SEXUAL VIOLENCE AND DISLOCATION AS SOCIAL RISK FACTORS INVOLVED IN THE ACQUISITION OF HIV AMONG WOMEN IN MANITOBA

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Project #25

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The Prairie Women's Health Centre of Excellence (PWHCE) is one of five Centres of Excellence for Women's Health, funded by the Women's Health Bureau of Health Canada. The PWHCE supports new knowledge and research on women's health issues; and provides policy advice, analysis and information to governments, health organizations and non-governmental organizations. The views expressed herein do not necessarily represent the official policy of the PWHCE or Health Canada.

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Sexual Violence and Dislocation as Social Risk Factors Involved in the Acquisition of HIV Among Manitoba Women

EXECUTIVE SUMMARY

The incidence of HIV infection among women is growing steadily, particularly within the Aboriginal community. Although Aboriginal persons comprise only 2.8% of the general population, they accounted for 5.5% of all prevalent infections and 8.8% of all new infections in Canada in 1999. However, few studies directly address the needs of Aboriginal women in Canada.

This project provides a more comprehensive understanding of social factors and environment on HIV risk behaviours among Manitoba women. Research is needed to develop a better understanding of why Aboriginal women migrate to urban centres, how and whether they connect with services upon arrival and how these patterns are influenced by victimization, substance abuse and reliance on income from the sex trade. It is within this context that the authors focused on the experience of violence, economic hardship and relocation/dislocation as they relate to HIV risk.

The specific objectives of this study were:

1. To describe a group of women who are HIV positive in Winnipeg with respect to age, source of income, education, risk behaviours for HIV infection, ethnicity, and residence;

2. To describe any past experience of violence or threat of violence in the home and community of HIV positive women in Winnipeg, and how this contributes to negotiating abilities; and

3. To describe the economic circumstances of HIV positive women in Manitoba and these circumstances contribute to behaviours associated with the acquisition of HIV; and

4. To describe the role of relocation/dislocation of Aboriginal women in the acquisition and transmission of HIV.

Methodology

The project began by inviting a group of 17 representatives from Winnipeg community service organizations that provide HIV/AIDS services to women attended a meeting to share their views on possible research initiatives and research questions which focus on

HIV positive women (See Appendix "A"). The group indicated a strong need for research that involved the participation of HIV positive women themselves from the outset.

A focus group was held with the assistance of Kali-Shiva AIDS Services, which sponsors an HIV positive women's support group in Winnipeg. The participants confirmed the need for further understanding of issues of violence, alienation and isolation of women and the role these social factors play in acquiring HIV. An Aboriginal woman who is HIV positive volunteered to review and provide advice on possible research questions for the study as part of the research team, provided feedback on the conceptual framework, recruitment posters and interview questionnaires. Service organizations that provide community outreach services for men and women living with HIV and the two hospitals who work with HIV positive women posted the research advertisement.

Twenty women agreed to participate in the study. In-depth open-ended individual interviews were conducted at a place chosen by the study participant. The interviews were transcribed and were coded by the research team. Themes recognized by individual team members and as a group emerged from the women's stories. This information was shared with the research participants in a focus group. The purpose of the focus group was to present and clarify emerging themes and to gather information from the group regarding prevention strategies based on the findings.

Social Risk Factors Involved in the Acquisition of HIV in Manitoba Women

The women who participated in the study shared information about their own history and experiences;

- A majority of participants self-identified as being of Aboriginal ancestry with the mean grade of **education** level attained by the participants was grade 9 with a range of grade 5-12.

- A small number of the participants reported that they acquired the virus from **unprotected sex** with a past partner, with the majority reporting that they likely became HIV positive through **IV drug use.**

- All the participants at the time of the interviews reported receiving **Social Assistance**. Most reported an ability to provide themselves with the basic necessities of life, but were limited in terms of being able to obtain **adequate housing** in Winnipeg.

- The majority of the women in this study reported past involvement in **prostitution**. All the women reported having the ability to insist on the use of a condom if they wanted.

- All the women indicated feelings of isolation and of being **unsafe as children**, in their home environment. Reasons for these feelings included sexual abuse, domestic violence, neglect, and emotional abuse. The reported age at which the abuse began ranged from five to twelve years.

- Most of the women reported at least one incident of being **sexually assaulted** as adults, these events involved past partners, clients and by men known to them on the streets.

- Of those who reported **childhood sexual abuse** in the interviews, half reported they did not talk about these events as they were occurring. The women cited a number of reasons, for example, a fear of reprisals from the perpetrator, feelings of shame, guilt and the inability to realize that talking about the events was a course of action open to them.

- The majority of participants were young **runaways** either from foster homes or from their families or origin; the main reason cited was to escape sexual abuse.

- As youths, most of the study group participants left home and were involved in foster care, as parents themselves; they have had **CFS involvement** in apprehension and custody of their children.

- Almost half the participants have been in correctional institutions either as children or as adults, a few citing theft as the reason for their **incarceration** and others indicating involvement in violent crimes.

- A majority of the women were from outside an urban center. The mean **number of moves** was three the main reason for moving was to escape abusive relationships.

- Most of the women reported past habitual use of drugs at some point in their lives, the main drug of choice being heroine and cocaine. The majority associated the use of IV drugs as a **coping mechanism** with past and present emotional issues surrounding their abuse.

- After becoming aware that they were HIV positive, a few women found support from spiritual beliefs/ religious institutions, more than half reported **support from social programs** offered in the community.

- Suppression of **memories**, suicide attempts, self harm and substance abuse was identified as a common coping mechanism for past emotional, physical and sexual abuse.

Discussion

Policy at present has focused on prevention through public advertising campaigns and the use of condoms in safe sex practices, and by and large has not addressed the social forces behind engaging in HIV risk behaviours. Women's lower economic status in society leaves them vulnerable to HIV. The lack of education and limited skills was the driving force behind entering the sex trade and eventually engaging in the use of HIV drugs.

The establishment of the Aboriginal AIDS Task Force and programs such as Kali-Shiva's Women's Support Group begin to recognize the need for a multi-pronged approach to AIDS prevention. However, resources are required in order to develop and implement strategies that go further in addressing the complex situation for women.

A concerted effort to include HIV positive women in the design, implementation and communication strategies in a meaningful way is paramount. Utilizing the experience and knowledge of HIV positive women themselves in new and beneficial ways will go a long way in developing appropriate action plans. Strategists must recognize the role women play in Aboriginal communities and begin to address the violence women are experiencing as well as the devastating impact of isolation.

Injection drug use and the rate of diagnosed mental health issues among the women requires further exploration, in particular, the influence this may have on coping strategies of the women and the impact this may have on prevention strategies in the future. In conclusion, it appears that there are a number of complex social factors that are unique to women, which influence engagement in HIV risk behaviour. The striking similarity of these women's stories underscores the importance of childhood isolation and lack of support networks. Childhood abuse often results in the act of running away, the interruption of education, and eventual entry into prostitution and IV drug use. The recommendations will require support from government health departments, but also require partnership building with AIDS service organizations, band councils, community members, educational institutions and child welfare agencies.

Policy Recommendations

1. That Health Canada and Manitoba Health and Manitoba Family Services in partnership with First Nations communities provide resources to develop and implement early intervention strategies which address childhood isolation and work to create support networks. In particular, these strategies should work towards reducing family violence and providing education in schools regarding childhood sexual abuse. The strategies must focus on prevention by developing educational tools for those who work with children at risk of violence in rural and First Nations communities.

