

## HIV/AIDS AND INDIGENOUS POPULATIONS IN CANADA AND SUB-SAHARAN AFRICA

### Introduction

In both high-income and low- or middle-income countries, indigenous peoples face some of the heaviest burdens of ill health. In particular, indigenous populations face a higher vulnerability to HIV due to a range of factors including stigmatization, structural racism and discrimination and individual/community disempowerment.

Despite the fact that HIV is highly prevalent in these populations, there is a gap in research and policy to address this epidemic, particularly for sub-Saharan Africa. Few countries have implemented policies or programs which specifically target the spread and impact of HIV in indigenous communities; those countries that do have such programs tend to be in high-income countries rather than in low- and middle-income countries. Integration of these issues into the global HIV agenda is needed to close the gap in reaching indigenous populations.

Using a social determinants of health lens, this factsheet highlights some of the particular issues facing indigenous populations regarding HIV, and provides some lessons learned from both the Canadian and African contexts that may be useful in determining next steps forward.

### Who are indigenous peoples in Canada and sub-Saharan Africa?

Defining indigenous populations is not straightforward; there are multiple indigenous communities in the world that are not easily categorized under one label, and the right of populations to choose their naming is paramount. It is estimated that there are approximately 370 million indigenous people

worldwide, living in 70 countries.<sup>1</sup>

In Canada, approximately 1.2 million people self-identified as Aboriginal in 2008, including First Nations, Métis and Inuit peoples.<sup>2</sup> Each of these distinct sub-groups is recognized as having unique cultural, economic and social characteristics. Geographically, these communities are located all across Canada, including remote, rural and urban areas; some populations live on lands designated for specific First Nations communities, known as reserves.

In sub-Saharan Africa, defining indigenous populations is a more complex task. According to one source, over 14.2 million people living on the continent have self-identified as indigenous.<sup>3</sup> These populations can be categorized into three groups: hunter-gatherers, migratory nomadic pastoralists and groups practicing drylands horticulture.<sup>4</sup> They can be further defined by the following characteristics: political and economic marginalization rooted in the legacy of colonialism; de facto discrimination based on the dominance of agricultural peoples in the State system; the particularities of culture, identity, economy and territoriality that link hunting and herding peoples to their home environments in deserts and forests; and, in some cases, physically distinct characteristics.<sup>5</sup> It should be noted that there is significant debate around these definitions, discussed at some length in the report of the African Commission on Human and Peoples' Rights (ACHPR) Working Group on Indigenous Populations/Communities. According to some views, all Africans can be considered indigenous to the continent, particularly if the frame of comparative reference is to European and other colonizers. However, it is also argued that indigenous peoples have particular features and characteristics – including attachment to land, cultural practices and production modes – that define them separately from other

populations and from dominant economic and social structures.<sup>6</sup> Self-determination, discussed later in this paper, is an important component of this debate.

### HIV and Indigenous Populations

Currently, there is no global health profile on indigenous populations. In Canada, HIV infection rates in Aboriginal populations are higher than amongst the general population; although they represented only 3.8% of the Canadian population in 2006, Aboriginal persons comprised 8.0% of persons living with HIV (including AIDS) in Canada and 12.5% of new HIV infections in Canada in 2008.<sup>7</sup> In sub-Saharan Africa, estimates of HIV infection in 2009 were 1.8 million people; specific rates for indigenous populations are not known.<sup>8</sup>

Generally, obtaining comprehensive and accurate data on HIV infection rates is difficult, particularly in low- or middle-income countries. The data which does exist is not always disaggregated by ethnicity and very few countries have indigenous-specific data at the national level.<sup>9</sup> Additionally, the geographic distribution of indigenous peoples may not necessarily correlate with the physical boundaries of nation states, although in some cases data can be inferred from regional differences in countries where indigenous populations are known to be concentrated in specific areas.<sup>10</sup> The epidemiology of HIV and AIDS can also be very different in different populations both within and across countries.

These gaps in surveillance data present a formidable challenge to developing appropriate health interventions, monitoring programs and other policies tailored to indigenous populations. In some cases, they may even have a negative effect as different methods of data collection can be used to “mask or illuminate health and social inequality for indigenous peoples”.<sup>11</sup>

### Using a Social Determinants of Health Lens to Examine HIV and AIDS Risk

A useful lens to examine HIV risk in indigenous populations is using the concept of social determinants of health. Social determinants of health can be defined as the economic and social conditions that shape the health of individuals, communities and jurisdictions as a whole.<sup>12</sup> This lens is particularly relevant when examining HIV and AIDS, where the social and biomedical contexts are deeply linked. In the words of one researcher, the disease is “complicated by the cultural reality of human behavior...the disease also needs to be understood in regional, historical, and socioeconomic contexts”.<sup>13</sup>

According to the World Health Organization, the general social determinants of health include: (1) income and social status; (2) education; (3) employment/working conditions; (4) social support networks; (5) healthy childhood development; (6) social environment; (7) physical environment; (8) personal health practices and coping skills; (9) health services; (10) gender; and (11) culture.

