generally recognized that in order for health care to be effective, it must be culturally sensitive and appropriate. As well, the most efficient way to ensure that health care is effectively delivered and accessible is to download health care services to community groups.

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[28] ARA, p.15

Aboriginal control over health care delivery is also part of a larger Aboriginal vision about the promotion and development of wellness in their community. When the Royal Commission heard from Aboriginal organizations, they were told that,

> non-Aboriginal agencies have different goals and priorities from Aboriginal social service agencies. Aboriginal agencies, such as friendship centres, view an individual person's problems as "symptoms of deeper problems" that are rooted in "racism, powerlessness and cultural breakdown". The non-aboriginal agencies, they said, tended to look at conditions as isolated problems and to view the individual as deficient.

This is especially true in urban centres where services are highly focused and specialized and such issues as mental illness for example, are singled out as a particular ailment accompanied by its own health program.

Aboriginal people do not want to address the symptoms of their health and social problems (i.e., alcoholism, sexual abuse, low self-esteem, high unemployment, etc.) in isolation, but want to treat the issues and disadvantages facing Aboriginal people in a holistic manner.

Lowered health, disability, poverty, substance abuse, violence, and homelessness are difficult issues to treat. However, the Aboriginal community has clearly stated that they want to take control over the treatment of the social and health problems affecting their community. Clearly, an Aboriginal response to these issues will be the most effective.

In short, great obstacle to Aboriginal control over health and social services exist in the form of the public's misunderstanding of the Aboriginal vision of their own health care delivery and the existence of jurisdictional divisions which do not allow for the co-ordination of Aboriginal service provision between reserves, remote communities, and urban centres. Jurisdictional divisions also impede the development of a holistic Aboriginal health care and social service system.

Part D
XII. AIDS in the Aboriginal Community

This section on AIDS in the Aboriginal community provides a history of the Aboriginal response to the disease, seroprevalence data, and funding sources. This information is important background information to funding a home for Aboriginal PHAs.

12.1 Introduction

Initially, rates of HIV infection in the Aboriginal community appeared much lower than those in the national population. However, this has changed. The number of reported AIDS cases in the Aboriginal community has quadrupled between 1989 and 1994. Today, Health and Welfare Canada reports that there are 116 AIDS cases in the Aboriginal community. However, this number is widely recognized to be underestimated. In 1995, the Ontario Aboriginal HIV/AIDS Steering Committee compiled the case loads of Aboriginal AIDS service organizations across Canada and estimated that there are 1000 to 1500 Aboriginal people living with HIV/AIDS in Canada.

A significant finding of a Joint National Committee on Aboriginal AIDS Education and Prevention (1990) was that HIV infection in the Aboriginal community is not following the same pattern of transmission as that of the general Canadian population. In fact, the national study found that unlike the mainstream Canadian population, AIDS in the Aboriginal population is following a "Pattern II country" process of being transmitted primarily through heterosexual contact. Aboriginal clinics such as Anishnawbe Health in Toronto are finding that increasing numbers of Aboriginal women are being diagnosed HIV+ which supports this concern. As the Ontario Aboriginal HIV/AIDS Strategy points out, "there is a real danger that Aboriginal communities may become Pattern II communities within a Pattern I country".

In general, the Aboriginal community is at high risk of HIV infection due to lower condom use, high levels of Sexual Transmitted Diseases (STDs), and different sexual attitudes and behaviours from the mainstream Canadian population. As well, poverty, low self esteem, and substance abuse place Aboriginal people in areas of high risk due to high levels of sexual assault, and entrance into street life where I.V. drug use is on the increase. As well, there is a disproportionate representation of Aboriginal people in the urban sex trade.

12.2 Concern in the Aboriginal Community

Front-line Aboriginal AIDS workers are very concerned that HIV/AIDS might reach epidemic proportions in the Aboriginal community. Aboriginal people have already been disproportionately affected by several Canadian health epidemics in this century

alone, and this fact remains in the minds of many people. As well, because HIV/AIDS tends to infect young people, there is a concern that the spread of HIV/AIDS within the young, mobile generation of Aboriginal people may interrupt the current process of community revitalization now underway.

12.3 The Aboriginal Response

When HIV/AIDS was first noted in the Aboriginal community, some key Aboriginally developed and executed attitudinal and behavioural studies were carried out by the Joint National Committee on Aboriginal Aids Education and Prevention (JNCAAEP) (1990), the National Roundtable on HIV/AIDS & First Nations, and the Ontario First Nations AIDS and Healthy Lifestyle Survey (1993)). These studies have assessed the risks and possible trends of HIV infection in the Aboriginal community and have made recommendations about how to address the issues.

Specifically, in 1989, the JNCAAEP was created to identify how HIV/AIDS affects the Aboriginal community in Canada and was useful in providing recommendations to Aboriginal governments, Aboriginal AIDS organizations, and non-aboriginal governments, including Health Canada, on how to most effectively address the infection of Aboriginal people and communities.