2. Parenting must be highlighted as a family and community responsibility if social risk factors such as poverty and violence are to be eliminated. Training and resources must be allocated to the development of culturally appropriate parenting models. While the majority of the women in this study are single mothers living in marginalized low-income sectors of urban centres, rural poverty also affects women's ability to raise their families.

3. Appropriate agencies develop youth activities and programs that teach and foster healthy coping strategies, with particular attention and resources for First Nation communities. These strategies must include mechanisms that increase children and youths' ability to complete school and provide options for continuing education. These approaches must be culturally appropriate, making use of the expertise and knowledge of other members of the community.

4. With limited education and options, run-away teenagers are vulnerable to entrance into the sex trade lifestyle. They need to be able to access appropriate education and training to develop employable skills. Groups and agencies which provide assistance for women and girls experiencing violence need sufficient funding and resources for the critical areas of housing, health, education and employment training. The allocation of resources to provide transition housing, affordable secondary housing, "safe houses", support groups and drop-in centres must be made available to facilitate women and girl's integration into the urban milieu.

5. Current AIDS services workers, and those working with women at risk for the acquisition of HIV, should be educated on the social risk factors for Manitoban women and how these factors influence the women's risk-taking behaviour. Develop and implement flexible and relevant training and education programs for women in Manitoba that include an understanding of the social factors that influence their lives. Increase HIV positive women's capacity and opportunities to educate young girls about the social risk factors based on their own experiences.

6. Provide stable and sustained resources to current AIDS service organizations to develop and implement women-centred and culturally appropriate outreach programs that address the socio-economic needs of HIV positive women. In particular, support women's transition from rural to urban communities through mechanisms that facilitate women's employability and entrance into the legal workforce.

I. INTRODUCTION

The incidence of HIV infection among women in Canada is growing steadily, particularly within the Aboriginal community[1]. In Canada, at the end of 1999, there were an estimated 6,800 women living with HIV infection (including those living with AIDS), an increase of 48% from the 1996 estimate of 4,600.[2] Manitoba Health reports that between 1985 and June 2001, 146 women have tested HIV positive in Manitoba,[3] 120 of whom reside in Winnipeg.[4] For women, the common modes of transmission involved heterosexual contact and injection drug use (IDU).[5] The proportion of Aboriginal women with reported AIDS attributed to IDU has dramatically increased over time, from 2% prior to 1991, to 15% during 1991-1995 and 34% during 1996-2000.

Research has begun to focus on HIV infection in Canadian Aboriginal populations.[6] However, few studies directly address the needs of Aboriginal women.[7] Available statistics indicate that, although Aboriginal persons comprise only 2.8% of the general population, they accounted for 5.5% of all prevalent infections and 8.8% of all new infections in Canada in 1999.[8] Manitoba Health reports that 29% of newly identified cases from January to June 2001were self-reported as Aboriginal while 25% self-reported as Caucasian. These numbers increase to 42% and 37% respectively when cases with unknown or missing ethnicity are included.[9]

Tseng[10] and Blanchard & Associates[11] suggest the significant movement of Aboriginal people between reservations and large metropolitan centers potentially facilitates the spread of HIV from urban centers of high incidence to more isolated communities. A better understanding of Aboriginal women's relocation patterns is needed.[12] In particular, research needs to develop a better understanding of why Aboriginal women migrate to urban centers, how and whether they connect with services upon arrival, and how these patterns are influenced by victimization, substance use and reliance on income from the sex trade.[13] There are virtually no data describing the social forces behind relocation and dislocation among Canadian Aboriginal women.

The literature suggests that a clear relationship exists between violence, engagement in risk behaviours and HIV exposure.[14] It is important to document the experiences of historical sexual assault and its impact on women's understanding of self-protective and risk reduction behaviours.[15] Gillis suggests that "[r]esearch needs to pay greater attention to the violence which women experience in steady relationships and how this violence contributes to women's vulnerability to HIV infection. Research must continue to document the interrelationship of social structures and women's vulnerability to violence and HIV."[16]

In the past, prevention strategies and research on HIV have focused primarily on men rather than women. Early in the AIDS epidemic, the rate of women testing positive was relatively low compared to men. However, the incidence of women testing positive has increased steadily over the years. Correction of the gender gap in HIV prevention research is required in order to understand the barriers to individual risk reduction, and to plan for prevention strategies, program and policy development among women as well as men.

The history of colonization, oppression, and the residual impact of the residential school system are integral to the reality of Aboriginal women in society today, and must be considered within the historical and current context of many Aboriginal persons. Substance use, poverty and other social factors that place Aboriginal women at high risk to become HIV infected can all be traced back to those historical issues. The significant influence of these factors is recognized by the research team and was considered when developing the research tools and in analyzing the data. However, the 'historical' issues are not only significant but also monumental, requiring a larger examination beyond this particular study.

This project is intended to provide a more comprehensive understanding of social factors and environment on HIV risk behaviours among Manitoba women. It is within this

context that the authors* focused on the experience of violence, economic hardship and relocation/dislocation as they relate to HIV risk.

The specific objectives of this study were;

1. To describe the group of women who are HIV positive in Winnipeg with respect to age, source of income, education, risk behaviours for HIV infection, ethnicity, and residence;
2. To describe any past experience of violence or threat of violence in the home and community of HIV positive women in Winnipeg, and how this contributes to negotiating abilities;
3. To describe the economic circumstances of HIV positive women in Manitoba and how those circumstances contributes to behaviours associated with the acquisition of HIV; and
4. To describe the role of relocation/dislocation of Aboriginal women in the acquisition and transmission of HIV.

II. METHODOLOGY

A literature search using Medline and the internet utilizing keywords "women" "HIV" and "AIDS" along with local pertinent studies were used to familiarize the researchers with the work in this area and to identify the gaps in knowledge.

To explore the social factors which might be involved in becoming HIV positive, a qualitative approach was utilized for this study. This approach provided the opportunity for study participants to contribute to the direction of the research, and allow exploration into the areas which women find most relevant to themselves.

* Dr. Iris McKeown is a family physician practicing in remote First Nations Communities for the J.A. Hildes Northern Medical Unit, Sharon Reid BSW, is on contract as a policy analyst for the Social Planning Council of Winnipeg, Dr. Pam Orr is an infectious disease specialist at the Health Sciences Centre in Winnipeg, providing services to HIV positive patients.

A community meeting (see Appendix A) was held to discuss potential areas of inquiry. A group of seventeen representatives from Winnipeg community service organizations that provide HIV/AIDS services to women attended the meeting. The group indicated a strong need for research that involved the participation of HIV positive women themselves from the outset.

Information from this meeting was then presented to a focus group of HIV positive women. A focus group was held with the assistance of Kali-Shiva AIDS Services, who sponsor an HIV positive women's support group in Winnipeg. The participants confirmed the need for further understanding of issues of violence, alienation and isolation of women and the role these social factors play in acquiring HIV. The group also highlighted the difficulties many women face when separation from their family of origin occurs at a young age for women with limited support following this event.

An Aboriginal woman who is HIV positive volunteered to review and provide advice on possible research questions for the study as part of the research team. She also agreed to provide feedback on a conceptual framework, recruitment posters and interview questionnaires.