Although a useful starting point, the aforementioned determinants do not encompass traditional indigenous concepts of health, which are holistic and incorporate mental, physical, spiritual, emotional and social aspects as well as biomedical aspects. Furthermore, the health and well-being of communities are intertwined with, and equally important as, the health of individuals. With this understanding, the Canadian-based National Aboriginal Health Organization developed a set of eight additional social determinants of health specific to indigenous populations.<sup>14</sup> While these broader social determinants of health were developed for the Canadian context, they can also be used to examine issues facing indigenous populations worldwide. Each of these factors is discussed in more detail below, with examples and issues highlighted for both Canada and sub-Saharan Africa as appropriate.

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### 1. Colonization

The colonization of people and lands is an issue which affects the health of indigenous populations across the globe. (Note that in this context, the term “colonization” does not refer exclusively to the European colonization of the African continent but rather to the general oppression of indigenous peoples by colonizing peoples.) One reason that many illnesses, including HIV, disproportionately impact indigenous peoples is due to systemic colonial and racist structures. The effects of colonization are numerous: breakage of a connection to land, family and community; environmental degradation of traditional lands; suppression of cultural and linguistic rights; institutional racism; development aggression; forced displacement; and economic exploitation.<sup>15</sup>

In Canada, the legacy of the residential school system in particular has had a profound impact. In the nineteenth century, the Canadian government established a “residential” school system for Aboriginal peoples, intended to teach English, Christianity and Canadian customs. A policy known as “aggressive assimilation” was used to educate youth, with mandatory attendance. It is now recognized that this system has had far-reaching negative impacts on Aboriginal peoples which has been handed down through generations. Many health issues including addictions, poverty and mental health issues can be traced back to the residential school legacy. This example is particular to Canada, with similar programs implemented in New Zealand and Australia, but there may be lessons learned here that link to the colonial legacy in Africa and the far-reaching impacts of colonization even today.

### 2. Globalization

In an increasingly interconnected world, it is impossible for any population to escape the effects of

globalization. But despite the increased integration of peoples, markets and resources, UN desk reports have identified marginalization, discrimination and exclusion of indigenous peoples as a persistent social issue.<sup>16</sup>

A number of factors linked to globalization affect the health of indigenous populations. Environmental degradation, changing migration patterns and newly developed trade and transportation routes all have an indirect impact on health outcomes. Integrated global health epidemics and international health reform have also directly affected indigenous populations. In particular, as the gap between the global North and global South widens, attention to the global HIV epidemic has shifted. Resources – both financial and otherwise – and international attention are limited; funding for HIV and AIDS as a whole has plateaued in recent years, making targeted funding for specific sub-populations even more challenging to access. International bodies and documents such as the UN Declaration on the Rights of Indigenous Peoples help to address some of these issues and ensure that they are tackled on the global level.

### 3. Migration

Many indigenous communities are concentrated in remote or rural areas. In some instances in Canada, this has led to higher HIV prevalence rates in these areas. In other instances, geographic or social isolation of these communities has offered a moderate level of protection from risk factors and exposure to HIV. For example, informal 2002 data on the HIV infection rate for the San people in the Ghanzi area of Botswana was lower at 21.4% than the national rate of 35.4%, implying that the geographical isolation of this community may have provided protection from higher rates of infection.<sup>17</sup> And in Namibia, HIV rates are extremely high overall but particularly low among the Ju/'hoansi people, with some conjecture that this might be due in part to high levels of gender equality,

as well as factors of isolation.<sup>18</sup>

However, this is changing as rural-urban migration and other shifting mobility patterns become increasingly common. As indigenous communities become more integrated with mainstream society, individuals are at greater risk because they may lack basic knowledge about HIV or other health issues, may face language barriers and may have preconceived notions about illness which make treatment via ARVs or other medications challenging. Migration may also mean that many individuals or families become disconnected from family or social support networks, leading to increased risk factors for HIV, including drug use or unprotected sex. Furthermore, movement away from traditional lands makes indigenous populations more vulnerable to racism, discrimination and abuse; women in particular may face sexual violence or may be engaged in sex work, all of which are social risk factors for HIV. There is some evidence of increased HIV exposure for indigenous populations due to resettlement camps and work camps for resource extraction activities – women in particular can be vulnerable in remote and sometimes insecure environments, and in locations along highways and other transportation routes.<sup>19</sup>