In 1993, the Ontario First Nations AIDS and Healthy Lifestyle Survey was designed to determine the extent of knowledge Ontario First Nation communities have about HIV/AIDS and determine which attitudes and behaviours place the community at particular risk of HIV infection. The study's results were used to design culturally appropriate education and prevention programs for Ontario reserve communities.

Other studies have been conducted by smaller Aboriginal organizations (Urban Aboriginal AIDS Awareness Project (UAAAP), TPFN, Feather of Hope). The survey conducted by the UAAAP included urban Inuit, Métis, and Indian people.

The literature has consistently shown that many Aboriginal people still think AIDS is a "gay white man's disease" and note that education programs in the Aboriginal community are impeded by denial, fear of discrimination, and cultural reticence around talking about sex. The Ontario First Nations Study found that some communities are knowledgeable about AIDS, but that people in the community still engage in high risk behaviour, and generally placed themselves in greater risk than people in the mainstream society. Overall, the literature is strong on identifying sexual attitudes and behaviours of Aboriginal people as regards HIV infection, and identifies the needs for culturally specific and appropriate messages, care, and treatment.

The Aboriginal response to AIDS did not stop with these studies. In the early 1990s, Aboriginal AIDS organizations emerged in every major region, urban centre, and province of Canada. Many territorial organizations also took on AIDS education and prevention programs. These efforts involve the delivery of culturally appropriate education and prevention programs, referral services, needle exchange programs, posters, peer counselling, the promotion of healthy and alternative lifestyles, videos, and other creative responses to educating the community.

In one example, Healing Our Spirit is an Aboriginal AIDS service organization based in British Columbia which provides a wide range of AIDS information and culturally appropriate services which includes: education and prevention services, workshops for care givers, referral information, a rent subsidy program, retreats for HIV positive individuals and their families, healing circles, feasts, and drumming. Healing our Spirit offers these services to all of B.C.'s Aboriginal people, whether or not they are living in urban centres, rural areas, or reserves (MSB 1995).

The province of British Columbia, Manitoba, and Alberta have successful interjurisdictional programming. In the other provinces, service delivery split by jurisdictional issues over funding. As a result of jurisdictional issues in these provinces, most urban centres and reserve communities have separate programming and administration. This is an unfortunate split in the pooling of knowledge, expertise, services, and skills in the treatment of a disease which does not discriminate based on place of residence. AIDS freely moves between reserves and urban centres as do Aboriginal people.

Outside of education and prevention programs, the Aboriginal community has expressed a clear desire to care for the 1000 to 15000 members of the community who are infected with HIV. Presently, there are no comprehensive Aboriginally developed continuum of care programs on reserves or in urban centres. However, proposals have been made (TPFN, the AFN).

12.4 The Data on the Number of Aboriginal HIV/AIDS Cases

Efforts to emphasize the disproportionately high level of HIV/AIDS in the Aboriginal community is hampered by the absence of reliable data on the number of Aboriginal people living with HIV/AIDS in Canada.

In April of 1994, Health Canada reported there to be 97 cases of AIDS in the Aboriginal community.[29] This figure represents a quadrupling of the reported number of AIDS cases in the Aboriginal community since 1989 when seroprevalence studies began to included ethnicity. However, this number stands in strong contrast to the estimate reached by the Ontario Aboriginal HIV/AIDS Strategy Steering Committee that there are presently 1000 to 1500 HIV infected Aboriginal people living in Canada.

Nevertheless, it is widely accepted that Health Canada's official figure is underestimate. For example, Health Canada reports that there are fewer than 5 reported Aboriginal AIDS cases in Ontario, while 2-Spirited People of the 1st Nations which is based in Toronto, has a client list of over 50 Aboriginal people living with HIV or AIDS, and has had 8 clients die of AIDS related illnesses in the last 2 years. At the same time, the Ontario First Nation AIDS and Healthy lifestyle Survey estimated that there are 212 HIV-positive Aboriginal people over the age of 15 living on Ontario Indian Reserves. Similarly, the JNCAAEP points out that although Health Canada reports no Aboriginal AIDS cases in Manitoba for 1989, a Winnipeg street-based program had reported several HIV and AIDS infected Aboriginal people during that time.

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[29] Health Canada, "Information: HIV/AIDS and Aboriginal People in Canada", July 1994

Health Canada's figure is underestimated for many reasons. First of all, prior to 1988, ethnicity was not included in Canadian seroprevalence studies and as a result, ethnicity is not known for a third of all AIDS cases in Canada. Although ethnicity is now included in the testing survey, ethnicity indicators remain inconsistent and unreliable. Secondly, Aboriginal people distrust the health care system and testing. Under reporting is often due to an Aboriginal fear of disclosure to their communities and fear that disclosure of their ethnicity or HIV status will further disadvantage them in achieving their immediate or short term goals. The JNCAAEP notes that Aboriginal people in the United States significantly underreport their HIV status.