The researchers anticipated that the community of women who would participate would include HIV+ women living in Winnipeg, and possibly HIV+ women residing outside of Winnipeg who travel to the city for care, or for other reasons. The study relied on a sampling of self-identified HIV positive women recruited throughout various clinics in the city.

The target population for this research is women living with HIV/AIDS residing in Manitoba. In our experience to date, Aboriginal women make up a significant number of this population. As such, it was anticipated a high percentage of the respondents would also be Aboriginal, however the project was geared towards **all** women who are HIV+.

Research questions and interview questionnaires were developed with involvement from the research team and input from the original focus group participants. Approval of

research tools, i.e. posters, consent forms, interview questions, was obtained from the University of Manitoba Health Research Ethics Board.

Multiple referral sites were involved in participant recruitment. Service organizations such as Kali-Shiva AIDS services, Klinic Community Health Centre and Nine Circles Community Health Centre, agreed to post the research advertisement and to support recruitment by directing HIV positive women's attention to the study. All three sites are centrally located in Winnipeg and provide services to HIV positive women. Kali-Shiva AIDS services is a community-based volunteer agency that provides community outreach and provides services such as home hospice services and support groups to both men and women who are HIV positive or living with AIDS in Winnipeg. Nine Circles Community Health Centre is an umbrella organization housing various agencies offering AIDS related services, Gay & Lesbian Health services and Aboriginal-specific programming, within one building in central Winnipeg. Two major hospitals in Winnipeg, the Health Sciences Centre and the St. Boniface General Hospital, hold regular clinics for HIV positive individuals. Both hospitals agreed to provide information about the study to their HIV positive female patients.

Twenty women contacted the study organizers and agreed to participate in the study. In-depth open-ended individual interviews were conducted at a place chosen by the study participant. Consent forms were read and signed, and verbal consent was obtained for taping of the interviews. A sum of $20.00 was offered to the participants as compensation for their time. Interviews occurred over a 7-month period, from December 2000 to August 2001. The individual interviews lasted approximately two hours each. Anonymity of the participants was maintained by use of unique study code.

The interviews were transcribed and were coded by the research team. Themes recognized by individual team members and as a group emerged from the women's stories. This information was shared with the research participants in a focus group. The purpose of the focus group was to present and clarify emerging themes and to gather information from the group regarding prevention strategies surrounding HIV exposure with respect to the findings.

III. RESULTS

A. DEMOGRAPHIC INFORMATION

Age

The mean age of the participants was 36.5 years, with a range of 22-48 years of age at the time of the interviews. Almost all of the participants resided in the core area of Winnipeg. Half of the participants identified as being single and half of the participants reported living in common law relationships with male partners.

Ethnicity and Education Levels

A majority of the participants self identified as being of Aboriginal ancestry. The mean grade of education level attained by the participants was grade nine, with a range of grade 5 - 12.

Table 1. Demographic Characteristics of Study Participants

		Number of Women
Mean Age (range)		36.5 (22-48) yrs
Birthplace	***Rural Manitoba***	16
	Rural Alberta	2
	Winnipeg	2
Mean School Grade Attained (Range)		8 (5-12)
Self reported ethnicity		
	Aboriginal	18
	Caucasian	1
	Other	1
Intimate relationship status		
	Single	10
	Living with partner	10
Current residence in core area of Winnipeg		20

Mode of Disease Transmission

A small number of the participants reported that they acquired the HIV virus from unprotected sex with a past partner, with a majority reporting that they likely became HIV positive through IV drug use. A majority of the participants indicated they had no knowledge or understanding of HIV before contracting the virus. Some of the women had heard of the word "AIDS" prior to testing positive, but did not know what it was. All of the participants at present have some knowledge of the virus, commonly obtained from their primary health care provider, and various AIDS service organizations (ASO).

Income Sources

All participants at the time of the interviews reported receiving Social Assistance with a mean monthly income of $1079.00. Most reported an ability to provide themselves with the basic necessities of life, but were limited in terms of being able to obtain adequate housing in Winnipeg. Almost half of the women reported involvement in legal employment at some time during adulthood. Almost all of these jobs were low paying, entry level positions which they maintained for short periods.

Table 2. Income Sources

Income Source		*Number of Women*
Present	***Social Assistance/Disability***	20
Past	***Prostitution***	13
	Social Assistance	20
	Theft	16
	Drug Dealing	2
	Casual employment	12

Prostitution

A majority of women in this study reported past involvement in prostitution. One woman reported she continues to be involved in prostitution at the time of the interview. All of the women reported having the ability and power to insist on the use of a condom if they wanted. However, only one participant reported always using a condom with clientele. The remaining women used condoms during work on an irregular basis depending on the situation.

After running away at about age twelve, one woman explained how she first began to work on the streets,

> ***"I was broke all the time, I never had any money for food or cigarettes or anything and it came to a point where I would hitchhike to get drugs and somebody would say I'll give you so much money if you do this for me, and I did it. I walked away crying the first time ... when you're that young and you have somebody do that to you it's like they have taken advantage of you. You see that later on in life but you don't realize what's going on at the time ... but that doesn't take away the hurt or the pain or the feeling that you've been used, manipulated."***
>
> **Study Participant**

B. VIOLENCE IN CHILDHOOD

Sexual Abuse

All the women indicated feelings of isolation and of being unsafe as children, in their home environment. Reasons for these feelings included sexual abuse, domestic violence, neglect and emotional abuse. A majority of the women experienced sexual violence as children, mainly from male family members. Two reported being assaulted at residential school by members of the clergy. The reported age at which the abuse began ranged from five to twelve years.

In describing abuse experienced at a residential school, one woman explained;

> ***"I used to hear things at night, like the children being bothered ... makes me scared it would be me ... eventually it was me too."***
>
> **Study Participant**

When asked how old one participant was at the time of her experience with sexual abuse, the response was;

> ***"Ah geez, I can't remember because I was so little, but I remember I was so little that I couldn't even reach the sink to wash the dishes."***
>
> **Study participant**

In discussing her current feelings surrounding childhood sexual abuse, one woman stated that;

> ***"At some point in time in your life you have to learn how to forgive and forget in order to go on ...I've found it in my heart to forgive them but I will never forget... you can forgive inside, but somewhere in the depth of your body, your soul, your mind you never forget ... that intimidation of running down the hall and slamming my door, pushing the dresser up against it, sitting there panting ... wondering if he's still on the other side of the door, you'll never forget that"***
>
> **Study Participant**

Physical & Emotional Abuse

Many of the participants reported physical violence inflicted on them in childhood, by family members. These acts included hitting, slapping, kicking, punching and the use of objects in the assaults. These assaults were usually perpetrated by the adult female caregiver, i.e. mother or aunt.

C. VIOLENCE AS ADULTS

Sexual Abuse

Most of the women reported at least one incident of being sexually assaulted as adults. These events involved past partners, clients and by men unknown to them on the streets.

One woman described an assault that occurred while she was an adult;

> ***"When I was raped I remember me getting in a car and this guy was very, very nice ... he said 'I'll give you forty dollars for a blow job' so I did. Then after that he just grabbed my hair, swung my head on the dashboard ... knocked me out and from there he stuck out a knife ... and I remember his straight words, 'if you do just what I tell you to do I promise I'll take you home', and he did too.***
>
> **Study Participant**

Physical & Emotional Abuse

As adults, a majority of the participants were involved in violent incidents, either on the streets or from partners. These incidents included kicking, slapping, choking, stabbing and being forcibly confined. Most of the study group had witnessed violence in their homes or on the streets including stabbings, shootings and physical assaults.

