

HIV/AIDS AND ABORIGINAL WOMEN IN SASKATCHEWAN:
COLONIZATION, MARGINALIZATION AND RECOVERY

A Thesis Submitted to the College of Graduate Studies and Research
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ABSTRACT

Since the onset of the AIDS (Acquired Immunodeficiency Syndrome) crisis in 1982, Aboriginal women have been contracting HIV (Human Immunodeficiency Virus) and Hepatitis C in increasing numbers. A new Aboriginal HIV/AIDS research agenda is imperative. This research was conducted in an attempt to understand why Aboriginal women in Saskatchewan remain marginalized in their continuing struggle against HIV/AIDS and Hepatitis C. Through the use of in-depth ethnographic profiles and personal histories, twenty-two Aboriginal women from Saskatchewan candidly shared their life histories. The women were asked a range of questions, including their knowledge about HIV/AIDS and Hepatitis C, and their attitudes and behaviours concerning sexual activities, alcohol and drug use, education, health, and lifestyle.

The key issues for Aboriginal women with HIV/AIDS and/or Hepatitis C focus on the fact that they sustain 'triple jeopardy,' in that they are discriminated against for having HIV/AIDS and/or Hepatitis C, for being a minority population by virtue of their Aboriginal ancestry, and for being women. Any analyses of what makes Aboriginal women vulnerable to HIV and Hepatitis C infection must take into account the role of poverty, independent of any risk factors, in leading to infection, illness, and in some instances, death.

The majority of the respondents were found to be prostitutes who continued to be involved in street prostitution, even after they had been diagnosed with HIV and/or Hepatitis C. Twenty percent of the respondents were infected through unprotected sexual activity, 20% through intravenous drug use, and 60% were infected through both unsafe sex and intravenous drug use. The results of this research the incidence of both HIV and Hepatitis C is high in Aboriginal communities in Saskatchewan, due largely to low condom use, high rates of STDs (sexually transmitted diseases), low self-esteem, a lack of self-identity, increasing intravenous drug use, violence, sexual abuse, and high representation in street prostitution. Research to date is inadequate to the task of preventing the further spread of HIV and/or Hepatitis C, and providing effective and culturally appropriate treatment to Aboriginal women in Saskatchewan. This thesis serves to fill some of the research gap in knowledge about the relationship between race, gender, social class, sexual behavior and HIV/AIDS and/or Hepatitis C infection.

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*HIV/AIDS and Aboriginal Women in Saskatchewan: Colonization,
Marginalization and Recovery*

There is an old native North American Indian tradition called Heyoehkah. The Heyoehkahs, or sacred clowns, were people within the tribe who “did things differently,” challenged people’s thinking, shook them up. Their function was to keep their people from getting stuck in rigid ways of thinking and living. They were also known as “contraries” because they lived backwards. They walked backward, danced backward; everything they did was contrary to the norm. By living they symbolized the shadow of the Creator God, reminding people of their spiritual center.

For gay people, the role of the Heyoehkah is especially important: not only are Heyoehkahs often gay, the role of the contrary is a sacred symbol of the role we play among society as a whole.

Not long ago a handsome, courageous, young Indian named Richard danced Heyoehkah at a powwow. When I heard about it shivers ran down my spine. It was a sign of remembering. It was a sign that we were remembering our relation to the Great Spirit and that the Creator God is remembering us.

His dance also made me realize that from the beginning there has been a Heyoehkah response to AIDS. When the normal response was to react with fear and panic, there were people dancing backward, responding with love and confidence. When the world began repeating a death mantra, our sacred clowns danced the dance of life. They talked about living with AIDS, surviving, healing, and recovering. When the normal reaction to a diagnosis was isolation, our Heyoekahs dragged us into a community. When the world wanted us to be victims, they drew circles of light around themselves and stood in their power.

Whenever it got dark, they turned toward the light. Whenever people said, “This isn’t about us,” they stood up and said, “This is about you. This is about all of us. Our planet is sick. Earth has acquired an immune dysfunction. We are all living with AIDS.”

The heart of this book is inspired by that magical AIDS community of sacred clowns, the contrary people who keep hope alive, who stay spirit-centered, who “do things differently.”

By Perry Tillerias

The Color of Light: A Meditation Book for all of us Living with AIDS

1.0 BACKGROUND

After completing my degrees in Native Studies and Sociology I decided to use the knowledge that I had obtained as well as my Nursing experience, in my Masters Program. I had chosen to do research on HIV/AIDS, but remained undecided about the issues on which I wanted to focus. Initially, I investigated the HIV/AIDS service organizations that are offered in Saskatoon. AIDS Saskatoon offered access to information on HIV/AIDS through articles, surveys, and pamphlets. The Persons Living With AIDS Network also volunteered a variety of sources of information, but recommended that I spend time there meeting a number of their members. The All Nations Hope Network, which offers information and assistance to Aboriginal people living with or affected by HIV/AIDS, works in conjunction with the PLWA. I was able to obtain cultural specific information concerning Aboriginal people and HIV/AIDS from them. While I was there, I noticed that Aboriginal women comprised a large segment of their membership. Consequently, I decided to research the incidence of HIV/AIDS in Aboriginal communities in Saskatchewan and to focus primarily on Aboriginal women.

While I was discussing the focus of this research with a member of my advisory committee I was asked directly, “What makes you feel that Aboriginal women will want to talk to you, a ‘White’ woman?” It was an open and honest question for which I had no immediate reply. That question helped me realize the enormity of the enterprise that I had planned to embark on, plus it had a ring of truth to it. The importance of the subject matter outweighed any reservations that I had. To be quite honest, that question encouraged me to pursue the effects of HIV/AIDS on Aboriginal women in Saskatchewan even more and I have not forgotten it.

1.1 HISTORY OF HIV/AIDS

The Human Immunodeficiency Virus (HIV) causes AIDS. A virus is an infectious agent that needs another living cell (called a host cell) in order to replicate it. The name AIDS stands for Acquired Immunodeficiency Syndrome. Acquired means that it is not inherited from birth or due

to faulty development. AIDS is transmitted in specific ways from one person to another by the virus. Immunodeficiency means that the body's immune system is not adequately able to protect itself from infection. Syndrome means that it is: a collection of symptoms and conditions, which are not specific enough to be labeled a disease; a disease whose cause is not known; and a disease, which has multiple causes (Health Canada, 2002a: 1).

The name AIDS dates back to 1984. It was in 1979, that doctors in Los Angeles and New York first noticed an increase in the number of cases of an unusual pneumonia and a rare cancer in gay men. After a few years of ever-increasing numbers of cases, the medical community admitted that they were viewing something that had not been seen beforehand. All of these patients had severely deficient immune systems and quickly succumbed to a number of unusual diseases. There were also cases appearing in intravenous drug users and hemophiliacs (Health Canada, 1998e).ⁱ

Initially there were numerous theories concerning the cause of this "new epidemic," but it was soon revealed that its source was a transmissible agent, most probably a virus.ⁱⁱ While cases were escalating in the United States, AIDS started appearing in Europe. What was most interesting about the cases in Europe was that many of them were immigrants from Central Africa. When investigators turned to Africa, they exposed an already existing epidemic, which looked as though it went back to at least 1976. However, where the American cases were mostly among homosexuals and intravenous drug users, the African cases were among heterosexuals and the proportion was even between men and women. As well, a closer search of the medical records of patients in Africa revealed evidence of HIV/AIDS as far back as 1963 (Health Canada, 1998e).

HIV/AIDS has:

rapidly emerged as a devastating global pandemic with major implications for the future vitality of humankind. While it is certain that we are much better equipped to develop treatments, possible vaccines, and prevention programs against AIDS on a global level today than we would have been, let's say, 50 years ago, it is equally certain that it is unlikely that AIDS could not have spread so rapidly without the development of modern commercial jet travel and the tremendous growth or urbanism in the Third World over the past decades (Feldman, 1990:1).

To date it is still not known where or how HIV/AIDS originated. One of the initial explanations for the origin of HIV/AIDS involves:

a simian immunodeficiency virus (SIV) mutates into human immunodeficiency virus, type two (HIV-2), perhaps from blood contamination while skinning an infected (green) monkey, possibly in a remote West African village many decades ago. This now human retrovirus rapidly evolves, and as it inadvertently spreads through sexual transmission into new tribal populations to the east, it takes on a more aggressive and more lethal character. By the late 1950's, the new virus HIV- 1 has entered into the Belgian Congo (now Zaire) and perhaps elsewhere in central Africa. With the rise of urbanism and jet travel in central Africa, the virus spreads rapidly from city to city throughout central Africa, into Haiti, and among gay men in North America. By the late 1970s, about 4 percent of all sexually active gay men in San Francisco are infected. By the early 1980s, about 4 percent of all men and women in the central African nation of Burundi are similarly infected (Feldman, 1990:1-2).

There are numerous other speculations concerning the origin of HIV/AIDS, but not all of them have been innocuous and have caused considerable harm to people. The speculation that HIV/AIDS “may have originated in Haiti severely stigmatized the citizens of that country. Tourists stayed away from Haiti. Economic investments declined. Haitian–Americans found themselves increasingly losing their jobs” (Feldman, 1990: 2). The story of HIV/AIDS is full of examples of ignorance and fear. This ignorance has led to confusion, which in turn has developed into distrust and hatred. HIV/AIDS cannot be spread by casual contact. People cannot become infected with the virus by shaking hands with those who have contracted the disease. HIV/AIDS is not, in short, a highly contagious disease, so it is not strictly speaking a “modern plague” equivalent to the Black Death, which decimated Europe in the Middle Ages.