To date, there has been no Aboriginally generated seroprevalence studies conducted in Canada. A realistic estimate of the number of HIV infected Aboriginal people in Canada, can easily be achieved by adding up the case loads of Aboriginal AIDS organizations across Canada. However, in estimating the number of HIV infected people in a community, it is necessary to compute the risk factors that exist within the community and contribute to its potential rate of infection. For example, an indicator of a community at risk is one with an existing high rate of sexually transmitted diseases (STDs). Other indicators (high risk activities) are low levels of condom use, I.V. drug abuse, involvement in the sex trade, low sexual self-esteem, lack of access to health information and facilities, and poverty.

12.5 Risk factors in the Aboriginal community

High risk factors are prominent in the Aboriginal community. The Ontario First Nations Survey found that among Aboriginal people over the age of 15, 90% of this group were sexually active and 41% of those surveyed have engaged in unsafe sex. In terms of STDs, the Ontario Aboriginal HIV/AIDS strategy reports that the rate of STDs in the Aboriginal community is 4 to 10 times higher than the Canadian average.

The JNCAAEP found Aboriginal I.V. drug use to be on the rise. As well, the Ontario First Nations Survey found that 14% of its sample have used I.V. drugs, and that 3% share needles. The Survey also found that I.V. drug use accounted for 36.4% of the reported cases of HIV among Aboriginal women. A study of Vancouver street youth found an HIV incidence rate among Aboriginal youth to be twice that of any other ethnic group.[30]

The urban environment puts people in additional risks. For example, in the absence of other economic opportunities, many Aboriginal migrants to cities enter the sex trade. Studies have found Aboriginal people to be over-represented in the urban sex-trade (Alberta Indian Health Commission 1993). The Aboriginal community as a whole also experiences high levels of sexual abuse. Sexual abuse stems for colonization, disempowerment, and racism. Sexual abuse places Aboriginal communities at risk of uncontrollable transmission of HIV.

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[30] Barbara Sanderson, Bonnie Gabel, "The Evaluation of the Native AIDS Coordinator Program: Ajoint Project of the Vancouver Native Health Society and St. Paul's Hospital", 1994

Finally, Aboriginal people are over-represented in Canadian prisons where culturally appropriate and effective HIV/AIDS education, prevention, and needle exchange programs have been hard to legitimize and implement.

It must be stated that economic and social conditions have an impact on health, health knowledge, and access to health care. As well, many of the factors that contribute to HIV/AIDS infection are accentuated by poverty, low self-esteem, low levels of education, and disempowerment. Aboriginal people are disadvantaged in all of these categories. For this reason, the potential rate of infection in the Aboriginal community is greater than that in many other communities.

Thus it is that AIDS education, prevention, and care programs in the Aboriginal community must address family violence, mental health, substance abuse, poverty, unemployment, and sexual empowerment as well as sexual behaviour and attitudes.

12.6 Problems with the Lack of Seroprevalence Data

Statistics are used by funding agencies to determine need. When Aboriginal organizations cannot provide the data that funding agencies want because the existing governmental data is seriously inaccurate, the Aboriginal organizations are presented with a difficult problem. In explaining the inaccuracies in Federal data, it is necessary to explain Aboriginal conditions, remoteness, denial, fear of white institutions, fear of identification -- in essence, explaining native cultural, social, and economic differences which can distract from the intended goals of a funding proposal.

The literature has emphasized a need for Aboriginal developed and controlled seroprevalence studies that can be used to assist Aboriginal organizations and be used to inform and educate funders and government. (Bridging the Gap (1994), Ontario Aboriginal HIV/AIDS (1995) Strategy, Canadian AIDS News).

12.7 Funding the Aboriginal Response

The Federal government is in Phase II of the National AIDS Strategy which includes Aboriginal issues. Funding for First Nations (reserves) HIV/AIDS programming comes from Medical Services Branch (MSB) of Health Canada. Funding for off-reserve programming flows through the AIDS Community Action Program (ACAP).

Funding for off-reserve efforts has been grossly inadequate. All Aboriginal AIDS organizations outside of Ontario have reported an inability to provide effective programming and operate an office due to significant underfunding. These groups explain that part of the problem is that ACAP has its funding priorities set by panels with limited Aboriginal representation. As a result, it is claimed that ACAP has a diminished understanding of the need for the funding of Aboriginal AIDS initiatives.