In describing a violent event involving one participant's boyfriend she explained;

> ***"He took me into the bedroom and he started hitting me ... he was punching, like trying to get my face ... then he broke my finger and my whole face was like swollen on one side and I had bruises all over my back."***
>
> **Study Participant**

Another woman described one of many events of partner violence that she experienced;

> ***"He broke my arm one time trying to throw me off the balcony. He didn't let me go to the hospital for two days."***
>
> **Study Participant**

A majority of the women reported controlling behaviours on the part of their present or former partners. This behaviour included attempts to control the participants' ability to travel at will; the use of the phone, the ability to talk freely with friends or family and restriction of the type of clothing the women could wear.

One woman described controlling behaviour of her partner;

> ***"I couldn't answer the phone, I couldn't answer the door, and I had no clothes. What clothes I did have he made sure that I didn't have any nice clothes, everything that I did have nice he cut or ripped up... it seemed like no one wanted to help me and I had nobody, nowhere to go."***
>
> **Study Participant**

> ***"I couldn't wear certain things ... I couldn't go out ... so I had to go to jail to get away from him"***
>
> **Study Participant**

Many of the women described witnessing violence, often on the street as well as in the home. One woman described some of the violence she witnessed;

> ***"I saw my friend get his head shot off in a parking lot over a drug deal."***
>
> **Study Participant**

Table 3. Lifetime Exposure to Violence

	As a Child n=20	*As an Adult n=20*
Sexual Violence	14	16
Physical Violence	15	19
Witnessed Violence	15	17

D. DISCLOSURE OF CHILDHOOD SEXUAL ABUSE

Of those who reported sexual abuse as children, half of the participants reported they did not talk about these events when they were occurring. The women cited a number of reasons, for example, a fear of reprisals from the perpetrator, feelings of shame, guilt and the inability to realize that talking about the events was a course of action open to them. They often expressed a feeling that they would not be believed if they were to disclose the abuse.

One participant described a sexual assault perpetrated by her mother's boyfriend, and explained the reaction to her disclosure:

> ***"Well at first I thought she believed me but then we had the school principal there. She seemed understanding about it. I thought she was going to help me, but after everyone was gone she called me a tramp and started hitting me and all that"***
>
> **Study Participant**

E. RUN AWAYS

A majority of the participants were runaways either from foster homes or from their families of origin. Many of these women said they 'ran' to escape their home situation, citing sexual abuse as the main reason.

> ***"I think when I hit the streets (at age twelve) I stopped growing emotionally."***
>
> **Study Participant**

> ***"I slept underneath doorsteps until it got light ... I am really afraid of the dark now, I nearly died underneath that doorstep."***
>
> **Study Participant**

F. CHILD & FAMILY SERVICES (CFS) INVOLVEMENT

As youths, almost all of the study group left home and were involved with foster care in Manitoba. Involvement of CFS was due to a variety of reasons including neglect, abandonment, alcohol abuse of parent(s) and physical/sexual abuse.

In discussing her experience of living in a foster home one woman explained,

> ***"I cried for years wondering when my mom and dad were going to come and pick me up, they never did."***
>
> **Study Participant**

A majority of the participants had biological children of their own. All but two of the women have had contact with CFS involving apprehension and custody issues. At the time of the interviews, many of the women were actively attempting to regain custody of their children. At the time of the interviews, a small number of the participants had at least one of their children living with them.

G. CORRECTIONAL INSTITUTIONS

Almost half of the participants have been in correctional institutions as adults, a few citing theft as the reason for their incarceration and others indicating involvement in violent crime, most often assault with a weapon. Half of the twenty participants were in correctional institutions as children (including; Knowles Centre, Manitoba Youth Centre, Seven Oakes and Marymound) in Winnipeg.

H. RELOCATION/DISLOCATION

A majority of the women were born in rural or remote areas, with two participants originally from Winnipeg. Most of the study participants moved from one geographic area to another, excluding their initial dislocation as children, within Canada or the United States. A few of the women reported leaving to escape legal repercussions from illegal activities. A majority of the women moved as a means of escaping abusive

relationships with many reporting stalking behaviour by past abusive male partners. The mean number of moves for each was three, with Vancouver, British Columbia being a common destination for the women.

Table 4. Lifetime Relocation / Dislocation (R/D) Patterns.

	CHILD n=20	*ADULT n=20*
Foster Care	19	--
Run away R/D	14	13
Reasons for running away		
Escape of abusive relationship	13	11
Stalking behaviour of past male partner		10
Escape legal authorities	--	2

I. INJECTION DRUG USE

A majority of the participants reported past habitual use of drugs including marijuana, cocaine, heroin, Talwin and Ritalin and ecstasy. Most reported they had used IV drugs on a regular basis in the past, with one reporting current use of IV drugs at the time of the interview. The main drugs of choice among these women were heroin and cocaine. Women who primarily used heroin began using in Vancouver. More than half of the women reported that they had shared needles in the past, and most reported using dirty needles at some point during their involvement with IV drugs. Dirty needles included reusing personal needles or buying used 'rigs' (equipment used to inject drugs) off the street.

When asked why they began using IV drugs, one-quarter of the women cited peer pressure and the majority associated the use of IV drugs as a coping mechanism with past and present emotional issues surrounding their abuse. Many reported involvement in social programs to stop using IV drugs, including methadone programs in Vancouver and Winnipeg.

When discussing her battle to stop using IV drugs, one woman explained,

> ***I guess it's my only tool of knowing how to cope*** **[using drugs]...** ***they help you forget about your problems, push them away, push them down, push them deeper and that is nothing but creating your own volcano, then it all comes exploding out. Learning the coping skills other than drug use to deal with my problems is important."***
>
> **Study Participant**

J. SOCIAL SUPPORT NETWORKS

A few of the women identified family as a specific emotional support for them while growing up. A majority of the women could not identify any source of support for them as children, including family, friends, counselors, school and clergy. After becoming aware that they were HIV positive, a few of the women found support from spiritual beliefs and religious institutions, more than half reported support from social programs offered in the community (including Kali-Shiva HIV women's support group and Nine Circles). Almost a quarter of the women identified positive relationships with a family member as a means of some support. A quarter identified their current partners as a major source of emotional support.

K. OTHER COPING MECHANISMS

All participants identified suppression of memories as a means of coping.
A majority of the study group identified substance use as a means of coping with past and or present emotional, physical and sexual abuse. A few of the women had past attempts of suicide. A number of the women, at the time of the interview, reported a diagnosis of mental illness including depression, multiple personality disorder, panic attacks, post traumatic stress disorder and schizophrenia. A majority physically ran away from their abusive situation as a means of survival.