“Speculation that HIV/AIDS may have begun in Africa has also allowed anti-African bigotry to flourish. HIV/AIDS is blamed on Africans, or blamed on gays, or blamed on Haitians. HIV/AIDS is a stigmatized and a stigmatizing disease and social phenomenon that is perceived to pollute everyone and everything” (Feldman, 1990: 2). The medical community tried to impede the growing hysteria concerning HIV/AIDS but it took a very long time for the message to take

hold. Part of the problem was that far too many people in a position to know better were still confused about how the disease was transmitted from one person to another. At present, many people with hemophilia are infected with HIV/AIDS. Feldman (1990:3) states that:

Persons with hemophilia, who have only recently lifted the stigma of having a poorly understood disease associated by the public in the past with royal inbreeding and pejoratively called the “bleeder’s disease,” are now finding themselves labeled with an even more stigmatized disease, AIDS, which is associated in the public consciousness with immorality, “promiscuity, “ drug addiction, and “perversion.”

However, African countries have borne the brunt of the rising tide of xenophobia that resulted from the spread of HIV/AIDS. Many governments outside of Africa have stipulated that foreigners must have a HIV/AIDS test before they can enter the country.

Feldman (1990:15) argues that, “Throughout history, disease has often been blamed on “outsiders,” as defined by race, ethnicity, religion, or nationality. In Western cultural concepts, disease is considered unnatural, and the genesis of disease is best placed as far from “people like us” as possible. “Outsiders” may be humans who are different, or better yet, some other animal species” (p.15). HIV/AIDS as a serious contagion arrived in North America under these circumstances. Feldman (1990:16) contends that,

Regardless of whether HIV existed in Africa before appearing in other parts of the world, the impact of this assertion has already occurred. For many of the people, who have been exposed to the media reports, it has become a fact. Cultural myths die hard, and the association of AIDS with Africa has become as much a part of American cultural attitudes towards the disease as its association with homosexuality.

This racialized facet of the history of HIV/AIDS has persisted to the present and remains an obstacle in the prevention of the disease. As long as people were able to view AIDS in terms of a disease that was contracted by “others,” they felt secure in the fact that it could not harm them or be blamed on them. It did not matter who the “other” was be it green monkeys, Africans or Haitians. Then when HIV/AIDS began to appear in the United States and Europe in white gay males, intravenous drug users, and hemophiliacs, people who could not identify with these groups remained secure in the fact that they could not contract it either. Mahkesis (2000: 10) reinforced

this view when she related, “I wasn’t stupid I didn’t know nothing about it just what’s on TV. I didn’t even know it existed in Prince Albert. I thought it was just in Africa that’s how naive I was.” This is a fundamental example of how cultural myths continue to be reproduced in society to the detriment of people’s social, economic, political, and physical well-being.

1.2 INTRODUCTION

HIV/AIDS does not recognize race, class or gender. Being among the first to become infected, gay men, sex workers, and intravenous drug users were mistakenly perceived as embodying the threat of AIDS, and the fear associated with it reduced society’s tolerance of infected people. Many sexual relationships and many sexual behaviors are not identified. There has been widespread denial of the extent and the risk of sexual transmission of HIV/AIDS through heterosexual intercourse. In Saskatchewan limited information has been a contributing factor in the spread of the disease. Certain circumstances and behavior place some people at greater risk than others. A great deal of public education is required to persuade individuals to think about themselves and HIV/AIDS, in these terms.

There is strong evidence that lower income and socioeconomic status are associated with poorer health in general, including lower standards of reproductive and sexual health. Earlier initiation into sexual activity and riskier sexual practices are common among youth with lower socioeconomic status (de Bruyn, 1998). Economic inequities often contribute to the continuing marginalization of certain groups, including women and Aboriginal communities.ⁱⁱⁱ

Marginalization is a deleterious effect of the colonization of Aboriginal people in Saskatchewan.^{iv} It is often manifested in reduced access to education and housing, low self-esteem, a diminished degree of control over one’s life and environment, unequal power in relationships and a lower capacity to make positive choices about health, including strategies aimed at reducing the risk of HIV/AIDS transmission (de Bruyn, 1998).

Health Canada’s establishment of a hierarchy of “high-risk” groups for contracting HIV/AIDS echoes the stratification and social inequality in the general population. Health Canada assigns

AIDS cases to a single exposure category in the hierarchy of modes of exposure or risk factors. If more than one mode is reported within a case, the case is classified in the exposure category that is listed first in the hierarchy. For example, persons who are intravenous drug users may also be at risk of HIV infection through heterosexual activity. However, intravenous drug use is prioritized as the higher risk activity. These are the conditions under which Health Canada statistically defines groups of people who have contracted HIV/AIDS.

Women in general and Aboriginal women in Saskatchewan in particular, who have contracted HIV/AIDS, have to face numerous obstacles. The fear and stigma attached to HIV/AIDS keeps many Aboriginal women from disclosing their status and as a result, this has led to a lack of adequate treatment as well as support. Family members, who would normally support a person dealing with grief and loss, stay away from the person touched by AIDS. Racism, sexism, and homophobia, which are also the result of colonization, can lead to further isolation.

The lack of proper education in the medical profession about HIV/AIDS has reinforced the denial of HIV/AIDS as a health issue for women. There is generally a lack of funding for women-centered AIDS research, as well as other services and resources for women infected and affected by the disease. The stigma attached to HIV/AIDS as a “gay disease” has led to a lack of proper education that is gender-specific for women. Women are viewed primarily as the nurturers of children. Initially, when women began contracting the virus they were assumed to embody all of the negative connotations of contracting the disease. When a man has multiple sex partners, it is viewed socially as a right of passage, and an acceptable practice. If a woman does it she is designated promiscuous and society condemns her for it. In the media’s initial images of homosexuals, junkies, and prostitutes acquiring HIV/AIDS, women were not seen as being “high risk.” A great deal of the time, women were left out of the picture and the threat to their health was not taken seriously.

It is not difficult to see from the viewpoint of a colonized group such as Aboriginal women in Saskatchewan, just how the HIV/AIDS crisis has once again brought the divisions of society to

the forefront. These are divisions based on race, ethnicity, gender, and class. Berer (1993:39) holds that the conviction that HIV/AIDS is only confined to specific marginalized groups has succeeded in perpetuating “stereotypical views and prejudices about sexual identity and immoral sex, rather than accentuate the commonalities in sexual behavior.” Discoveries about the nature of HIV/AIDS - the increase in the heterosexual population and among women - have raised concerns of its potential for rapid spread in the Aboriginal community (Aboriginal Nurse’s Association, 1996).

The sexual transmission of HIV/AIDS appears less frequent than it is. Epidemiology has not been gender-specific in the past, and gender is often unclear in AIDS statistics. Figures often do not state whether people who are infected through heterosexual intercourse, intravenous drug use, or blood transfusion are men or women. This has made risks among women less visible, even where many of them are known to have HIV/AIDS. Epidemiological descriptions of HIV/AIDS in women have suffered from a mix of too much and too little visibility of women, to women’s detriment. Initially, people considered HIV/AIDS to be a “promiscuous women’s disease,” along with all other sexually transmitted diseases. Early HIV/AIDS posters warned men to beware of “those women,” as posters had done in the past with regard to venereal disease (Berer, 1993). Unfortunately, stereotypes do continue to exist and many education and prevention efforts have not focused on women in particular.

Much of the concern about women contracting HIV/AIDS is focused on the potential risk to infants and not on the health of the mother. Although men infect most women, it is women, and not their male partners, who are seen as the source of pregnancy-related infection of infants. As a result of all of these highlighted factors, women are often held responsible for spreading HIV/AIDS, whether as sex workers, wives and sexual partners, or mothers. Preventing women from transmitting HIV/AIDS has often had a higher priority in policy and programs than preventing women from getting the disease (Health Canada, 1998e).

Women have been largely forsaken in the AIDS crisis in Saskatchewan. The initial discourse

surrounding AIDS, as a “gay disease” or a disease of the “other” has been extremely detrimental to the health of all women, including Aboriginal women. Feminists argue that, from the onset of the AIDS crisis, women were virtually invisible. Squire (1993:5) argues that frequently the AIDS discourse “repeats the common cultural erasure of women treating them as undifferentiated people as if their gender were invisible and unimportant.” The primary campaign against AIDS reflects male needs and experiences, because the dominant AIDS agenda in Canada was white and male. Even the categories that Health Canada describes as “high-risk” are dominated by the male persona: homosexuals, bisexuals, and homosexuals who use intravenous drugs. Easton (1992:14) contends that AIDS emerged “in a world governed by patriarchal ideology and institutions” and that the response “was primarily defined by male-biased attitudes and values.” Women, specifically Aboriginal women in Saskatchewan, were not considered against the “high-risk” behaviors of white, gay males.

The fact that Aboriginal communities in Saskatchewan have been systematically oppressed and economically disenfranchised through colonization places them at substantial risk of HIV infection. Amid the flurry of information, in medical and scientific journals, regarding HIV, its transmission, its link to AIDS, and groups most at risk, one thing has remained constant: poverty as one of the key consequences of colonialism, continues to provide the virus with a relatively invisible but fertile breeding ground. Health Canada (1998e) maintains that the physical and social conditions on reserves and in urban areas in Saskatchewan have led to extremely high rates of HIV infection. As the HIV/AIDS crisis among Aboriginal peoples in Saskatchewan continues to evolve, Health Canada (1998e: 2) argues, “The lack of information for Aboriginal women concerning the gravity of the disease limits the understanding of its impact on Aboriginal communities.”

The risk that HIV/AIDS poses to Aboriginal communities in Saskatchewan has not decreased. In fact, the general perception is that the risk level has risen and continues to rise. Discoveries about the nature of HIV infection - the increase in the heterosexual population and among women

- have raised concerns about its potential for rapid spread in the Aboriginal community.

Aboriginal communities remain unprepared, as Aboriginal women with HIV/AIDS continue to be banished, discriminated against, and isolated due to ignorance and fear (Aboriginal Nurse's Association, 1996). From a sexuality perspective, it has been pointed out that many Aboriginal women in Saskatchewan, especially young Aboriginal women, lack power and assertiveness in their sexual relationships. The fear of abandonment and violence often precludes their insistence on safer sex practices and on a discussion about their partner's sexual history, to an even greater degree if a child is also involved in the relationship (Aboriginal Nurse's Association, 1996).