The Royal Commission heard from a wide range of urban Aboriginal organizations who all reported to be "understaffed, underfunded and too dependent upon unpaid, untrained volunteers".[31]

On reserves, the National Roundtable on HIV/AIDS & First Nations Populations found that "the paramount stumbling block expressed by Roundtable participants [from across Canada] has been attributed to inadequate funding".[32]

[31] Royal Commission on Aboriginal People in Urban Centres p.15

[32] Bridging the Gap

Part E
XIII. Housing for Aboriginal PHAs

This section pulls the above information together and reviews why AIDS is a housing issue, why housing is needed by Aboriginal PHAs, explains the rationale for a culturally appropriate home specifically for Aboriginal PHAs, and then examines design considerations for this home.

13.1 Why is Housing is an AIDS Issue?

Housing has become an AIDS issue because PHAs are living longer, care is no longer being delivered by hospitals, there is an incomplete housing system in Canada, and because many existing social housing providers are refusing to accept PHAs out of a fear of HIV/AIDS or because they are homophobic.

It is well documented that the majority of people living with HIV/AIDS would prefer to receive treatment and care in their own homes. However, this is not always possible. Unfortunately, we do not have separate statistics for Aboriginal PHAs, but we can presume that they feel the same way. In the late 1980s, it started to become clear that supportive housing for people living with HIV/AIDS was a significant and unmet need. As a result, over 20 housing projects specifically for people living with HIV/AIDS were developed across Canada. These homes were funded by the Federal government with contributions from provincial health ministries and others based on the fact that PHAs represent a special need group in Canada for which the housing market can not provide the appropriate residence. Government funding of Aboriginal PHA housing is consistent with the Federal government's long-standing objective to provide a *complete housing system* in Canada. Homes built for PHAs are not designed as clinical/hospital type facilities where people can receive intensive care, but rather, have been designed to offer people a home where they can live out the course of their illness with dignity. Providing people with a place where they can die with dignity is in fact the major impetus for these homes.

In keeping with the early AIDS demographics, most of these housing projects were designed to serve gay white men. However, the demographics of the disease have changed. Today, Aboriginal People and minority groups are showing increased rates of HIV/AIDS infection.

PHA housing is particularly needed for those who cannot afford to continue to live where they are because of a loss of employment, a reduction in income, or inability to work full time because of an HIV/AIDS illness or need; and to those who did not have suitable or affordable housing before the onset of the disease.

It has been shown that Aboriginal people are greatly disadvantage in accessing affordable and suitable housing due to poverty created by low income, high unemployment and racial discrimination. It has also been shown that existing Federal Aboriginal housing programs have failed to make adequate housing sufficiently available to

Aboriginal people living on reserves and in urban centres. It will also be shown that existing Aboriginal housing is not suitable for people living with HIV/AIDS. Finally, it has also been shown that Aboriginal people are experiencing rapidly increasing levels of HIV infection. As a result, it can be safely predicted that unless homes for Aboriginal PHAs are built, that the housing needs of Aboriginal PHAs will become one of the most unmet supportive housing needs of the 1990s.

To date, there are no specifically Aboriginal PHA housing projects in Canada.

13.2 The Unsuitability of the Existing Stock of Aboriginal Housing

For Aboriginal people who are presently housed, a large portion of their housing is not suitable for people living with HIV/AIDS.

It has been argued in the literature that housing for PHAs must be easily kept hygienic, not damp or drafty, be accessible, affordable, not overcrowded, have a proper sewage disposal system, be supplied with a source of uncontaminated water, have sufficient room for daily living, have private bathrooms, and have sufficient room for guests (Wilms, Hayes, and Hulchanski (1991), Berman 1993, Lieberman 1993) However, many existing Aboriginal homes do presently meet these criteria.

In 1994, the Department of Indian Affairs reported that 54% of reserve homes failed to meet basic standards. Of special concern to PHAs, 31% of reserve homes have neither piped nor well water, and 24% have neither piped sewage service nor septic fields. As well, the 1991 census found that nearly 100% of the homes in Canada have bathrooms, but that on average, only 91.2% of Aboriginal homes in Canada have bathrooms. Specifically, only 83.4% of reserve homes have bathrooms and 92.3% of off-reserve homes have bathrooms.

In the Aboriginal Peoples Survey of 1992, it was found that Aboriginal people living throughout Canada (urban and non-urban) experience exceptionally high problems with inadequate living space. Of the total Aboriginal population, 52% of Aboriginal dwellings need additional bedrooms, 60% need additional storage space, 56% need better ways to keep the place warm, and 25% of the homes need a better roof. Aboriginal people living on reserves and northern settlements reported the highest problem with living space at 61%, while 57% of the Inuit people surveyed , 48% of the Métis population, and 51% of the urban Aboriginal populations surveyed require additional living space (APS 1992).