In discussing alcohol use at a young age one participant explained,

> ***"I started because everybody else was and after a while it just became a coping mechanism to cope with the feelings ... I was always taught not to show anger or to cry"***

When asked how she dealt with her feelings around abuse in her childhood one woman explained,

> ***"I didn't. I pushed it all down and never dealt with it and that was part of the reason I guess why I kept turning to drugs and alcohol seeing it take a bit of the pain away."***
>
> **Study Participant**

One woman described her use of solvents as a means of coping with abuse at home:

> ***"When I started running away I started sniffing gasoline because that was the only thing I could do because I was small... there was a garbage dump, people were throwing food away and we used to eat from there because they*** **[parents]** ***were always drinking and not buying food... that was the only thing we had to do 'cause all the little kids were together, protecting each other... it was always in the bush where we hung around together like that, 'cause nobody touched us."***

In describing how she felt during these periods, she explained,

> ***"Safe, yah I felt like I could play and I could laugh."***
>
> **Study Participant**

Table 5. Coping Strategies Identified by Study Participants

	As a Child n=20	*As an Adult n=20*
Alcohol and/ or Drugs	18	19
IV Drugs	2	14
Runaway	13	16
Suppress feelings/memories	--	19
Identified support - Family	3	4
Friends	--	12
Spiritual beliefs	--	2
Support group	--	12

IV. DISCUSSION

The women's stories share some common themes of loss throughout their life. Losses include home, family, friends and children, sense of safety, love, self-esteem, childhood, health and financial stability, among others. The majority of participants were Aboriginal from Manitoba reserves who were dislocated from their families of origin due to an unstable home environment. Reasons for original dislocation included abandonment, neglect, physical and sexual violence in the home and caregiver substance abuse.

Many women ran away from their homes at a young age citing sexual abuse as the main reason. By running away (at a mean age 12) their education was interrupted, and given their ages, their economic resources limited. This partially contributed to eventually becoming involved in illegal means of financial support including sex trade work and theft.

A large number of women felt emotionally isolated as children, with non-existent support networks. Many of the women used IV drugs as a means of coping with their situations, which was a contributing factor in becoming HIV positive.

A conceptual framework was developed based on the emerging themes from these women's stories. The framework highlights the contributing social factors involved in engaging in HIV risk behaviours among this group of women. See Figure 1.

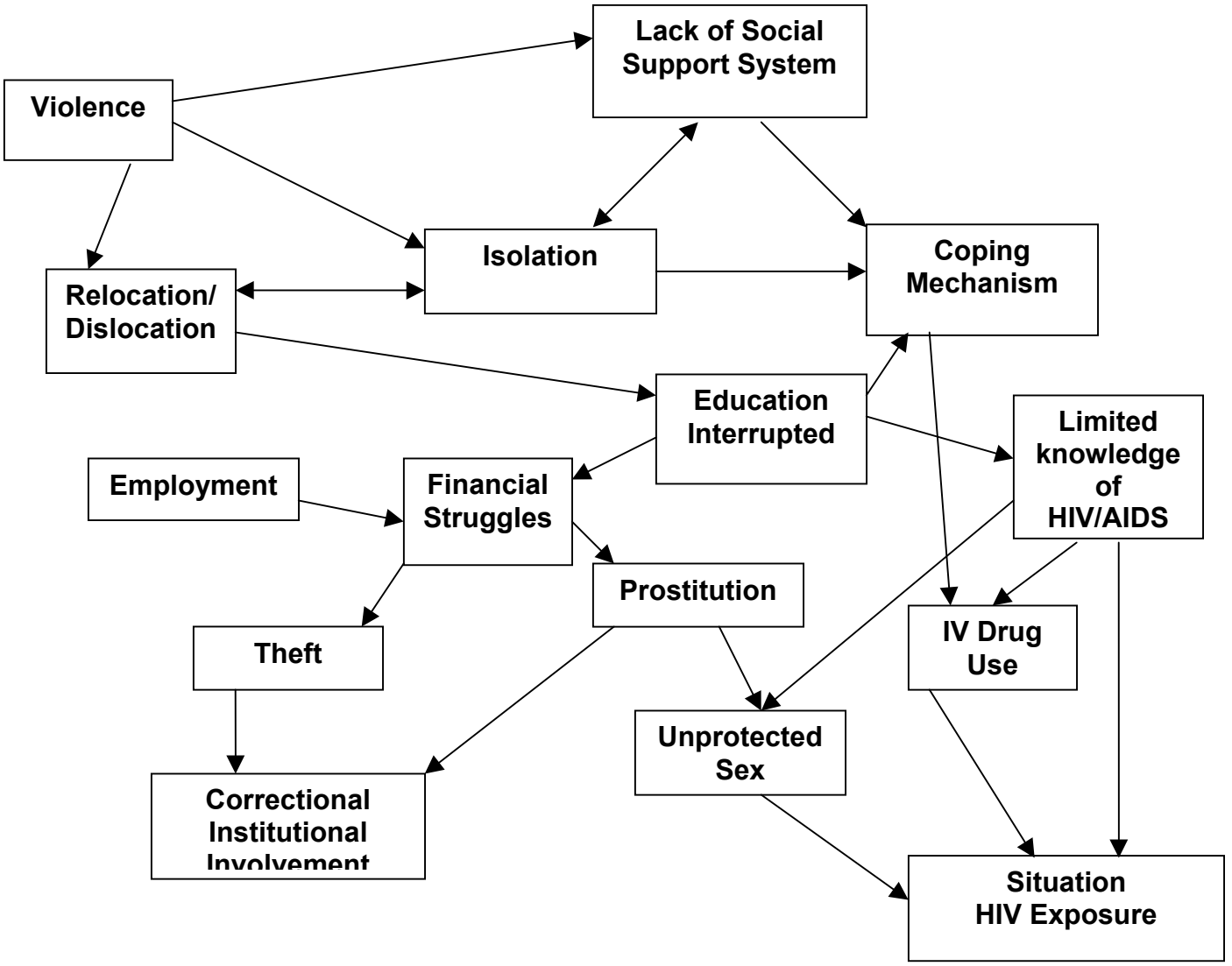
The fact that a majority of the participants were of Aboriginal ancestry and had used IV drugs may not be reflective of the general female HIV population in Winnipeg, and may indicate a selection bias of this study. Although a variety of recruitment sites were utilized, a high proportion of the participants were referred to the study from core area sites, where geographically there is a higher population of IV drug use[17] and Aboriginal residents. Despite this the over representation of Aboriginal women is reflected in current trends in HIV acquisition in Manitoba.

The average education level attained by the study participants was grade nine. The majority of women had their education interrupted. The main reason was lack of a consistent connection with one school due to running away, and continuous movement from one foster home or group home to another. The effect of abuse on the ability to perform in school was not explored in this study. This has implications for them in their ability to partake in 'mainstream' workforce and has a detrimental impact on their economic situation as well.

The majority of participants described the experience of social and emotional isolation as children and as adults. Social networks conducive to encouraging healthy coping strategies were essentially non-existent for the women in this study. The majority expressed using IV drugs as a coping mechanism to deal with past abuse issues. Their isolation and victimization continues in adulthood, with abusive partners and experiences of physical and sexual assault on the streets.

CONCEPTUAL FRAMEWORK

Figure 1



A. MODE OF TRANSMISSION

The majority of the study participants reported that they acquired HIV through injection drug use, while a few reported acquiring the virus from sex with men. This is in accordance with available data indicating that the major modes of HIV acquisition in Canadian women are by IV drug use and unprotected heterosexual sex. Reasons for being tested reported among this group of women were illness, pregnancy and known exposure.

The study finding that the majority of the women indicated they had no knowledge of HIV prior to acquiring the virus requires further examination. It is possible that study participants were provided with information about HIV/AIDS in the past but failed to remember, understand or comprehend the information provided. Given the age of the study participants, it is possible that education strategies may not have been in effect at the time some women were engaging in high risk behaviours that led to acquiring the virus.