For Aboriginal women, unprotected vaginal sex with an infected partner is the primary method of HIV/AIDS transmission. The use of contaminated needles for intravenous drug injection is the second leading cause (Health Canada, 1998e). There are three main categories of Aboriginal women in Saskatchewan affected by HIV/AIDS: women whose life choices place them at risk of HIV infection, women infected with HIV or who have AIDS, and women who care for persons with HIV/AIDS (Aboriginal Nurse's Association, 1996: 7). In heterosexual relationships, women are often conditioned to assume a passive or submissive role, therefore, do not have the power or control to insist on safer sex practices. Some Aboriginal women have been subjected to violence when they insist on safer sex. There is an increased risk of HIV/AIDS for those women who are unable to openly discuss their partners' sexual histories (Aboriginal Nurse's Association, 1996).

The history of AIDS has shown that HIV can enter a community in many different ways. In each community, where and among whom HIV enters obviously defines the early history of the epidemic. In each society those people who were marginalized, stigmatized, and discriminated against, before the onset of HIV/AIDS have become over time those at highest risk of HIV infection. Regardless of where and among whom it may start within a community, the brunt of the epidemic gradually and inexorably turns towards those who bear this societal burden. Therefore, in Saskatchewan the epidemic has turned increasingly toward "minority" populations in inner cities, which are intravenous drug users, and mostly women. HIV/AIDS is concentrated

among the poor and dispossessed. The risk of HIV infection experienced by Aboriginal women, as a result of their overrepresentation among intravenous drug users, cannot be understood or addressed without recognizing the events and structures, both past and present, that have contributed to substance abuse, migration, unemployment, cultural displacement, and despair among Aboriginal peoples in Saskatchewan. Any analysis of what makes Aboriginal people vulnerable to HIV infection, or what makes Aboriginal people with HIV/AIDS vulnerable to sickness and death, must take into account the role of colonization independent of any risk factors in leading to HIV infection, sickness and death, and how the structures of our economy and our society benefit (discriminate in favor of) people with superior socioeconomic status (de Bruyn, 1998).

Women played a prominent role in the political and cultural life of many traditional Aboriginal societies.^v First and foremost, they were honored as the givers of life. Their ability to bear, raise and nurture the new generation was seen as a special gift from the Creator, a source of awesome power and equal responsibility. Women are known to be primary caregivers in Aboriginal society. They care for the children, feed the family, care for the sick and elderly and serve as the foundation of the family in the traditional sense. In the wake of the HIV/AIDS crisis, measures must be taken to ensure that Aboriginal women in Saskatchewan are able to continue their responsibilities for future generations of Aboriginal children. Aboriginal women face many difficulties when dealing with HIV/AIDS, and carrying out their roles as mothers, lovers, caregivers, and educators. There is no mistake that HIV/AIDS is already in evidence in the Aboriginal population in Saskatchewan. There is concern within the community that Aboriginal people are more susceptible to HIV infection than other Canadians, due to lower condom use, high levels of sexually transmitted diseases (STDs), low self-esteem, substance abuse, increasing intravenous drug use, sexual abuse and high representation in the urban sex trade (Health Canada, 1998e). Through colonization, Aboriginal people in Saskatchewan have experienced a legacy of destructive racism, oppression, discrimination, and a loss of control over their own affairs,

including how HIV/AIDS is dealt with in their own communities.

1.3 Need For Research

While researching available statistics, it became grossly apparent that information concerning Aboriginal communities is not readily available. What was even more surprising was the lack of research that had been done on the effects of HIV/AIDS on Aboriginal women. From the onset of the HIV/AIDS crisis, remarks have been made by government agencies, such as Health Canada, that there is a critical need for more research in Aboriginal communities. So far, there has not been a great deal of it done. When HIV/AIDS was initially confined to “white gay males” and intravenous drug users, the Aboriginal population felt a false sense of security, in that their communities were safe from contracting the disease. When the number of HIV/AIDS cases increased, through heterosexual contact, Aboriginal women still felt safe, because they were in monogamous relationships, even though their partners were not (Aboriginal Nurse’s Association, 1996:11). This is no longer the case in Saskatchewan.

In Saskatchewan, the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) have disproportionately affected those people and groups in society who occupy the lowest rung of the socioeconomic ladder. This may include intravenous drug users, sex trade workers, and people that have been segregated and disenfranchised from society, such as Aboriginal peoples. Health Canada (1998e: 6) stresses: “There are numerous factors that put Aboriginal people at risk, including their socioeconomic living conditions, poor health status, high rates of sexually transmitted disease, high-risk behaviors associated with unprotected sex as well as alcohol and drug abuse.”^{vi} In turn, these are all symptoms of a much greater disease that is poverty.

As the Canadian Aboriginal AIDS Network (1998:1) highlights, in their fact sheet titled, *AIDS & Aboriginal Peoples*:

No one is immune to HIV/AIDS. The economic and social power imbalance between Aboriginals and non-Aboriginals in this country, plagues our [their] communities with a host of social problems. HIV is

rapidly becoming one of them. Studies in mainstream society also show that instances of HIV infection occur more frequently where poverty, violence, drug abuse and alcoholism are present.

The discourse surrounding HIV/AIDS marginalizes ethnic and racial minorities, as well as women. It is only recently, as rates of new HIV infections among women have increased at alarming rates, that some attention has been given to the significant impact that HIV/AIDS has had on Aboriginal women. Aboriginal women in Saskatchewan with HIV/AIDS constitute one of the least powerful and most burdened segments of Canadian society. The impact of the AIDS epidemic on women from minority populations in Saskatchewan must be examined within the broader context of race/ethnicity, gender, socioeconomic status, and social inequality.

1.4 Objectives of Research

The primary objective of this research is to ascertain the quantity and the availability of knowledge that Aboriginal people in Saskatchewan have, concerning HIV/AIDS as well as the prevention and spread of HIV/AIDS, among Aboriginal women. A discussion of the magnitude of high-risk behavior within this population, sexual practices, substance abuse, and barriers to behavioral change, that affect their well-being and recovery, are dominant issues. The influence of attitudinal, lifestyle, socioeconomic, and cultural factors that prevent the progression and the spread of HIV/AIDS and other sexually transmitted diseases are also explored. Through the use of in-depth profiles, the researcher aspired to afford Aboriginal women the opportunity to openly discuss how HIV/AIDS has affected their experiences and their lives. In doing so, the researcher sought to validate their experiences as significant to other members of society.

Unique issues for Aboriginal women in Saskatchewan with HIV/AIDS center on the fact that they sustain “triple jeopardy” (Aboriginal Nurses’ Association, 1996). They are discriminated against because they have HIV/AIDS, they are racial minorities by virtue of being Aboriginal, and they are women. Not all women are equally vulnerable when it comes to illness and its consequences, and HIV/AIDS is no exception. Poor and marginalized women have been affected the most. All of the inequalities and injustices that affect women’s health and access to health

care also occur with HIV/AIDS. Easton (1992:14) holds that it is important for women to refuse to contribute to “a hierarchical strategy against AIDS that deals with discrimination based on gender and furthers discrimination based on race, class, or sexual orientation.”

The present hierarchy of HIV/AIDS cases in Canada is a reflection of the divisions in society based on social inequality. The initial male domination in the struggle against HIV/AIDS renders invisible those HIV positive people whose needs and experiences are not the same as white gay males, in this instance Aboriginal women. The strong male association with HIV/AIDS, specifically white gay males and intravenous drug users, obscures many people in their ability to recognize their possible HIV/AIDS risk behaviors, if they do not identify with either of these groups. Treatment and education strategies that have been developed according to a male model are not necessarily effective with other individuals or groups (Easton 1992; Hansen 1998; Holland, Ramazanoglu, Sharpe, and Thomson, 1990). All marginalized people, whose needs and experiences are different from homosexual and bisexual men, need to be able to access and develop treatment and education programs of their own.

1.5 Limitations of Study

One of the major limitations of this research involved finding Aboriginal women with HIV/AIDS or Hepatitis C who felt comfortable enough to share their sexual experiences with a virtual stranger. When a woman did agree to share her life experiences, it was difficult to actually pinpoint a time and place that were suitable for everyone involved. As a result, it was easier to contact women while they are incarcerated; they had nowhere else to go and they seemed to enjoy the company. At the time, I was worried that I was not getting a sample of women that represented a typical Aboriginal community in Saskatchewan, but even the women who were interviewed outside the prison setting had been incarcerated at least once in the past. The living conditions under which many Aboriginal women found themselves, their poor health status, high rates of sexually transmitted diseases, high-risk behaviors associated with unprotected sex, and alcohol and intravenous drug use, place them in a sub-group of the Canadian population that is

difficult to access.

There is a scarcity of literature with respect to how HIV/AIDS has affected the Aboriginal population in general and Aboriginal women in particular. A new Aboriginal HIV/AIDS research agenda is necessary, because Aboriginal AIDS cases are under-reported, due to delays in reporting and variation in the completeness of reporting ethnic status between provinces; interpretation of AIDS data among Aboriginal people is difficult, because ethnic information is lacking for many reported AIDS cases.^{vii} With respect to HIV data, HIV testing and clinical data are available only for those who volunteer for testing and/or treatment, therefore they do not represent the total number of Aboriginal people infected with HIV (Health Canada, 1998e).

The literature on risk factors associated with HIV/AIDS in the Aboriginal community in Saskatchewan is very inadequate. This literature was generally focused on individual risk behaviors, knowledge, and attitudes, and rarely addressed the broader social determinants, such as poverty, discrimination, and marginalization. There is virtually nothing in the literature linking general social trends, such as migration between reserves and urban areas, changing employment opportunities, and housing availability, to high-risk activities. Interviews conducted also revealed a lack of acceptance of people with HIV/AIDS in their communities.

Chapter Two of this thesis deals with the literature used to address the impact that HIV/AIDS has had on Aboriginal women in Saskatchewan. It looks at how (colonialism---include impact earlier) had and continues to have, negative consequences in the social, economic, and political spheres of Aboriginal women's lives. The literature review deals with surveys, statistics, workshops, and reports that reveal the marginalization of Aboriginal women, from contact to the present day. It then speaks to both the negative and the positive approaches that Aboriginal women are taking, to address the consequences of HIV/AIDS in their communities.