In 1990, The Canada Standing Committee on Aboriginal Affairs found that 29% of reserve dwellings were overcrowded. The same study found that 11% of the dwellings occupied by Status Indians off-reserves were overcrowded. The average rate of overcrowding for homes in the national population is 2%. Overcrowding of homes was also surveyed in the 1991 census. The census found that Aboriginal dwellings were 50% more crowded than the total dwellings in the national population. Specifically, Aboriginal dwellings were found to have an average of 0.6 persons per room. The corresponding average for dwellings in the national population was 0.4. However, neither of these "averages" is above the overcrowding standard of more than 1 person per room. In terms of a breakdown, the Inuit experience the most crowding among Aboriginal groups

at 0.8 persons per room (twice that of the Canadian average) and the lowest levels of crowding were found among Métis people and Aboriginal people living off reserves, at 0.6 persons per room.

In effect, these conditions of crowding, the possibility for contaminated water, the absence of bathrooms in homes, inadequate living space, poor heating, improper sewage treatment, and leaking roofs means that a majority of existing Aboriginal housing across Canada is not suitable for Aboriginal people living with HIV/AIDS.

The literature has already shown that poor housing on reserves has been linked to asthma and respiratory problems (Young 1991, Dubois 1994, AFN). Poor housing conditions and the presence of air born viruses presents a real threat to people living with compromised immune systems.

In recognition of the fact that poor housing conditions is commonplace among Aboriginal people, Marcel Dubois (1994) has generated a check list for Aboriginal PHAs to determine whether or not their community can provide suitable housing (reproduced in appendix A).

13.3 The Identification of the Need for Aboriginal PHA Housing

The need for an Aboriginal PHA home has been recognized by the Royal Commission on Aboriginal Peoples in Urban Centres (1993), the Assembly of First Nations' First Nations Health Commission National Roundtable on HIV/AIDS (1994), the National Aboriginal PHA Network, the Ontario Aboriginal HIV/AIDS Strategy (1995), Feather of Hope, and individual communities such as the Island Lake First Nation. Already, Healing Our Spirit in British Columbia is providing housing subsidies to Aboriginal PHAs.

In terms of specifics, the First Nations Health Commission has recommended that hospices be developed on-reserve. The Ontario HIV/AIDS Strategy has called for the funding of 40 to 45 units of Aboriginal PHA housing across Ontario.

13.4 The Rational for Culturally specific housing

The literature from existing AIDS care residences cautions that cultural insensitivities have damaged the effectiveness of many existing projects (Berman 1993, Lieberman 1993).

Specifically, as the cultural demographics of AIDS cases changes, many housing planners and providers are trying to figure out how to house people with diverse cultures and backgrounds in the same facility, and serve all of their needs. In the United States, a comprehensive AIDS care residence development study concluded that culture is a central issue to the delivery of supportive housing.[33]

Once it is recognized that culturally appropriate care is a central issue in the delivery of effective PHA housing, complicated planning solutions should be easily

[33] Breaking New Ground p.47

sidestepped by allowing individual cultures to take their own initiatives. By developing PHA housing projects that are specifically focused on Aboriginal people, most of the multi-cultural dynamics that complicate mainstream PHA housing efforts can be avoided and make every housing program more effective. As well, the creation of a specifically Aboriginal PHA house is integral to the Aboriginal community's vision of a holistic health care program.

There is often a concern among designers and planners that culturally specific AIDS care housing is tantamount to segregation. This concern has in fact been considered by most mainstream AIDS care housing projects in Canada and the United States, and has largely been dismissed on the grounds that PHAs strongly support the idea of forming their own supportive, physically, and culturally appropriate housing facilities for themselves and other PHAs who cannot afford the cost of their own shelter. A much greater concern is that planners will not understand the need to have separate, culturally appropriate, supportive homes for Aboriginal PHAs and that planners and funders will continue to insist upon admitting Aboriginal PHAs to "white" hospices where there are no culturally and spiritually appropriate services, and where Aboriginal PHAs have already experienced a lack of respect for their culture, lifestyle, and traditions.

13.5 What is needed in a specifically Aboriginal PHA house?

Until the early 1990s, the AIDS literature largely ignored the housing needs of PHAs. To this day, there remains a limited amount of literature which can assist in the design and development of a house for people living with HIV/AIDS. Only the following sources appear to offer planning advice, design issues, and include experiences, case studies, and examples of barriers: Leiberman (1993), Berman (1993), Wilms, Hayes, and Hulchanski (1991).

There are no existing models of Aboriginal PHA housing in Canada. The only models of existing culturally appropriate, supportive housing initiatives in Aboriginal communities are Elders homes and disabled housing on reserves. However, these facilities are not well suited as models for Aboriginal HIV/AIDS housing because of the particular symptomology and intermittency of HIV/AIDS.

In short, there are no sources of information on what should be included in the design and development of a specifically Aboriginal PHA house. In the absence of such data, mainstream advice and experiences have to be drawn upon.

Wilms, Hayes, and Hulchanski (1991) have stressed that in creating supportive housing, planners must be guided by a principle of allowing choice, voice, and dignity. This means the location, design, and size of the housing project must embody a range of choice, and involve voice in its planning.