None of the women reported having heard of HIV at school, through the media or from their health care contact prior to testing positive. A few had heard of "AIDS" but reported that they had no idea what it was. With lack of social support experienced by these women, and engagement in unhealthy coping strategies, it is not clear that better knowledge of HIV would have necessarily altered their behaviours in terms of HIV risk. Nonetheless, the fact that the majority of the women expressed a lack of knowledge of HIV should be examined further for its implications for prevention programs and strategies.

B. INCOME SOURCES AND ECONOMIC SITUATION

In Canada, women are more likely to be poor then men.[18] Zieler et al. suggest all the risk factors that leave women vulnerable to HIV and sexual violence have a strong correlation to economic conditions.[19]

The links between social inequality and HIV infection are well documented.[20] The maldistribution of social and economic resources is a more fundamental issue in shaping the epidemic.[21] Despite the links between societal structures and social forces, the literature suggests few prevention programs have attempted to create change on a societal level.[22] Waterson suggests that prevention strategies fail if they assume that all women are engaging in risk behaviours by choice.[23]

All participants at the time of the interviews reported receiving Social Assistance. Most reported an ability to provide themselves with the basic necessities of life but were limited in terms of the area of the City in which they could reside. Many of the women reported involvement in legal employment at some time during adulthood. The majority of these jobs were low paying, entry level positions which they maintained for short periods. The women supplemented their income through engagement in the sex trade, theft and participating in the distribution of illegal drugs.

Limited economic opportunity has two major effects in relationship to HIV exposure. The choices for economic survival among women with little education/skills is limited. Many of these women entered into the sex trade as a means of financial income. Some had tried to obtain long-term legal employment but found that lack of education, skills and in some instances a criminal record were barriers to obtaining employment. Activity in the sex trade is associated with drug IV use and the two behaviours are predictive for HIV exposure.

Lack of money also often dictates where affordable housing will be found. Often the only available housing is in the core area of cities which are often geographic centres of drug distribution and use.

C. PROSTITUTION

The majority of women in this study were introduced to prostitution by a friend or boyfriend, but later continued the activity in order to support themselves and their children. Environment and the internalization of life experiences contribute to the

shaping of behaviours. Many of these women came from unstable and abusive homes as children, ran away at an early age and became involved in prostitution as a means of survival The pattern of abuse, loss of self-esteem and involvement in prostitution was consistently seen throughout the life histories of the study participants. These experiences can limit one's ability to develop self-initiated healthy coping strategies.

Women's struggles with social and economic subordination include strategies for survival within an environment of drug use, violence, social disintegration and sexual risk.[24] Experiences of gender based violence such as incestuous sexual and physical abuse lay the ground work for drug and alcohol addiction, as well as a state of dissociated sexuality in which women may not be aware of their right and capability to claim when, how and with whom they are sexual.

The women reported sporadic use of condoms while working. The women often explained that men would offer more money if a condom was not used. The poor economic situation of these women along with the involvement of drugs in their lives, combine to limit their ability to insist on the use of a condom. Reported lack of knowledge about HIV transmission is also a likely factor in failure to use condoms. Whether education would have altered their behaviour in terms of condom use is not clear. However, the pressure and circumstances surrounding the choice presents a challenge to educators to effect behavioural change. The women in this study reported a strong ability to negotiate condom use among current intimate partners. Whether this ability existed for them prior to acquiring knowledge of HIV/AIDS is not clear from their reports.

D. CHILDHOOD EXPERIENCE OF ABUSE

Sexual abuse of children is disproportionately inflicted upon girls, making this an especially poignant issue for these women as adults. All the women indicated feelings of isolation and of being unsafe as children. A majority of the women who participated in the interview process reported having been sexually abused as children. The age of

incidence ranged from ages five to twelve. Feelings of powerlessness and hopelessness often accompanied these women as childhood survivors of sexual abuse. This experience, when compounded with continued isolation for women in adult life, especially for Aboriginal women who leave their home communities for an urban area, becomes a potent mix, to engage in unhealthy coping strategies.

Finkelhor and Browne[25] provide four factors affecting trauma based on subjective factors expressed by the victim, traumatic sexualization, betrayal, powerlessness and stigmatization. Traumatic sexualization refers to a "process in which a child's sexuality is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse."[26] This contributes to promiscuity, multiple sex partners and possible engagement in sex trade work. Many of the women interviewed were involved in the sex trade, and this involvement is likely related, in part, to their past experiences of abuse in addition to their economic situation at the time.

Stigmatization involves a process where negative connotations are communicated to the child around the experience of sexual abuse, and then become incorporated into the child's self-image. Finkelhor and Browne argue that '"keeping the secret of sexual abuse may increase the sense of stigma, since it reinforces the sense of being different."[27] This is an additional barrier to disclosing abuse and attempting to cope in a healthy way.

Betrayal has an effect on the ability to trust other people in many subsequent situations, especially those involving interpersonal relationships. This contributes to the inability to form trusting relationships, which contributes to feelings of isolation and an inability to communicate as an alternate coping strategy. Barriers to communication further contribute to engaging in unhealthy coping mechanisms, such as substance abuse, self harm behaviours, suicide attempts and aggressive acts.

E. DISCLOSURE OF CHILDHOOD SEXUAL ABUSE

Powerlessness, which occurs during sexual victimization involves an intricate process in which the child's sense of efficacy, will and desires are continually contravened. The authors argue that prolonged assaults may lead to a permanent sense of powerlessness in the victim, and an inability to avoid further victimization, be it sexual, social or economic.[28] Powerlessness can manifest as the inability to initiate change in an abusive situation. Only half of the study participants disclosed their abuse at the time that it was occurring during childhood. When this failed many chose to runaway as a means of survival.

Bagley & King[29] suggest that the act of disclosure carries significant trauma of its own. The act of disclosure, suggest the authors, "demands new coping strategies from both the victim and family members. This can be particularly disruptive when sexual abuse has happened within the family and over a period of time."[30]

Half of the women in the study who had experienced child sexual abuse did not disclose these events for a number of reasons, including fear of reprisals from the perpetrator, feelings of shame, guilt and lack of awareness that disclosure was a course of action open to them. They often expressed a feeling that they would not be believed if they were to disclose the abuse. A final course of action for these women was escaping their home situation by running away.

F. RUN AWAYS

The majority of women in this study left home either by running away or being removed from the home by Child and Family Services. All of the women who reported child sexual abuse experiences ran away, citing the sexual abuse by a relative as the primary reason for fleeing. The mean age of leaving home was 12 years.

Most of the women interviewed ran away with no permanent destination in mind at the time. The first place of refuge was either with friends, or boyfriends. Some lived on the

streets until they connected with adult men who took them in. These were often also the same individuals who eventually introduced them to prostitution.

The consequences of childhood abuse are often implicated in the reasons these children run away from home. For women this frequently leads to limited economic support as well as limited psychological and spiritual support. The isolation experienced as children often extends into adulthood. In adulthood a majority of study group reported sexual assault by their partners or on the streets.

For runaways economic opportunity is limited in an unfavorable environment. These women had limited education and few marketable skills when they left home. This greatly reduces the possibilities for economic survival with limited personal resources. Many of these women as young girls were economically dependent on their partners, and ironically it was often these contacts that introduced them into prostitution, allowing for some personal economic control.

The chance of gaining the required supports needed in these circumstances diminishes for young runaways. Early intervention becomes crucial. The women in this study recounted, however, that such support was either unavailable or they perceived it to be inadequate. The reality for many women who relocated from a rural area, was that supports were nonexistent for them.