Chapter Three describes how the qualitative research was conducted to obtain the data.

Chapter Four presents and analyzes the data obtained, while profiling the twenty-two respondents in Saskatchewan.

Chapter Five discusses the implications of this research and offers recommendations to support Aboriginal women in Saskatchewan in dealing with HIV/AIDS in the future.

Chapter Six deals with conclusions that may be drawn from the completed profiles of the respondents and a closer examination of how their lives have been affected by HIV/AIDS.

Notes

- i. Bernard D. Davis, Victor A. McKusick, and Ronan O’Rahilly, *Dorland’s Pocket Medical Dictionary* (W.B. Saunders Company: Toronto, 1968), p.291. A hemophiliac is a person affected by hemophilia. ‘Hemophilia is a hereditary hemorrhagic diathesis characterized by hemarthroses and deep tissue bleeding, due to the deficient generation of intrinsic thromboplastin (clotting factor)’ As a result, hemophiliacs are forced years of blood transfusions to replace the clotting factor that their body does not produce.
- ii. Ibid, p.226. An epidemic is defined as “the simultaneous occurrence in a human community of a great many cases of a specific disease.” In Canada, the number of Canadians who have contracted the human immunodeficiency virus or that have had HIV develop into full-blown AIDS is steadily increasing everyday. As such, HIV/AIDS has reached “epidemic” proportions in groups of people all over Canada.
- iii. The term “marginalization” is defined in the Appendices at the end of the thesis under *Definition of Terms*.
- iv. The term “colonization” is defined in the Appendices at the end of the thesis under *Definition of Terms*. Razack, H. *Race, Space, and the Law: Unmapping a White Settler Society* (Between the Lines: Toronto, 2002). p.1-2. Sherene Razack discusses the colonization of Aboriginal people in Canada and the result was what she describes as “a white settler society.” She states that a white settler society is one established by Europeans on non-European soil. Its origins lie in the dispossession and near extermination of Indigenous populations by the conquering Europeans. As it evolves, a white settler society continues to be structured by a racial hierarchy. In the national mythologies of such societies, it is believed that white people came first and that it was they who principally developed the land; Aboriginal peoples are presumed to be mostly dead or assimilated. European settlers thus become the original inhabitants and the group most entitled to the fruits of citizenship. A quintessential feature of white settler mythologies is therefore, the disavowal of conquest, genocide, slavery, and the exploitation of the labour of people of colour. In North America, it is still the case that European conquest and colonization are often denied, largely through the fantasy that North America was peacefully settled not colonized.
- v. Peggy Brizinski, *Knots in a String: An Introduction to Native Studies in Canada* (The Division of Extension and Community Relations: Saskatoon, 1989), p.113. The traditional Plains Indian society was egalitarian, where women were equal in status to men, although they performed different roles. Men dominated decisions about hunting and war. The women were respected for their work in raising children and managing the home. They also played a crucial role in religion. Women were responsible for much of ritual life, including the maintenance of medicine bundles and the management of rituals in men’s societies. They also taught and

practiced sacred arts and crafts. Celebrated in myth, women were expected to be faithful, generous, skilled, industrious, and hospitable.

vi. B.C. Aboriginal HIV/AIDS Task Force, *The Red Road: Pathways to Wholeness* (Health Canada: Ottawa, 1998) p.16. HIV/AIDS can be easier to contract or transmitted in the presence of another STD. As such, prevention efforts must also work to lower rates of STDs in Aboriginal communities.

vii. Gordon Marshall, *The Concise Oxford Dictionary of Sociology* (Oxford University Press: New York) p.157. Ethnicity defines individuals who consider themselves, or are considered by others, to share common characteristics that differentiate them from the other collectivities in a society, within which they develop distinct cultural behaviour. The term was coined in contradistinction to race, since although members of an ethnic group may be identifiable in terms of racial attributes, they may also share other cultural characteristics such as religion, occupation, language, or politics. According to this definition Aboriginal people in Canada can be described as an “ethnic group.”

2.0 LITERATURE REVIEW

European patriarchy was initially imposed upon Aboriginal societies in Canada and in Saskatchewan during the fur trade, and it continued with Christianity and government policies. “As a result of white intrusion, the matriarchal character of Aboriginal spiritual, economic, kinship, and political institutions was drastically altered” (La Rocque, 1994:3). Acoose (1995:15) a Metis author and historian, argues that, “in eurocanadian literature Indigenous women are imprisoned in stereotypical images, which perpetuate racism and sexism and foster cultural attitudes that encourage violence against Indigenous women.” Historically, the impact of the market, the military, the church, and the state has created the sexual oppression of Aboriginal women as a class condition. The prostitution of Aboriginal women depends upon this class of devalued women (Lynne, 1998:3). As Lynne (1998:3) so poignantly states, “It takes a village to create a prostitute.”

In traditional Aboriginal societies in Saskatchewan, the thoughts and views of Aboriginal women were sought before decisions were made that affected the whole community. With the onset of colonization, that changed for many Aboriginal women. As Emma La Rocque (1994:1) points out: “Colonization has taken its toll on all Aboriginal peoples, but it has taken perhaps its greatest toll on women. Prior to colonization, Aboriginal women enjoyed comparative honor, equality and even political power in a way European women did not at the same time in history.” The colonization of Aboriginal people in Canada has been described by numerous authors and through a multiplicity of venues. Acoose (1995: 15-16) describes her own personal experiences,

My own journey towards liberation and empowerment left me often feeling angry, frustrated, and confused. At numerous times throughout my journey, I felt overwhelmed by negative feelings, and confused because my own way of seeing, being, knowing, and understanding the world (ideology) which had sustained my ancestors for thousands of years, and had continuously been assaulted by the canadian nation’s ideological forces.

The consequences of colonization for Aboriginal women in Saskatchewan have invariably been the same. In her account of colonization, Razack (2002: 24) points out that:

In order to maintain Canadians' self-image as a fundamentally "decent" people innocent of any wrongdoing, the historical record of how the land was acquired – the forcible and relentless dispossession of Indigenous peoples, the theft of their territories, and the implementation of legislation and policies designed to effect their total disappearance as people – must be erased. It has therefore, been crucial that the survivors of this process be silenced – that Native people be deliberately denied a voice within national discourses.

Aboriginal women in cities all over Canada, who have prostituted themselves, are telling examples of how deeply patriarchy wounds (Lynne, 1998:1). Lynne (1998:1) proposes: "When sexual oppression is intersected by racism, and capitalism, the wounding worsens - this compounded wounding for Aboriginal women has occurred for over 500 years."

Most studies about HIV/AIDS have been carried out in select populations that reflect the epidemiology of high-risk groups, such as Aboriginal women and prison populations.^{viii} Even though anxiety and fear of the spread of HIV/AIDS in Aboriginal communities is widespread with respect to Aboriginal people, Health Canada (1999a: 13) reports:

Forty percent of males and 18% of females had more than one sex partner in the preceding 12 months. Of these, 8% always used condoms, 31% sometimes and 61% never used condoms. Those who knew someone with HIV/AIDS or had good knowledge of AIDS were more likely to use condoms.

Health Canada (1998e: 17) also argues: "there has been very little systematic research on determinants of HIV/AIDS in on-reserve communities. Most research has focused on intravenous drug users and women in the urban population." With the high prevalence of STDs in the Aboriginal population in Saskatchewan, there is a great deal of concern, as the same risk behaviors for STDs apply to HIV/AIDS. Social and cultural factors involved in condom and safer intravenous drug use needs to be identified.

Health Canada's establishment of a hierarchy of "high-risk" groups for contracting HIV/AIDS echoes the stratification and social inequality in the general population. Health Canada assigns AIDS cases to a single exposure category in the hierarchy of modes of exposure or risk factors. If more than one mode is reported within a case, the case is classified in the exposure category that

is listed first in the hierarchy. For example, persons who are intravenous drug users may also be at risk of HIV infection through heterosexual activity. However, intravenous drug use is prioritized as the higher risk activity. These are the conditions under which Health Canada statistically defines groups of people who have contracted HIV/AIDS.

The lack of proper education in the medical profession about HIV/AIDS has reinforced the denial of HIV/AIDS as a health issue for women. There is generally a lack of funding for women-centered AIDS research, as well as other services and resources for women infected and affected by the disease. The stigma attached to HIV/AIDS as a “gay disease” has led to a lack of proper education that is gender-specific for women. Women are viewed primarily as the nurturers of children. When women contract the virus, they are assumed to embody all of the negative connotations of contracting the disease. When a man has multiple sex partners, it is viewed socially as a right of passage, and an acceptable practice. If a woman does it she is designated promiscuous and society condemns her for it. In the media’s initial images of homosexuals, junkies, and prostitutes acquiring HIV/AIDS, women were not seen as being “high risk”, and a great deal of the time, they are left out of the picture and not taken seriously.

It is not difficult to see from the viewpoint of colonized and marginalized groups, such as Aboriginal women in Saskatchewan, just how the HIV/AIDS crisis has once again brought the divisions of society to the forefront. These are divisions based on race, ethnicity, gender, and class. Berer (1993:39) holds that the conviction that HIV/AIDS is only confined to specific marginalized groups has succeeded in perpetuating “stereotypical views and prejudices about sexual identity and immoral sex, rather than accentuate the commonalties in sexual behavior.”

Razack (2002:126) when discussing the Pamela George case, argues:

While it is certainly patriarchy that produces men whose sense of identity is achieved through brutalizing a woman, the men’s and the court’s capacity to dehumanize Pamela George came from the understanding of her as the (gendered) Other whose degradation confirmed their own identities as white – that is, as men entitled to the land and the full benefits of citizenship... I underline how prostitution itself (through enabling men to mark the boundary between themselves and degenerate

Others) and the law's treatment of it as a contract sustain a colonial social order.