By drawing on information in the existing literature, it may be suggested that an Aboriginal PHA house must be culturally appropriate, safe, hygienic (not damp, drafty), accessible, have rooms with their own environmental controls, be close to doctors or HIV clinic and other HIV services, be able to accommodate guests, be in a place where the PHA feels comfortable and secure, be accessible to elders and families, be affordable, and

have laundry facilities. The house may also contain nursing assistance, meal preparation, cultural activities, recreational activities, information seminars, and child care.

The literature also recommends not trying to be all things in one house. Designers should be reminded that there is a spectrum to housing types and functions that ranges from shelters to hospices. In the middle of this spectrum there is a variety of independent and supported living arrangements. It is recommended that planners map out this spectrum of housing and plan what it is you want to build on that spectrum.

Finally, the authority on what should exist in a house specifically for Aboriginal PHAs should be Aboriginal PHAs themselves. It is recommended that a careful needs assessment be conducted with the potential client group of Aboriginal PHAs. It is their voice that is the most important.

13.6 A Proposed Needs assessment

Survey approaches are needed when no currently existing or appropriate base of information exists. This is the case here. A needs assessment conducted among Aboriginal PHAs will be instrumental in:

1. generating data that can be used to influence or persuade funders about the need for appropriate and supportive housing for Aboriginal people living with HIV/AIDS, and will be able to;
2. assist planners in the design and development of a housing facility that reflects the choices and needs of Aboriginal PHAs.

There are many types of questions which should be included in a needs assessment.

First, a needs assessment should survey the present economic and housing circumstances of Aboriginal PHAs and determine the extent and types of their "needs". To obtain this information, a straight forward set of income, employment, and housing situation questions should be asked.

When asking questions about present housing conditions, it is important to determine whether or not the PHAs present housing situation is affordable, accessible, safe, in good conditions, and suitable for a person living with a compromised immune system. To determined whether or not a home is these things, it is necessary to use government definitions so that the information is relevant to funders.

Finally, it is necessary to survey Aboriginal PHAs on the type and location of the housing they would like, as well as the services they feel should be offered in-house. These questions should allow for Aboriginal voice and expression of choice in the design of a proposed facility. To achieve this end, open-ended questions should be asked, and as well, a list of possible choices and services should be provided for consideration.

An Aboriginal AIDS service organization may also want to survey when people became infected with HIV so as to be able to project the numbers and times of full blown AIDS cases at any one time in their community. This information may enable planners to prepare for times of peak demand.

The execution of a needs assessment among Aboriginal PHAs may also be used as an opportunity to test assumptions that is relevant to your proposals. For example, questions about the method of infection, involvement in the sex trade, mobility between urban centres and reserves, or negative experiences with mainstream health services and housing authorities may also be surveyed.

XIV Conclusions to the literature review

The literature clearly demonstrates that Aboriginal people living on reserves, in Inuit communities, in Métis settlements, and in urban centres experience the worst housing conditions in Canada. This includes overcrowding, poor housing conditions, an absence of pipe or well water, lack of proper sewage treatment, inadequate space, un-affordability, and long housing backlogs.

In terms of AIDS in the Aboriginal community, the literature is strong on identifying attitudes and behaviour which put Aboriginal people at risk of infection. This literature is also clear on the need for culturally specific and appropriate messages and care programs. However, there is an absence of reliable data on number and trends of HIV infection in the Aboriginal community.

PHA housing has been built by mainstream AIDS housing organizations. These projects have provided a limited amount of experience-based published literature on design plans and strategies.

The need for Aboriginal specific housing has been identified in the literature. However, no such housing has been built and there is no literature which can guide policy makers and others developing housing specifically for Aboriginal PHAs.

Statistical information suggests that much of the existing Aboriginal housing stock is inappropriate for Aboriginal people living with HIV/AIDS. As well, housing is becoming less accessible to the Aboriginal population as funding decreases, existing housing deteriorates, the Aboriginal population increases, and economic and employment opportunities for Aboriginal people continue to remain low.

It is noted that due to a currently insufficient supply of housing in Canada, low levels of Aboriginal employment, and rapidly growing rates of AIDS in the Aboriginal community, that Aboriginal PHA housing will become one of the most under-met supportive housing needs of the 1990s.

Currently, there is a limited opportunity for funding for an Aboriginal PHA house from existing federal Aboriginal housing programs. It is hoped that a new Federal Aboriginal housing program that is being submitted to Cabinet this summer (1995) will offer new opportunities.

After reviewing the literature and considering the gaps, it is recommended that Aboriginal AIDS organizations carry out needs assessments to determine the housing needs and choices of Aboriginal PHAs living in their communities. Information specifically from Aboriginal PHAs is critical to the design and development of AIDS care residences reflective of their choices.

It is also recommended that Aboriginal people continue to call for an end to jurisdictional issues that complicate present Aboriginal AIDS programming and AIDS housing initiatives.