#### **4. Cultural Continuity**

Cultural continuity refers to the “intergenerational connectedness of individuals, families and communities”.<sup>20</sup> This connectedness ensures that cultural knowledge, values and practices are shared over time and amongst people. However, in many cases in Canada and in sub-Saharan Africa, cultural continuity has been broken as communities have been forced to assimilate into mainstream cultures. And in many countries, such as Uganda, Rwanda and Burundi, indigenous status is not recognized by the government, thereby undermining the sense of cultural belonging.<sup>21</sup> Embedded in the concept of cultural continuity is the

importance of recognizing cultural beliefs, and how these beliefs may affect decision-making processes, particularly around sexual practices. For example, belief systems around fertility, death or causes of HIV may affect choices on condom use or decisions to seek medical care via traditional or Western medicine. This challenge highlights the importance of finding an appropriate balance between traditional and biomedical approaches to prevention and treatment.

#### **5. Access to Health Care**

Access to health care by indigenous populations can be compromised by a number of factors. Many indigenous populations live in rural or remote areas and this geographical distance, sometimes compounded with seasonal isolation, can limit their ability to reach health care services. In Canada, within fly-in or isolated communities, women must sometimes fly over a thousand kilometers to reach a hospital in order to give birth, have a tooth extracted or treat an illness. Many have never left their communities before and there is a reluctance to do so in many cases. Even when affordable services do exist in indigenous communities, some studies have shown that they are of lower quality than services available for non-indigenous populations.<sup>22</sup> In Canada, health care priorities set by the government may not match the priorities that would otherwise be set by indigenous communities; however, some progress has been made on this front as many communities have moved to managing and administering their own health care systems.<sup>23</sup>

The role of traditional or indigenous medicine in addressing both the prevention and treatment of HIV is of special consideration. Many health care clinics or health care practitioners may not have a thorough understanding of indigenous health practices; moreover, the reliance on Western medicine and interventions may lead to health care services which

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are unsuitable or even offensive to indigenous patients. Services and resources may not be available in the appropriate languages, and in some cases, discrimination or stigmatization may also act as a deterrent to individuals seeking health services.

However, useful alternative models do exist. For example, the Keur Massar Leprosy Treatment Center in Senegal has successfully used traditional therapies to treat different illnesses, including HIV and AIDS. The treatments used are non-toxic, address secondary infections such as tuberculosis and are based on natural components which do not require financial or scientific support from high-income countries in order to work. Treatments such as these can act not only as an effective complement to biomedical treatment but may also be more culturally appropriate than some Western approaches.<sup>24</sup> Other options are systems which balance indigenous and mainstream healthcare systems. While there are some challenges with such intercultural systems, there is evidence that integrating traditional healers into HIV prevention programs can “significantly improve the[ir] effectiveness”.<sup>25</sup>

### 6. Territory

For many indigenous communities, relationships with the land and the environment are a critical component of self identification. Impacts on physical territory by factors such as migration, globalization and climate change therefore have a profound effect on lifestyles and health outcomes.

Land rights in particular are described by the ACHPR as “fundamental for the survival of indigenous communities”. In Canada, land rights are an issue of ongoing debate, with some lands specifically designated for First Nation populations. In Africa, land rights are an issue facing many indigenous populations including populations in the Niger Delta of Nigeria; the Batwa populations in Rwanda who have been

dispossessed of ancestral lands and the Batwa people who have been displaced in Uganda due to the creation of national parks and conservation zones; and various peoples in Tanzania who have been displaced due to the expansion of agricultural lands as well as the creation of national parks.<sup>26</sup> In addition, one report finds that the majority of armed conflicts across the globe are being fought on territories of indigenous peoples, such as in the Democratic Republic of Congo.<sup>27</sup>

This displacement does not simply mean the loss of land; there is a strong link between this type of territorial displacement and poor health.<sup>28</sup> For example, as the pygmy populations of central Africa have been forced to move away from their traditional way of life and join the formal economy due to the encroachment on their land by logging and farming, they have also faced increased risk of sexual exploitation and HIV and AIDS. Climate change and environmental degradation can also affect the lifestyles of many indigenous peoples, particularly those who have hunter/gatherer lifestyles. As these populations migrate and mix with non-indigenous populations, additional culturally-appropriate HIV sensitization will be needed.<sup>29</sup>

### 7. Poverty

For indigenous populations worldwide, poverty is widespread. The relationship between poverty and risk of HIV infection is well recognized and documented; those living in poverty are far less likely to have access to education and health care, be food insecure and have limited means for income generation. Studies have also shown that HIV-positive status can further exacerbate poverty, thus creating a vicious cycle which has further negative impacts on health.<sup>30</sup>