The sexual transmission of HIV/AIDS appears less frequent than it is. Epidemiology has not been gender-specific in the past, and gender is often unclear in AIDS statistics. Figures often do not state whether people infected through heterosexual intercourse, intravenous drug use, or blood transfusion are men or women. This has made risks among women less visible, even where many women are known to have HIV/AIDS. Epidemiological descriptions of HIV/AIDS in women have suffered from a mix of too much and too little visibility of women, to women's detriment. Many people consider HIV/AIDS to be a "promiscuous women's disease," along with all sexually transmitted diseases. Early HIV/AIDS posters warned men to beware of "those women," as posters have done in the past, with regard to other sexually transmitted diseases. Stereotypes continue to prevail, and many education and prevention efforts have not focused on women in particular (Berer, 1993:39).

Much of the concern about women contracting HIV/AIDS is focused on the potential risk to infants and not on the health of the mother. Although men infect most women it is women, and not their male partners, who are seen as the source of pregnancy-related infection of infants. As a result of all of these highlighted factors, women are often held responsible for spreading HIV/AIDS, whether as sex workers, wives and sexual partners, or mothers. Preventing women from transmitting HIV/AIDS has often had a higher priority in policy and programs than preventing women from getting the disease (Health Canada, 1998e: 4-5).

Women have been largely forsaken in the AIDS crisis in Saskatchewan. The initial discourse surrounding AIDS, as a "gay disease," has been extremely detrimental to the health of all women, including Aboriginal women. Feminists argue that, from the onset of the AIDS crisis, women were virtually invisible. Squire (1993:5) argues that frequently the AIDS discourse "repeats the common cultural erasure of women treating them as undifferentiated people as if their gender were invisible and unimportant." The primary campaign against AIDS reflects male needs and

experiences, because the dominant AIDS agenda was white and male. Even the categories that Health Canada describes as “high-risk,” are dominated by the male persona: homosexuals, bisexuals, and homosexuals who use intravenous drugs. Easton (1992:14) contends that AIDS emerged “in a world governed by patriarchal ideology and institutions” and that the response “was primarily defined by male-biased attitudes and values.” Women, specifically Aboriginal women in Saskatchewan, were not considered against the “high-risk” behaviors of white, gay males.

The fact that Aboriginal communities in Saskatchewan have been systematically oppressed and economically disenfranchised, places them at substantial risk of HIV infection. Amid the flurry of information, in medical and scientific journals, regarding HIV, its transmission, its link to AIDS, and groups most at risk, one thing has remained constant: poverty continues to provide the virus with a relatively invisible but fertile breeding ground. Health Canada (1998e: 7) maintains that the physical and social conditions on reserves and in urban areas in Saskatchewan, have led to extremely high rates of HIV infection. As the HIV/AIDS crisis among Aboriginal peoples in Saskatchewan continues to evolve, Health Canada (1998e: 2) argues, “The lack of information for Aboriginal women concerning the gravity of the disease limits the understanding of its impact on Aboriginal communities.”

The risk that HIV/AIDS poses to Aboriginal communities in Saskatchewan has not decreased. In fact, the general perception is that the risk level has risen and continues to rise. Discoveries about the nature of HIV infection - the increase in the heterosexual population and among women - have raised concerns about its potential for rapid spread in the Aboriginal community. Aboriginal communities remain unprepared, as Aboriginal women with HIV/AIDS continue to be banished and isolated due to ignorance and fear (Aboriginal Nurse’s Association, 1996:56). From a sexuality perspective, it has been pointed out that many Aboriginal women in Saskatchewan, especially young Aboriginal women, lack power and assertiveness in their sexual relationships. The fear of abandonment and violence often precludes their insistence on safer sex practices and

on a discussion about their partner's sexual history, to an even greater degree if a child is also involved in the relationship (Aboriginal Nurse's Association, 1996:11).

For Aboriginal women, unprotected vaginal sex with an infected partner is the primary method of HIV/AIDS transmission. The use of contaminated needles for intravenous drug injection is the second leading cause (Health Canada, 1998e: 9). There are three main categories of Aboriginal women in Saskatchewan affected by HIV/AIDS: women whose life choices place them at risk of HIV infection, women infected with HIV or who have AIDS, and women who care for persons with HIV/AIDS. Aboriginal women, whose choices place them at risk, comprise the largest number and that number is increasing (Aboriginal Nurse's Association, 1996: 7). In heterosexual relationships, women are often conditioned to assume a passive or submissive role, therefore do not have the power or control to insist on safer sex practices. Some Aboriginal women have been subjected to violence when they insist on safer sex. There is an increased risk of HIV/AIDS for those women who are unable to openly discuss their partners' sexual histories (Aboriginal Nurse's Association, 1996:49).

Sexuality and sexual behavior have received very little attention in the Aboriginal population. Little is known about the broader understandings of sexuality, including attitudes towards multiple partners, early sexual experience, and the rights of women. These attitudes need to be understood in the context of traditional/spiritual worldviews and the impact of Christianity on Aboriginal beliefs, which vary significantly across the country. Communicating with Aboriginal people, at the local or grassroots level can only help shed some light on these factors (Health Canada, 1998e: 18).

In their study titled, *HIV/AIDS and its Impact on Aboriginal Women in Canada*, the Aboriginal Nurses Association of Canada (1996:24) stresses:

It is important to note that ~19% of the respondents had their first sexual experience by age 14, ~33.5% by age 16, and ~ 47.2% by the age of 18. It can be surmised from this study that Aboriginal women have sexual relations at an early age, thereby increasing the opportunities for early pregnancy and also infections from sexually transmitted diseases

including HIV.

Health Canada (1999c: 1) and the Royal Commission on Aboriginal Peoples III (1996:11) argue that with regard to high rates of STDs, that in general, high reported case rates occur in Aboriginal communities with large social disparities and access to health care being major issues. As an example, Health Canada (1999b: 3) highlights that “in Quebec a total of 556 gonorrhoea cases were reported in 1997, representing an incidence rate of 7.5 per 100,000 population. For the same year, the Nunavik region had reported 23 cases or an incidence rate of 236.3 per 100,000 population; this is 31 times the incidence rate of the province.” The rate of gonococcal infection varies widely from province to province. Health Canada (1999b: 2) holds that the “rates for Manitoba and the Northwest Territories were three and fifteen times the national average respectively. The rate for the Northwest Territories (222.1 per 1,000,000 population) was the highest in the country and had increased by 18% in 1997 compared to 1996.” The Northwest Territories have the largest Aboriginal population in Canada, so the higher rate of gonococcal infection is understandable.

With respect to other sexually transmitted diseases, Health Canada (1999b: 4) points out that the “highest incidence of genital chlamydia has consistently been found in the Northwest Territories (1547.5/100,000, 13 times the national rate in 1997).” Aboriginal communities in Saskatchewan contend daily with a number of visible social and health problems. Many have also come to believe that they lack the power to change their disadvantaged social, economic, and political circumstances. The challenge for social researchers then becomes one of demonstrating to individuals that they do possess the power to change their own behaviors, in favor of more positive and safer alternatives (Leah 1995:8; Mariasy and Thomas 1990:13; Price 1989:17).

Through Health Canada statistics, it has been made clear that many Aboriginal communities in Saskatchewan are at increased risk of HIV infection, because of their low socioeconomic status and cases in Saskatchewan have grown steadily over the past decade. Women who are HIV infected are usually alone and often without the support of family or friends. Women may also

experience discrimination in a professional, social, and economic sense, if knowledge of their infection becomes known, whether it is in the community, on the street, or in a prison setting. Sexually transmitted disease rates among Aboriginal women are higher than the mainstream population. The Aboriginal Nurse's Association (1996:11) reports, "In some areas the rate is three to four times greater than the national average for some STDs, including chlamydia, syphilis, herpes and genital warts."

Saraswati and Sahas (1996:11) hold that "the role of religious institutions and the government through the implementation of residential schools can be directly linked with the increase of sexual violence in Aboriginal communities and the origins of a generation of victims of abuse." Besides serving as indicators of community disintegration, high rates of sexual and physical abuse are risk factors for HIV/AIDS transmission. Still, the AIDS issue continues to be inappropriately viewed in terms of blame and personal responsibility.

This is one of the more recognizable aspects of Aboriginal people in Saskatchewan, the ability to overcome and persevere.

2.1 Gender and HIV/AIDS

The fact that early AIDS was defined entirely by male clinical manifestations of HIV-related illnesses reflects the medical community's deadly refusal to recognize women's specific AIDS-related conditions. AIDS data provide information concerning HIV infections that have occurred in approximately the past ten years, whereas HIV data offer the patterns of more recent infections (Health Canada, 2001d: 3). Health Canada (2001d: 1) explains: "In Canada, of the 17,384 cumulative AIDS cases in adults reported up to December 31, 2000 to the CIDPC, 1,330 (7.7%) were among women. In 2000 women accounted for 10.1% of adult AIDS cases, however, the sample size so far for 2000 is small and further data are needed before this apparent decline can be confirmed." Women with HIV/AIDS in Saskatchewan are predominately women from Aboriginal communities. These women have historically been subjected to differential treatment that has resulted in substandard medical treatment and medical care. As Trypuc (1988:154)

indicates, they have more of a tendency than men “to be psychologically and socially dependent and economically disadvantaged.” Women can be at risk regardless of how they identify sexually.

Table 2.1 Number and cumulative total of adult AIDS cases by year of diagnosis and gender, Canada, and reported to LCDC up to June 30, 2001.						
Year of Diagnosis	Males		Females		Total	
	# Cases reported	Cum. Total	# Cases reported	Cum. Total	# Cases reported	Cum. Total
<1992	7,243	7,243	434	434	7,677	7,677
1992	1,599	8,842	115	549	1,714	9,391
1993	1,620	10,462	115	664	1,735	11,126
1994	1,581	12,043	132	796	1,713	12,839
1995	1,423	13,466	131	927	1,554	14,393
1996	926	14,392	125	1,052	1,051	15,444
1997	584	14,976	99	1,151	683	16,127
1998	509	15,485	94	1,245	603	16,730
1999	358	15,843	69	1,314	427	17,157
2000	312	16,155	38	1,352	350	17,507
June 2001	81	16,236	14	1,366	95	17,602
Total	16,236		1,366		17,602	

Source: Health Canada. *HIV and AIDS in Canada: Surveillance Report to June 30, 2001*. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD and TB, LCDC, HPB, Health Canada.