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Appendix A

reproduced from Marcel Dubois (1994)

THE ENVIRONMENT

1. How many people live in the community?

2. Is there a clinic/nursing station in your community? If not, how close in kilometres is the nearest clinic/nursing station?

   1. Yes
   2. No (distance _____ km)
   3. Don't know

3. Is there a hospital in your community? If not, how close in kilometres is the nearest hospital?

   1. Yes
   2. No (distance _____ km)
   3. Don't know

4. What type of health and social services are present in your community? Please indicate all of them.

5. Is your community accessible by road or by air?

   1. Road
   2. Air
   3. Train

6. Is transportation available for someone in need of medical services? Please explain what is available.

7. How close is the nearest town and city? Please indicate its name and the distance in kilometres.

8. Do you think there is a garbage disposal problem in this community?

   1. Yes
   2. Uncertain
   3. No

9. Is there a gas storage problem in this community?

   1. Yes
   2. Uncertain
   3. No
   4. Does not apply

10. Are the toilets flushable?

    1. Yes, all are
    2. Yes, most are
    3. Yes, some are
    4. Uncertain
    5. No

11. Is there a sewage system in or near the community?

    1. Yes
    2. Uncertain
    3. No

12. What types of sewage systems are present?

    1. Municipal/Band sewage system
    2. Septic tank and field
    3. Holding tank
    4. A combination of the above (please indicate) _____
    5. Uncertain

13. Do you think there is a sewage problem in the community?

    1. Yes, all the time
    2. Certain times of the year there are problems
    3. At one time, but not now (When) _____
    4. No, never
    5. Don't know

14. Is there a water treatment plant serving the community?

    1. Yes
    2. Uncertain
    3. No

15. Do you think the water is safe to drink?

    1. Yes
    2. Uncertain
    3. No

16. Do you think the rivers and lakes nearby are safe to engage in aquatic activities (ie. fishing, swimming)?

    1. Yes
    2. Uncertain
    3. No

17. Do you think it is safe to eat fish and other aquatic life if the water is polluted?

    1. Yes
    2. Uncertain
    3. No

18. Do you think other forms of life are affected if the water quality is poor?

    1. Yes
    2. Uncertain
    3. No

19. If yes to the above question, please explain.

20. How is water delivered to your house/dwelling?

    1. Via pipe
    2. By truck
    3. By a well
    4. Other (specify): _____
    5. A combination of the above (specify): _____
    6. Don't know

21. Have there been any problems with contaminated water in the last year?

    1. Yes
    2. Uncertain
    3. No

22. If yes to the above question, what type of contamination?

    1. Bacteriological (ie. human waste)
    2. Chemical
    3. Uncertain

23. How many of the houses were involved?

    1. All of them
    2. Some of them
    3. None of them
    4. Does not apply

24. How was the problem resolved?

25. Is bottled water easily available?

    1. Yes
    2. Uncertain
    3. No

26. If yes to the above question, is this water easily affordable?

    1. Yes
    2. Uncertain
    3. No

27. If no to #26, would you like bottled water to be made available?

    1. Yes
    2. Uncertain
    3. No

28. If no, why?

29. Does the place where you live have any of the following problems?

    1. Insulation
    2. Ventilation
    3. Overcrowding
    4. A combination of the above
    5. Uncertain

30. Is there a lot of cigarette smoke in the air where you live?

    1. Yes
    2. No
    3. Uncertain

31. What kind of energy is used where you live?

    1. Wood burning stove
    2. Gas stove
    3. Electric
    4. Other

32. Is there an air conditioner, humidifier or air purifier in the dwelling?

    1. Air conditioner
    2. Humidifier
    3. Air purifier
    4. Combination of the above (_____)
    5. Uncertain

33. Is this equipment properly maintained?

    1. Yes
    2. No
    3. Uncertain

34. If no, please explain.

35. Is there proper ventilation?

    1. Yes
    2. No
    3. Uncertain

36. What is the humidity level in percentage?

37. Is the dwelling regularly inspected?

    1. Yes
    2. No
    3. Uncertain

38. Do animals roam free within the community?

    1. Yes
    2. No
    3. Uncertain

39. If yes to the above question, what kind of animal(s) roam free?

40. Have you ever had problems with contaminated food?

    1. Yes
    2. No
    3. Uncertain

41. If yes, please explain?

42. Have there been any problems with contaminated food in the community?

1. Yes
2. No
3. Uncertain

43. If yes, please explain?

HEALTH RISKS I

44. Do you think any of the above-mentioned problems can have an impact on your health?

1. Yes
2. Uncertain
3. No

45. If yes to the above question, please specify.

46. Do you think spirituality is important to the members of your community?

1. Yes
2. Uncertain
3. No

47. What denominations are present?

1. Catholicism
2. Protestantism
3. Pentecostal
4. Traditional
5. Other

48. Are there areas of spiritual power in the community?

1. Yes
2. Uncertain
3. No
4. Does not apply

49. Do you think that environmental problems such as those indicated above could have an impact on areas of spiritual power?