Mill[31] suggests some HIV risk behaviours have become survival techniques for Aboriginal women, to deal with past experiences of unstable family relationships, physical sexual and emotional abuse being linked to the high-risk behaviour of running away as a survival technique.

The expressed attitude toward their childhood involvement with social agencies was often negative. The women interviewed often expressed a feeling that Child and Family Services and other agencies had let them down. The fear of disclosing abuse, and feelings of not being believed if they disclosed, were major factors in their decision to run away.

One woman had this to say about her feelings around apprehension by Child & Family Services,

> ***"Children need stability, you remove that and you pull the carpet out from underneath their feet, they're lost and that just extends into their adult time and it's a snowball effect, getting bigger and bigger and bigger"***
>
> **Study Participant**

The involvement of Child and Family Services in some of the lives of the participants and the perceived inability to provide the support they needed highlights the need to supplement existing programs. The women often reported being physically punished in their foster homes, some indicated that they were sexually abused by a foster father and many reported emotional abuse through name calling and being made to feel they were not part of the family, with preferential treatment given to biological children in the home.

The women in the study reported a lack of family and social support throughout their childhood and adult years, many feeling that activities such as prostitution and IV drug use resulted. Given their experiences they expressed that there is a strong need to develop early intervention and education for young women. They also expressed the need for education among adults who have a role in their upbringing. This must include social workers, teachers, nurses, parents, all family members, police officers, judges and others.

G. PHYSICAL AND EMOTIONAL ABUSE AS AN ADULT

Sadly, the fact that violence was so prevalent among the participants in this study should be startling. The impact of violence in its various forms is disproportionately felt by women, and by women who are also disproportionately isolated. It has been shown that physically abused women experience a greater degree of psychosocial distress, are more likely to be involved in substance abuse, have lower self-esteem and are more likely to engage in sex for pay.[32]

The experience of violence causes further lowering of self-esteem, contributes to the instability of relationships and propagates feelings of mistrust. These effects further isolate women from themselves and the outside world. Low self-esteem contributes to the inability to foster the growth of healthy negotiating abilities and ways of coping in a positive way with violent partners.

There are also external factors such as violent controlling behaviour of partners that precludes the opportunity for the women to access programs for battered women. Almost all of the women reported controlling behaviours in their partners, including controlling the ability of the women to travel at will, the use of the phone, the ability to talk freely with friends or family and restriction of the type of clothing the women could wear.

Often in this type of environment the most accessible short-term coping strategies are unhealthy. These include suppression of feelings, acceptance of violent treatment, and "giving up."[33] Excessive use of alcohol and drugs become an easier alternative. Many of the study group stayed in abusive relationships due to traditional beliefs about family, feeling it was important to keep the family together for the sake of the children. Other reasons included the belief that the abusive partners would change their behaviour.

H. CORRECTIONAL INSTITUTIONS

Many of the women cited involvement in violent crime as the reason for their incarceration rather than, for example, involvement in prostitution or drug related activities. Given that violence was pervasive in these women's lives, both in childhood and adulthood, it may be that by acting out in violent ways themselves the women felt a greater sense of control in their lives and thus less vulnerable as a result.

Some of the adult women who were in correctional institutions reported positive experiences in these institutions, citing a structured environment as being beneficial. Few

reported that jail had operated as a deterrent for them. Availability of programs in jail was varied, as some of the women had been incarcerated in the early 1980's.

The experience of incarceration as children did not lead to behavioural change for the majority of the study group. Many indicated that they came out better informed about illegal activities and met friends that facilitated future involvement in unhealthy activities.

I. RELOCATION/DISLOCATION

Most of the women were originally from rural areas of Manitoba and many moved from one geographic area to another, excluding their initial dislocation as children, within Canada or the United States. A few of the women left to escape legal repercussions from illegal activities, however, many moved as a means of escaping abusive relationships.

The women who relocated to Winnipeg from their home communities expressed no desire to return to live there. A few of the women have returned to visit their home communities, expressing that although family members remained, they would not relocate to live there. Often the reason for not wanting to return was that they felt there was no opportunities for them there, family would not be supportive, that they would be discriminated against because of their HIV status and that their health needs would not be met in remote communities. None of the women have ever used IV drugs in their home reserve communities.

The fact that many of the women reported that their initial reasons for leaving their home community for Winnipeg was a means of escaping abuse, returning to this environment was not considered an option by them. It is unlikely then that the relocation and dislocation patterns of these women would contribute to the spread of HIV to Northern remote communities in Manitoba. Although the transmission of HIV seems unlikely, the detailed HIV risk behaviours of these women during their visits to their home

communities was not explored in depth, and this is possibly an area for future investigation.

J. INJECTION DRUG USE

The Winnipeg Injection Drug Epidemiology (WIDE) Study conducted in Winnipeg reports that IDU has become an important risk factor in newly diagnosed HIV infection. The report also highlights concern regarding the role IDU may play in the wider spread of HIV.[34]

A few of the women reported becoming HIV positive from unprotected sex with a past partner, while the majority reported that they became HIV positive through IV drug use. Many of the women were introduced to IV drugs by boyfriends or friends at a party. Cocaine and heroin were the drugs of choice. The women who reported primarily using heroin were introduced to it in Vancouver. All identified the use of IV drugs as a coping mechanism for past abuse among other reasons. In addition, economic strain often contributes to the use of unhealthy coping strategies, including the use of IV drugs.

A survey of HIV infected women in British Columbia[35] found the most frequently reported risk factor for HIV infection was sex with a man (49%), 19% reported sex with a man and injection drug use and about 13% reported injection drug use alone. The fact that the majority of the women in this study identified IDU as the likely mode of transmission may be reflective of a recruitment bias. However, the fact that such a high portion of the women who did respond to the advertisement also used injection drugs requires the attention of policy makers and health professionals.

The survey from British Columbia also had a much higher portion of their respondents identifying as white (almost 81%) whereas in this study 80% reported as Aboriginal. This difference may be a reflection of the higher Aboriginal population in Manitoba compared to British Columbia.

Studies have begun to show that injection drug use among Aboriginal women is higher than its use among non-Aboriginal women.[36] The implication of this trend in Manitoba requires further inquiry and understanding. Injection drug use among women will not be adequately addressed by policy makers without a better understanding of the social, cultural, economic and psychological situation surrounding IDU.

K. SOCIAL SUPPORT NETWORKS

The majority of the women expressed that they felt they could not speak to immediate family members, local clergy or school counselors. Many also said they had no close friends during their childhood.

Limited access to a positive social support network in childhood left many of the women with difficulties in developing trusting relationships and with feelings of 'not belonging'. The impact of isolation and the lack of positive adult role models had a ripple effect into adulthood. Interventions that were implemented were felt to be ineffective and inadequate by the women, often with even more negative outcomes for them. Opportunities to provide support to the women as children, through CFS, foster homes and correctional institutions in better ways is paramount.

L. COPING MECHANISMS

A survival technique which is recurrent throughout the lives of these women is running away. A majority of the participants ran away from their family of origin or foster homes as a means of escaping an abusive home situation. One Winnipeg study (personal communication with Kusham Sharma, October 21, 2001)[37] showed that teenagers living on the streets had the ability to construct reasonable plans when faced with a situation, but that the plan wasn't always realistic in terms of available options for them. As children, running away is often a last resort and ultimately a survival technique. The

women often reported that there were limited or no sources of support on which to rely as children, leaving limited options open to them in dealing with the abusive situation at home.