Each year as the proportion of cases due to heterosexual transmission increases in Saskatchewan, proportionally more of those infected are women. Women are getting HIV infection at a younger age than men are and this factor is easily overlooked if gender and social factors are not taken into account. Health Canada (2001d: 2) reports: “Before 1995, 9.9% of all positive HIV reports were among women. Between 1995 and 2000 this proportion increased from 18.8% to 23.9%. In 2000 women accounted for 51.5% and 40.8% of positive HIV test reports among those aged 15 to 19 years and 20 to 24 years respectively.” There is also an increase in positive HIV reports attributable to heterosexual sexual contact. As Health Canada (2000c: 2) points out: “In 2000 heterosexual contact and IDU (intravenous drug use) exposure categories together accounted for 94.4% of newly diagnosed HIV infections among women; this represents an increase from 81.0% for the period before 1995.” The data in Table 2.1 are incomplete, because the numbers do not

include AIDS cases diagnosed between January 1, 2001 and June 30, 2001 for the province of Ontario, as these data were not available at the time of publication. Numbers also exclude AIDS cases for which gender was not known. However, the data in Table 2.1 show that the number of women in Canada that had contracted HIV/AIDS had steadily increased from before 1993 to 1996. The total number of female AIDS cases peaked in 1994, with 132 cases. From 1995 to 1998 the number of female AIDS cases reported decreased from 131 cases in 1995 to 14 cases as of June 30, 2001. More recent data from Health Canada (2001d: 1) maintain that: “The proportion of AIDS cases among women (relative to all reported AIDS cases in adults, for which gender and age are known) has increased over time from 6.3% in 1991 to 8.5% in 1995 and peaking at nearly 16% in 1998 and 1999.” The number of AIDS cases among males has steadily decreased. The number of AIDS cases in males in Canada peaked in 1993 at 1,620 cases reported. From 1993 to June 2001 the number of male AIDS cases reported decreased from 1,620 cases to 81 cases. This is a decrease of 93% of total AIDS cases reported in 1993 to 85% of total AIDS cases reported in June 2001.

Prior to 1998, Blood/Blood Products was a combined exposure category, but has since been separated into two subcategories where possible. In Quebec the information on exposure categories of individuals who have tested positive for HIV are not available. Numbers include HIV test reports among females, for which age was unknown.

The HIV data in Table 2.2 are incomplete. As Health Canada (2000c: 11) states: “Prior to 1998, HIV data from Alberta were not available by age group and gender. Therefore, pediatric data are included in adult data for this reporting format.” Regardless, the data reveal a relatively high number of women in Canada who have been infected through heterosexual intercourse (782 cases) and intravenous drug use (1,174 cases).

Table 2.2 Number of positive HIV test reports among adult females by exposure category and year of test:								
Year Of Test								
Exposure Category	1985-1995 N/%	1996 N/%	1997 N/%	1998 N/%	1999 N/%	2000 N/%	2001 June N/%	Total N/%
IDU	533/ (36.2)	158/ (51.0)	125/ (45.0)	94/ (38.5)	127/ (48.1)	95/ (39.6)	42/ (33.1)	1,174/ (40.0)
Blood/Blood Products	157/ (10.7)	4/ (1.3)	4/ (1.4)	2/ (0.8)	1/ (0.4)	0/ (0.0)	2/ (1.6)	170/ (5.8)
Recipient of Blood	N/A	N/A	N/A	7/ (2.9)	2/ (0.8)	3/ (1.3)	1/ (0.8)	13/ (0.4)
Recipient of Clotting Factor	N/A	N/A	N/A	0/ (0.0)	0/ (0.0)	1/ (0.4)	0/ (0.0)	1/ (0.0)
Heterosexual Contact	586/ (39.8)	108/ (34.8)	88/ (31.7)					782/ (26.6)
Pattern II Country	N/A	N/A	N/A	15/ (6.1)	26/ (9.8)	30/ (12.5)	8/ (6.3)	79/ (2.7)
Contact with Person at risk	N/A	N/A	N/A	72/ (29.5)	63/ (23.9)	47/ (19.6)	45/ (35.4)	227/ (7.7)
NIR-HET	100/ (6.8)	27/ (8.7)	39/ (14.0)	42/ (17.2)	37/ (14.0)	55/ (22.9)	25/ (19.7)	325/ (11.1)
Other	98/ (6.6)	13/ (4.2)	22/ (7.9)	12/ (4.9)	8/ (3.0)	9/ (3.8)	4/ (3.1)	166/ (5.7)
NIR	324	22	16	15	18	20	9	424
Exposure Category Not Reported	1,630	208	204	208	243	228	117	2,838
Total	3,428/ (100)	540/ (100)	498/ (100)	467/ (100)	525/ (100)	488/ (100)	253/ (100)	6,199/ (100)

Source: Health Canada. HIV and AIDS in Canada: Surveillance Report to Dec. 31, 2001.
 Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS, STD, TB, LCDC, HPB, Health Canada, May/2001.

Intravenous drug use and unprotected sex in Canada are fueling the spread of HIV infection in women, particularly Aboriginal women, in Saskatchewan. Over time Health Canada (2002c: 18) indicates: “In 2001, heterosexual contact and IDU exposure categories together accounted for 95.1% of newly diagnosed HIV infections among women; this represents an increase from 82.7% for the period 1985-1995.”

Nevertheless, it is difficult to draw accurate conclusions when there is such a large number of positive HIV test reports, among adult females, that have no exposure category reported, 2,838 of 6,199 or approximately 46% of cases reported. Male-centered heterosexual expression is the acceptable norm against which all sexual expression is measured. Sexualities that do not emulate or support male-centered heterosexual sexuality are at best devalued and stigmatized and at worst legally restricted and violently opposed. Such are the conditions under which Aboriginal women in Saskatchewan are placed in their battle with HIV/AIDS in their communities.

2.2 Race, Ethnicity and HIV/AIDS

Health Canada (1999a: 4-5) suggests: “Issues related to ethnicity are not simple to address, especially when dealing with AIDS diagnosis or HIV infection.” Health Canada (2002a: 4) states: “HIV ethnicity data are not available for the remaining provinces and territories. As a result, the ethnicity data for HIV test reports should not be viewed as representative of all of Canada.”

There are numerous limitations regarding the accuracy of ethnicity data obtained from HIV and AIDS surveillance information. Patients in some communities may not wish to identify their ethnic background, resulting in under-representation. Also patients and physicians may only choose from a defined list that could artificially constrain choices for accurate ethnicity reporting. Furthermore, there is a wide variation in the completeness of ethnicity, among regions that may result in systematic under-representation of specific communities (Health Canada, 2002a: 4). Caution is recommended in interpreting the data, as there are no mechanisms for validating reported ethnic status. AIDS ethnicity data should not be interpreted as representative of HIV/AIDS specific to groups of people, but only as reported AIDS cases (Health Canada, 2002a: 4).

As a result of these limitations, caution should be taken in translating the HIV and AIDS ethnicity data presented. This is particularly true of the HIV test report data that are presented, which lack ethnicity information (Health Canada, 2001a: 6). Health Canada (2000a: 5) notes:

“Despite the limitations associated with ethnicity reporting, available evidence suggests that Aboriginal people are infected at a younger age than non-Aboriginal people, that intravenous drug use is an important mode of transmission, and that the HIV crisis among Aboriginal people shows no sign of abating.”

Health Canada (2002a: 1) also stresses: “As with other demographic identifiers, ethnic information can contribute to the creation and evaluation of targeted prevention and treatment programs, as well as to the development of health policy.” To reach a better understanding of how the HIV/AIDS epidemic in Saskatchewan is affecting different ethnic communities, there needs to be a more complete and accurate reporting of Aboriginal specific data.

Health Canada (2002a: 1) explains: “Since 1982, when the first AIDS case was reported in Canada, a total of 85.1% (15,339/18,026) of AIDS case reports have emerged in the period between 1992-2001.” The consistency of ethnicity reporting in AIDS cases has improved over time. Health Canada (2002a: 1-2) found that: “Between 1982 and 1991, 80.2% of reported AIDS cases indicated ethnicity. This figure increased to 88.8% in the period between 1992-2001. Reporting on ethnicity peaked in 1998 at 93.7%, but has since declined to 87.8% in 2001.”

Year	1998	1999	2000	2001
Percent	26.1%	30.5%	32.2%	30.9%

Source: Health Canada. *Ethnicity Reporting for AIDS and HIV in Canada*. Bureau of HIV/AIDS, STD, and TB Update Series, April 2002.

The ethnicity data concerning HIV reports in Canada has only increased from 26.1% in 1998 to 30.9% in 2001. There is still a great deal of work to be done to generate an increase in ethnicity reporting in HIV/AIDS cases.

“The majority of positive HIV test reports with ethnicity information are among Whites, similar to the situation seen in reported AIDS cases. Whites represented 66.9%, 60.6%, 60.3% and 59.8% of positive HIV reports with known ethnicity in 1998, 1999 and 2000 and 2001 respectively”(Health Canada, 2002a: 4). In 1998, “19.3% of positive HIV tests with known

ethnicity were among Aboriginal persons, as compared to 24.3% in 1999 and 22.3% in 2000 and 25.9% in 2001. These proportions are higher than the proportions attributed to Aboriginal persons for reported AIDS cases. This is likely due, in part to the HIV ethnicity information being primarily from the western provinces, where the Aboriginal population is greater” (Health Canada, 2002a: 4). Compared to other ethnic groups in Canada, Aboriginal persons account for a higher proportion of positive HIV test reports where ethnicity has been reported. For AIDS diagnoses in 2000, 74.8% were reported among Whites, marking a continuous decline in the proportion of AIDS cases in this ethnic category since 1991. This is not so for Aboriginal peoples. Aboriginal AIDS cases have shown the smallest decline in the annual reported cases in Aboriginal communities. Instead, they have continued to increase since the onset of the AIDS crisis in Canada. Health Canada (2001b: 1) contends: “In 1999 an estimated 370 Aboriginal persons in Canada were newly infected with HIV; at the end of 1999 an estimated 2,740 Aboriginal persons were living with HIV.” The annual number of Aboriginal AIDS cases has steadily increased until 1995 and has remained stable since then. This trend is in stark contrast to the decline in the overall number of reported AIDS cases for other ethnic groups (Health Canada, 2001b: 4).