1. Yes
2. Uncertain
3. No
4. Does not apply

50. Do you think spirituality has an effect on health?

1. Yes
2. Uncertain
3. No

51. Regarding #50, is this effect:

1. Positive
2. Negative
3. Sometimes Positive... Sometimes Negative
4. Uncertain
5. Does not apply

52. Do you think the health of a person with an immune deficiency can be negatively affected by the environment?

1. Yes
2. Uncertain
3. No
4. Does not apply

HEALTH RISKS II

1. Not dangerous at all
2. Not too dangerous
3. Dangerous
4. Very dangerous
5. Uncertain of danger

53. How would you rate the health risks of the following to people in general? Please use the above scale for each question.

In the case of #5 (uncertain of danger), please explain. For each statement circle one response - don't leave any blank):

a)	Drinking the local water	1 2 3 4 5
b)	Drinking tea, coffee or other beverages using the local water	1 2 3 4 5
c)	Fishing in nearby lakes or rivers	1 2 3 4 5
d)	Eating fish from nearby lakes or rivers	1 2 3 4 5
e)	Eating animals caught near the community	1 2 3 4 5
f)	Eating animals caught away from the community	1 2 3 4 5
g)	Eating berries or plants picked near the community	1 2 3 4 5
h)	Eating vegetables grown in the community (skip if does not apply)	1 2 3 4 5
i)	Being in an overcrowded house	1 2 3 4 5

j)	Living near a waste disposal site	1 2 3 4 5
k)	Sewage problems	1 2 3 4 5
l)	Pollution of traditional plant medicines	1 2 3 4 5
m)	Living near Nuclear Power Plants	1 2 3 4 5
n)	Living near High Voltage Power Lines	1 2 3 4 5
o)	Waste burned at the dump	1 2 3 4 5
p)	Nuclear Waste	1 2 3 4 5
q)	AIDS	1 2 3 4 5
r)	Chemical pollution in the environment	1 2 3 4 5
s)	Pesticides in Food	1 2 3 4 5
t)	Depletion of the ozone layer	1 2 3 4 5
u)	Global warming/Greenhouse effect	1 2 3 4 5
v)	Chemicals used to preserve food or colour food to improve its taste	1 2 3 4 5
w)	PCBs or dioxin	1 2 3 4 5
x)	Contaminated food	1 2 3 4 5

HEALTH RISKS III

1. Not dangerous at all
2. Not too dangerous
3. Dangerous
4. Very dangerous
5. Uncertain of dangerous

54. How would you rate the health risks of the following for someone with an immune deficiency? An immune deficiency (such as the one caused by HIV) is a breakdown of the body's ability to fight off illness. Please use the above scale for each question.

In the case of #5 (uncertain of danger), please explain. For each statement circle one response - don't leave any blank):

a)	Drinking the local water	1 2 3 4 5
b)	Drinking tea, coffee or other beverages using the local water	1 2 3 4 5
c)	Fishing in nearby lakes or rivers	1 2 3 4 5
d)	Eating fish from nearby lakes or rivers	1 2 3 4 5
e)	Eating animals caught near the community	1 2 3 4 5
f)	Eating animals caught away from the community	1 2 3 4 5
g)	Eating berries or plants picked near the community	1 2 3 4 5
h)	Eating vegetables grown in the community (skip if does not apply)	1 2 3 4 5
i)	Being in an overcrowded house	1 2 3 4 5

j)	Living near a waste disposal site	1 2 3 4 5
k)	Sewage problems	1 2 3 4 5
l)	Pollution of traditional plant medicines	1 2 3 4 5
m)	Living near Nuclear Power Plants	1 2 3 4 5
n)	Living near High Voltage Power Lines	1 2 3 4 5
o)	Waste burned at the dump	1 2 3 4 5
p)	Nuclear Waste	1 2 3 4 5
q)	AIDS	1 2 3 4 5
r)	Chemical pollution in the environment	1 2 3 4 5
s)	Pesticides in Food	1 2 3 4 5
t)	Depletion of the ozone layer	1 2 3 4 5
u)	Global warming/Greenhouse effect	1 2 3 4 5
v)	Chemicals used to preserve food or colour food to improve its taste	1 2 3 4 5
w)	PCBs or dioxin	1 2 3 4 5
x)	Contaminated food	1 2 3 4 5

DOCUMENTATION

55. Does documentation exist concerning your community's environment (ie. water quality, water treatment, housing)?

    1. Yes
    2. Uncertain
    3. No

56. What other kinds of information would you like available?

57. What kind of changes, if any, would you like to see?

COMMENTS

Please add any further comments or questions here.