In Canada, the average annual income of Aboriginal peoples is much lower than the non-Aboriginal

population; according to the 2006 census, the average male income was 62% of the income of a non-Aboriginal male, while the average female income was 75% of a non-Aboriginal female.<sup>31</sup> In Africa, extreme poverty has been one of, if not the, largest contributing factor to the HIV epidemic. For example, in Uganda, the poorest households are more likely to be HIV positive than wealthier households.<sup>32</sup> In Uganda, Tanzania and Rwanda, the indigenous populations are among the poorest and most marginalized.<sup>33</sup> Just as importantly, the “absence of hope” and depleted emotional resources which are often associated with poverty may leave people without the resources needed to protect themselves and others from HIV infection. HIV interventions will, of necessity, have to address poverty as well.

### **8. Self-Determination**

Self-determination can be defined as a “conscious and deliberate objective by indigenous peoples to assert their right to be the driving force in policy processes and in the design and delivery of HIV/AIDS services”.<sup>34</sup> This need for meaningful engagement by indigenous populations is not limited to the design, delivery and evaluation of health care systems but it also extends to policy formulation, the development of international agendas, engagement in political processes and beyond. At the 2007 International Symposium on the Social Determinants of Indigenous Health, it was recognized that Indigenous populations’ right to self-determination, including the standards outlined in the UN Declaration of the Rights of Indigenous Peoples, was a key factor for reversing colonization.<sup>35</sup>

However, in many cases, self-determination for indigenous peoples does not occur, and this marginalization through the denial of rights can be extremely harmful. The lack of political and social power held by indigenous populations has been identified by UNAIDS as a key risk factor which leaves

indigenous communities “acutely vulnerable to HIV” with this vulnerability being “insufficiently recognized in international responses”.<sup>36</sup> Furthermore, self-determination can help to develop a number of protective factors at the individual, family, community and system level that provide strength and resiliency. When these factors – such as positive self-concepts, social inclusion and cultural continuity – are not compromised, they help to inform healthy self images and decision making.<sup>37</sup>

Alongside self-determination, recognition of indigenous peoples by government and non-indigenous populations remains important. In Canada, various formal processes exist to recognize the legal status of indigenous peoples. In African countries, legal recognition and protection for indigenous people is highly uncommon, contributing to a lack of legal and social power. The Republic of Congo was actually the first African country to recognize indigenous peoples in January 2011, developing a law aimed to counter the chronic marginalization of indigenous populations.<sup>38</sup> In other instances, the challenges range from indifference to outright discrimination; for example, in Kenya, it was once illegal for indigenous populations to hold meetings or to discuss issues faced by indigenous communities<sup>39</sup> and in Rwanda, the government has banned the use of the term indigenous and any promotion of ethnic identity.<sup>40</sup> Comprehensive self-determination remains one of the most important factors to improving health outcomes of indigenous populations.

## Conclusion

In both Canada and sub-Saharan Africa, social determinants of health can be used as an appropriate lens to examine some of the underlying reasons for health disparities and the particular vulnerabilities of indigenous communities to HIV. Addressing the epidemic in these communities will require targeted



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and effective programming as well as a consideration of the underlying health determinants to ensure long lasting and meaningful interventions.

At the 2009 5<sup>th</sup> International Policy Dialogue in Canada (jointly hosted by UNAIDS, PHAC and Health Canada), indigenous peoples and HIV was a priority topic for discussion. The final report from the dialogue argued that the relationship between HIV and indigenous peoples has not received sufficient international attention, and calls for the identification of indigenous peoples as a priority group when addressing the epidemic.<sup>41</sup> Strategies for doing so include the development of national strategies and increased collaboration with representatives from indigenous communities. These strategies and an awareness of some of the issues highlighted in this fact sheet will help to ensure meaningful interventions to address the HIV epidemic.

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### Additional Resources

Aboriginal Affairs and Northern Development Canada:  
<http://www.ainc-inac.gc.ca/index-eng.asp>

Canadian Aboriginal AIDS Network:  
<http://www.caan.ca>

Center for World Indigenous Studies:  
<http://cwis.org/>

Cultural Survival:  
<http://www.culturalsurvival.org/>

Indigenous Peoples of Africa Co-ordinating Committee:  
<http://www.ipaac.org.za>

National Aboriginal Health Organization:  
<http://www.naho.ca>

Public Health Agency of Canada:  
<http://www.phac-acsp.ca>

UN Permanent Forum on Indigenous Issues:  
<http://www.un.org/esa/socdev/unpfii>

UNAIDS:  
<http://www.unaids.org/en/>