Ethnicity data for positive HIV/AIDS test reports are not available for all provinces and/or territories. Health Canada (2000a: 3) maintains: “In 1998 25.6% (597 cases) of the 2,330 positive HIV tests had associated ethnicity information. In 1999 this number increased to 29.1% (650 cases) of 2,231 positive HIV tests reported.” The largest numbers of HIV-positive test reports that do have ethnicity information are among the White population.

As well Health Canada (1998b: 3) points out: “the proportion of new HIV-positive tests among Aboriginal persons attributed to heterosexual groups were 12.8% in BC, 13% in Alberta, and 28% in Saskatchewan; 481/1,742 of individuals who tested positive at anonymous HIV testing programs in 1996 were Aboriginal.” Aboriginal people constitute a significant proportion of positive HIV/AIDS tests with known ethnicity. Health Canada (2000a: 3) suggests: “Although

the percentage of positive HIV tests with reported ethnicity is low (27.3% since 1998), Aboriginal persons constitute a significant proportion of positive test reports.” Whites continue to comprise the majority of cases with reported ethnicity but Aboriginal people represent a growing proportion of positive tests. Health Canada (2000a: 3) found in 1998: “19.4% of positive tests were among Aboriginal people as compared to 24.8% in 1999.” Since ethnicity data for positive HIV/AIDS tests have only been available since 1998, comparisons can only be made in a limited time frame (Health Canada, 2000a: 4). Health Canada (2001b: 3) points out: “Positive reports from provinces with ethnicity reporting (British Columbia, Yukon Alberta, Saskatchewan, Manitoba, Newfoundland, and Prince Edward Island) indicate that Aboriginal persons were over-represented among new HIV diagnoses, i.e. 19.5% in 1998 and 17.7% in 2000.”

Table 2.4 Aboriginal AIDS cases in Canada with respect to exposure category and gender, and percentage distribution April/2000:		
Exposure Category	Male	Female
Men who have sex with Men (MSM)	49.4%	N/A
Intravenous drug use (IDU)	26.1%	64.7%
MSM/IDU	12.9%	N/A
Heterosexual contact	9.4%	30.7%
Blood/clotting factors	0.6%	2.3%
Perinatal transmission	1.6%	2.3%
Total	316 (100%)	93 (100.0%)

Source: Health Canada. HIV/AIDS Epi Update. *HIV and AIDS Among Aboriginal Persons in Canada Remains a Pressing Issue*. Bureau of HIV/AIDS, STD and TB CIDPC, Update Series Health Canada, May/2001.

The data in Table 2.5 reveal that the majority of male Aboriginal AIDS cases are attributed to men who have sex with men (MSM) (49.4%), and intravenous drug use (26.1%). The interpretation of AIDS data, among Aboriginal people in Saskatchewan, is difficult when ethnic information is lacking. Health Canada (1998e: 9-10) notes:

With respect to HIV data, HIV testing and clinical data are available only for those who volunteer for testing and/or treatment; thus they do not represent the total number of Aboriginal people infected with HIV. Therefore, generalizability of these results to the general Aboriginal population or populations living on reserve is limited.

The consequences of epidemiological research are not always positive. As O'Neil et al. (1998:10) state: "Blind HIV testing is recognized to potentially cause harm to groups or individuals through stigmatization or discrimination and ethical guidelines have been developed in an attempt to minimize this effect." The information revealed above may be invaluable to community health groups and public health planners for planning outreach and public health campaigns, whose goals are to reduce the number of HIV infections and to treat afflicted members of their respective communities.

2.3 Class and HIV/AIDS

Female poverty brings with it an increased risk of HIV infection through restricted access not only to health information but also to health services, such as STD treatment and condom supplies. Apart from the fact that women in Saskatchewan with low incomes cannot afford condoms, often their negotiating position with sexual partners is undermined by economic dependence. Poverty affects attitudes to conscious risk-taking in complex ways. When too much energy is expended upon basic survival, people tend to ignore a disease that may or may not materialize for seven to ten years. The contending issues of poverty can crowd out the seriousness of HIV/AIDS (Easton, 1992:16). This, according to Mariasy and Thomas (1990:36), can result in "a lack of economic, social, cultural, sexual and technological options to lead vulnerable women to concentrate on addressing the more immediate risks in their lives: poverty, homelessness and the frequent disruption of socioeconomic support systems."

As the heterosexual spread of HIV/AIDS increases in Saskatchewan, the relationship between social and economic advantage and risk behaviour becomes clearer. Many of the factors that contribute to a higher risk of HIV infection are associated with economic and social disadvantage. Saraswati and Sahas (1996:10) claim that: "HIV infection rates are interrelated with the general health conditions of communities." The general health of Aboriginal people in Saskatchewan indicates that there is a very high risk of HIV/AIDS transmission. De Bruyn (1998:11) points out: "The cumulative effect of HIV/AIDS-related stigma and discrimination is to objectify,

marginalize and exclude people with HIV/AIDS. Those who were already objectified, marginalized and excluded are pushed even further from recognition of shared humanity and from the support of human society.”

Stigma and discrimination contribute to the vulnerability of people living with or affected by AIDS at both the societal and personal level. Stigma is a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed by others. People who are stigmatized are usually considered deviant or shameful and as a result, are shunned, avoided, discredited, rejected or penalized. As such, stigma is an expression of social and cultural norms and marks the boundaries a society creates between “normal” and “outsiders” (de Bruyn, 1998:12). HIV/AIDS is associated with behaviors that are already stigmatized or considered deviant, particularly homosexuality and intravenous drug use. Often HIV/AIDS is seen as a moral fault, such as promiscuous or deviant sex, that deserves punishment.

Ethnic groups in Saskatchewan such as Aboriginal women, who have already been discriminated against with respect to employment, housing, and health care, are further discriminated against because they are HIV-positive. The majority of Aboriginal women in Saskatchewan live under very low socioeconomic conditions and in a class of poverty. In Canada and the United States de Bruyn (1998:18) argues: “those people who were marginalized, stigmatized and discriminated against before HIV/AIDS arrived, have become over time those at highest risk of HIV infection.” Regardless of where it began the brunt of the epidemic has inexorably moved toward those who bear the greatest societal burden. In Saskatchewan, the epidemic has increasingly occurred among ethnic minority populations in inner cities, intravenous drug users and women.

The experience of stigma and discrimination within a specific community is complicated by the fact that the community is already a minority in society as a whole and often marginalized. This has implications for both the person with HIV/AIDS and for the community. For the person with HIV/AIDS it means that there may be nowhere else to go once he/she has been isolated

within his/her own community. For the community it means that it is difficult to address issues associated with vulnerability to HIV infection (such as sexual activity, homosexuality and relations between men and women) and supporting people with HIV/AIDS (de Bruyn, 1998:18).

De Bruyn (1998:19) maintains, “women have experienced discrimination when their physicians have failed to advise them about HIV testing, have discouraged them from being tested or have associated the risk of HIV infection with negative connotations of “promiscuity.” This discrimination cannot be understood or adequately addressed without first looking at the cultural identities of women, perceptions of risk of HIV infection, and populations most affected by HIV infection among women (de Bruyn, 1998:19). De Bruyn (1998:19) also argues:

...the risk of HIV infection experienced by Aboriginal peoples, as a result of their overrepresentation among drug users and in prison populations, cannot be understood or addressed without recognizing the events and structures, both past and present, that have contributed to substance abuse, migration, unemployment, cultural displacement and despair among Aboriginal people in Canada.

The poor health status prevalent among Aboriginals in Saskatchewan is a significant risk factor in the rapid spread of HIV/AIDS and other infectious diseases. This is further exacerbated by the increased incidence of tuberculosis in the Aboriginal community. As (RCAP, 1996 III: 8-9) in their chapter titled, “Gathering Strength” contends: “To the extent that they have continued to experience lower incomes, inferior housing conditions and more contaminated water, they continue to suffer from infectious diseases in like measure.” It is not difficult to envision the ultimately deadly impact of the co-infection of HIV/AIDS and tuberculosis. ^{ix}De Bruyn (1998:19) indicates:

...any analysis of what makes people vulnerable to HIV infection or what makes people with HIV vulnerable to sickness and death, must now take into account the role of poverty, independent of any risk factors, in leading to HIV infection and to sickness and death and how the structures of our economy and our society benefit (discriminate in favor of) people with higher incomes or more wealth.

HIV/AIDS feeds on poverty and is insidiously linked to sexually transmitted disease; discrimination and marginalization exacerbate women's inequality and the migration of populations and all of these issues. Saraswati and Sahas (1996:11) in their conference titled "Building Bridges: Responding to HIV/AIDS in Ethnocultural and Aboriginal Communities," state:

A combination of poverty, powerlessness and loss of Aboriginal societal values is characteristic of the conditions in many Aboriginal communities. The lack of self-esteem that contributes to a higher than average suicide rate among Aboriginal people also contributes to high-risk behaviors and substance abuse. Aboriginal homosexuals face discrimination from their own communities as well as the combination of homophobia and racism within non-Aboriginal society.

The likelihood of an Aboriginal person contracting HIV/AIDS is much greater than the non-Aboriginal person (Health Canada, 1999b: 4). It is important that Aboriginal communities in Saskatchewan receive education that is appropriate to understanding the "real" impact that AIDS is having in their communities (Saraswati and Sahas, 1996). As well, the impact of colonialism on Aboriginal communities in Saskatchewan cannot be ignored.