A number of women described using alcohol and/or drugs at a young age as a means of coping with their disruptive family situation. Children who experience sexual abuse often feel isolated, have low self-esteem[38] and tend to self-blame. It can have a lasting impact into adulthood. These events among the participants in this study were often emotionally unresolved which was associated with substance abuse as a means of coping.

Another strategy of coping with their situations (past and present), adopted by some of the women, was self-harming behaviour. For some of the participants this included suicide attempts, usually involving medication overdoses. The women indicated they felt there was no support available to them at these times. The fact that some of these women were also living with a mental illness at the time, may have played a factor in the suicide attempts and requires further exploration.

V. POLICY CHANGES NEEDED

A complex interplay of events and situations have affected the decision making of the women interviewed in this study. Prevention strategies will be ineffective without an understanding of the position of women in society and a recognition of the impact of variables such as violence, economics and isolation among women.

The HIV education and prevention focus in Manitoba to date has largely been on men having sex with men and injection drug use among males. This focus is understandable given the early manifestations of the disease. However, given recent epidemiological trends of HIV acquisition, the focus must shift to respond to the unique needs of women and the influences that generally have more impact on women. Given that the incidence

of HIV infection among women in Canada is growing steadily,[39] this policy shift is essential.

Policy at present has focused on prevention through education by public advertising campaigns and promoting the use of condoms in safe sex practices, and by-and- large has not addressed the social forces behind engaging in HIV risk behaviours.[40] Where a shift in focus regarding HIV/AIDS and women at a policy level has taken place, it has been in large part related to the reproductive capabilities of women (that is, the focus is on the health of the unborn baby).[41] This focus underscores the perception that in policy development women are at times not valued in and of themselves, but in relation to their reproduction capabilities. Although policy and research is necessary and valuable in this area, when it becomes the focus, it may send a negative message about how one values women.

Women's lower economic status in society also leave them vulnerable to HIV. The lack of education and limited skills was a driving force behind entering the sex trade and eventually engaging in the use IV drugs.

Intervention at an early age, in particular on-reserve programs, must be implemented. The participants expressed the need for youth to be provided with activities and programs to encourage healthy living. They highlighted the need for more on-reserve community centres and recreational programs that include not only the youth, but the entire family.

The women expressed a need for increased support for parents in raising their children and fostering an environment that encourages the community to take responsibility for children as paramount. The participants also highlighted the urgent need for runaways coming to urban centres to be able to access culturally appropriate programs and support to assist them in a difficult transition.

The silence that surrounds child abuse, in particular the effects for girls living on reserve must be acknowledged and addressed in a meaningful way. The developers of more healthy coping strategies must be better informed about the prevalence and associated effects of this abuse.

All programs and prevention strategies must be culturally sensitive and have relevance to the Aboriginal community. The fact that many of the women relocate to Winnipeg from remote communities while very young, make support for them when they arrive essential. The experience of domestic violence as adults also requires increased resources for support for these women. The women indicated a need to assist those experiencing violence in their homes.

The women expressed the need for resources to support "safe houses" for women that have flexible hours and provide over-night service. In particular, a safe place for young girls that recognizes their particular situation and addresses their immediate needs, but also provides a sense of some stability for them in a non-judgmental environment is essential.

The establishment of the Aboriginal AIDS Task Force and programs such as Kali-Shiva's Women's Support Group begin to recognize the need for a multi-pronged approach to AIDS prevention. However, resources are required in order to develop and implement strategies that go further in addressing the complex situation for women.

Utilizing the experience and knowledge of HIV positive women themselves in new and beneficial ways will go a long way in developing appropriate action plans. A concerted effort to include HIV positive women in the design, implementation and communication strategies in a meaningful way is paramount. Strategists must recognize the role women play in Aboriginal communities and begin to address the violence women are experiencing as well as the devastating impact of isolation. While recognizing the burden many of these women already carry, they still have a great deal to offer our communities and these resources must not continue to be untapped. The participants expressed a strong desire to be part of the strategies and in assisting young women. These are the voices that must be heard and understood if one is to begin to address the spread of HIV.

Injection drug use, in particular among Aboriginal women, requires further study, including exploration of the reasons behind the use of this coping strategy. The rate of diagnosed mental health issues among the women requires further exploration, in

particular, the influence this may have on coping strategies of the women and the impact this may have on prevention strategies in the future.

In conclusion, it appears that there are a number of complex social factors that are unique to women, which influence engagement in HIV risk behaviour. The striking similarity of these women's stories underscores the importance of childhood isolation and lack of support networks. Childhood abuse often results in the act of running away, the interruption of education, and eventual entry into prostitution and IV drug use.

VI. RECOMMENDATIONS

This study has attempted to investigate possible root causes of social risk factors involved in the acquisition of HIV infection among women. The results indicate that the recognition of the impact of violence and isolation among women will assist in directing policy makers and in developing effective prevention strategies.

The recommendations are directed to multi-dimensional approaches that include HIV positive women themselves as well as those who interact with them. Both existing and future programs, services and prevention strategies must be culturally sensitive and have relevance to the Aboriginal community, with a particular focus and understanding of the unique and complex situation of women. The recommendations will require support from government health departments, but also require partnership building with AIDS service organizations, band councils, community members, educational institutions and child welfare agencies.

Policy Recommendations

1. That Health Canada and Manitoba Health and Manitoba Family Services in partnership with First Nations communities provide resources to develop and implement early intervention strategies which address childhood isolation and work to create support networks. In particular, these strategies should work towards reducing family violence and providing education in schools regarding childhood sexual abuse. The strategies must focus on prevention by developing educational tools for those who work with children at risk of violence in rural and First Nations communities.

2. Parenting must be highlighted as a family and community responsibility if social risk factors such as poverty and violence are to be eliminated. Training and resources must be allocated to the development of culturally appropriate parenting models. While the majority of the women in this study are single mothers living in marginalized low-income sectors of urban centres, rural poverty also affects women's ability to raise their families.

3. Appropriate agencies develop youth activities and programs that teach and foster healthy coping strategies, with particular attention and resources for First Nation communities. These strategies must include mechanisms that increase children and youths' ability to complete school and provide options for continuing education. These approaches must be culturally appropriate, making use of the expertise and knowledge of other members of the community.

4. With limited education and options, run-away teenagers are vulnerable to entrance into the sex trade lifestyle. They need to be able to access appropriate education and training to develop employable skills. Groups and agencies which provide assistance for women and girls experiencing violence need sufficient funding and resources for

the critical areas of housing, health, education and employment training. The allocation of resources to provide transition housing, affordable secondary housing, "safe houses", support groups and drop-in centres must be made available to facilitate women and girl's integration into the urban milieu.

5. Current AIDS services workers, and those working with women at risk for the acquisition of HIV, should be educated on the social risk factors for Manitoban women and how these factors influence the women's risk-taking behaviour. Develop and implement flexible and relevant training and education programs for women in Manitoba that include an understanding of the social factors that influence their lives. Increase HIV positive women's capacity and opportunities to educate young girls about the social risk factors based on their own experiences.

6. Provide stable and sustained resources to current AIDS service organizations to develop and implement women-centered and culturally appropriate outreach programs that address the socio-economic needs of HIV positive women. In particular, support women's transition from rural to urban communities through mechanisms that facilitate women's employability and entrance into the legal workforce.

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