The arrival of the Europeans, disease, paternalism, segregation, assimilation, Christianization and the Indian Act transcend into who Aboriginal people are today. It is only by understanding the past and recognizing the issues that they have had to face that it will be possible for them to move forward (La Rocque, 1994:3). La Rocque (1994:10) insists:

People need to understand the disintegrative processes of colonization; they need to know the consequences of having been defined outside themselves, of being powerless. Aboriginal people need to understand the institutional forces of invasion in their worlds and what that has done to their lands and economies, their relationships, their cultural values and symbols, their self-determination and self-confidence.

Razack (2002: 25) argues that: "For Indigenous people, telling our histories involves recovering our own stories of the past and asserting the epistemological foundations that inform our stories of the past. It also involves documenting processes of colonization from the perspectives of those who experienced it." Aboriginal people in Saskatchewan must also

understand that they have within themselves the power to move their lives forward, in a more positive direction. La Rocque (1994:10) stresses that in order to make restoration possible, “they need to believe that they can act to make changes and that by acting on issues they are empowering themselves. People may best be able to make changes once they can articulate the places of invasion in their lives and in their histories.”

Excessive use of alcohol, which increases the chance of unprotected sexual activity, is also a risk factor in some communities in Saskatchewan. Groups in which the rate of HIV/AIDS is already high, such as street youth, prostitutes, and the prison population include a significant number of Aboriginal women. Even more troubling is the fact that many Aboriginal people in Saskatchewan apparently do not think of AIDS as a disease that affects them. Some think of it as a gay disease, imagining that homosexuality is rare among Aboriginal people; as a city disease, imagining that it will not follow them into small or isolated communities; or as a white man’s disease, imagining that it can somehow be restricted to non-Aboriginal people. These are false hopes (RCAP, 1996 III: 12).

The fact that many, perhaps most Aboriginal people in Saskatchewan who are gay choose to hide their sexuality increases their risk. Further, the tendency of Saskatchewan Aboriginal women to migrate freely between their home communities and urban centers makes it inevitable that transmission of the virus from city to country will occur. As for cultural or group distinctions HIV/AIDS spares no one. In other words, Aboriginal women are vulnerable, all the more so if they do not think they are and, therefore, take no precautions. In their chapter titled “Gathering Strength”, The Royal Commission on Aboriginal Peoples: Final Report (1996:1) states:

Many Aboriginal women are isolated, impoverished and suffering from low self-esteem and sometimes emotional pain. Frequent barriers these women encounter in accessing health care [include] lack of medical coverage. Often women are transient and come here from other provinces, and there’s a lapse in their care. Sometimes [such a lapse] occurs when teens are away from their families [when pregnant] and don’t have communication with them and they don’t have their [health] card numbers, and it takes us days and days to get them to a physician.

These are the Aboriginal women in Saskatchewan who end up in large urban centers, and living on the streets of cities. RCAP (1996, IV: 3) argues: “Low self-esteem and loss of identity [is an issue]. Many are grieving individual and/or collective Aboriginal spiritual and cultural losses and, therefore, feel powerless [to help themselves].” There is no doubt in the minds of many Saskatchewan Aboriginal women that they suffer from low self-esteem, feel that they are powerless to make any positive changes in their lives and that life is a daily struggle for them. According to (RCAP, 1996 IV: 1), titled “Perspectives and Realities,” the plight of Aboriginal women in urban areas is highlighted:

Although their roles in formal and informal institutions are crucial to the day-to-day survival of urban Aboriginal people, the needs of urban Aboriginal women are virtually invisible and the reality of their lives often remains unrecognized and invalidated. In their submissions to Commissioners, they called for their presence to be recognized and their needs acknowledged.

When Aboriginal women in Saskatchewan move to urban centers they become oppressed, marginalized, and disenfranchised from their community and from society. RCAP (1996 IV: 12) in the chapter titled “Perspectives and Realities”, argues: “Almost half of all Aboriginal people in Canada live in urban areas... culture is not something Aboriginal people discard at the city limits. The cultures in which people are raised and given their identity reside deep inside them and shape every aspect of their being - wherever they happen to be living.” There are numerous reasons that Aboriginal women in Saskatchewan move from their home communities to the city. As RCAP (1996 IV: 12) reports:

Some 320,000 self-identified Aboriginal people live in cities - that’s 45 percent of the total Aboriginal population, and the proportion is expected to grow. Aboriginal people come to the city for many reasons. Often they seek new opportunity - education, a job, and a chance to improve their lives. Some women leave home to escape abuse. Others are denied residence in their home communities.

Aboriginal women in Saskatchewan are markedly disadvantaged in comparison to their non-Aboriginal neighbors. Aboriginal women face an enormous struggle to maintain their culture and identity in urban settings, let alone pass them on to their children. RCAP (1996 IV: 12) notes:

...City life, with its myriad of cultures and lifestyles, does not necessarily validate theirs. Episodes of racism lead many to question their identity, and self-worth. Some told us they fear losing themselves, or they feel torn between worlds. Others repudiate their identity by denying their aboriginality of falling into self-destructive behavior.

In a submission to the Commission, Shirley Gamble (RCAP, 1996 IV: 1) states:

Indian country is not [just] a man's world. Women will continue to be resident as long as man will exist and inhabit these same territories, and so will our children and their children always. Status women resident off reserve are too often a forgotten minority. Many become urbanized due to family abuse, separations and deaths, others, for personal reasons. These women and their children are the abused, personally and mentally.

The majority of Aboriginal people in Saskatchewan who become city dwellers are women. The reasons that Aboriginal women leave their communities are more often than not sexual and physical abuse (RCAP, 1996 IV: 2). As RCAP (1996 IV: 2) points out:

All too typical was the woman who told of leaving home at 13 and growing up on the street. For her, the choice was either living in a small rural community and being sexually abused and silenced by her family, or leaving the community and living on the streets of the city, which though violent, felt safer.

Another major reason that Aboriginal women have moved away from their home communities is because of disenfranchisement.^x (RCAP, 1996 IV: 2) describes how disenfranchisement has affected many Aboriginal women in Saskatchewan:

...because they lost status (usually by marrying a non-Indian) and the legal right to reside there under paragraph 12(1)(b) of the Indian Act. Since 1985 and the passage of Bill C-31 which amended the act, many have regained their status. Women who have regained status are more likely than men to live in urban areas are, as are women who have applied for reinstatement. Many Aboriginal women have no option therefore, but to live in urban areas, even though they would prefer to live in their community of origin. Their options are circumscribed by abuse, loss of status or the fact that their needs and perspectives are not taken into account by decision-makers in their communities.

The experience of urban Aboriginal women in Saskatchewan has been one of isolation and enhanced risk potential for substance abuse and HIV/AIDS. (RCAP, 1996 IV: 2-3) points out:

While some women with Bill C-31 status prefer to live in urban areas, others want to return to their reserve community, but cannot, because there are no resources to accommodate them, or band membership codes exclude them...Unemployed and left to their devices, they often feel alienated and alone, helpless, powerless, and “without a voice”...Instead of solving the status question once and for all, Bill C-31 created new divisions and new fears.

Aboriginal women have also had to deal with negative stereotypes, racism, sexism, and discrimination that are rampant in Canadian society, including Saskatchewan. Discriminatory policies have been aimed at the direction of Aboriginal women since the implementation of the first Indian Act. RCAP (1996 IV: 8) contends:

It is necessary to begin by recalling that for a century, as a result of the enactment of the Indian Act, which purely and simply legalized discrimination, an Aboriginal woman who married a non-Aboriginal was driven out of her community, cut off from her family and deprived of her status and some of the rights pertaining. Before the legislation of the first Indian Act in 1876, there was a “subjective sense of belonging” that was implied by membership in an Aboriginal nation thereto [translation].

RCAP (1996 IV: 9) stresses:

Membership was thus a function of the sense of belonging, the “common mental experience”, and was determined by each nation on the basis of age-old principles derived from its own traditions of recognition, acceptance and kinship. In all cases, questions of membership were for the Aboriginal nation itself to decide. There was no externally imposed definition of who could identify with and belong to a particular people or nation.

Following the enactment of the Indian Act, RCAP (1996 IV: 9) states: “Canadian law changed all that, beginning in the historical period of displacement and assimilation. Many of the laws from this period are still operative.” The definition of who was and was not an Indian and the entitlements afforded to those who fell within that definition, was now legislated by the Canadian government. RCAP (1996 IV: 9) reports:

Many Aboriginal people told the Commission that government policies and legislation designed to undermine their collective sense of identity

have chipped away at the right to be self-governing, self-determining peoples. From this perspective, Aboriginal peoples have been distinctly disadvantaged. If we accept this-and in the face of irrefutable evidence, we do-then Aboriginal women must be considered doubly disadvantaged.

With respect to the AIDS crisis, one can go one step further and say that Aboriginal women in Saskatchewan with HIV infection are triply disadvantaged. According to RCAP (1996 IV: 9), the disadvantages that Aboriginal women face emanate from the fact that:

The colonial and post-Confederation legislation applied to Aboriginal people finds its conceptual origins in Victorian ideas of race and patriarchy. Its effects have been increasingly to marginalize women in Aboriginal society and to diminish their social and political roles in community life. For example, after 1876 and the passage of the Indian Act, Indian women were denied the rights to vote in band elections or to participate in reserve land-surrender decisions and where their husbands died without leaving a will, they were required to be 'of good moral character' in order to receive any of their husband's property.

Aboriginal women no longer controlled their own identity and were defined in relation to their husbands and their husband's status. As RCAP (1996 IV: 10) maintains:

The issue of identity under the Indian Act has been and continues to be a source of personal pain and frustration for Indian women. Through its restrictive and sexist definition of 'Indian' and the selective application of the involuntary enfranchisement provisions, the Indian Act has created a legal friction as to cultural identity. This has profoundly affected the rights of women in Indian ancestry, denying these rights entirely in the case of the thousands of women and their descendants who were subject, against their will, to loss of status and enfranchisement and to subsequent removal from their home communities because they married men without Indian status. Categories of aboriginality have been created through Canadian laws as though Aboriginal identity and the rights that go with that identity could be chopped and channeled into ever more specific compartments or, in some cases, excised completely.

For many Aboriginal women in Saskatchewan, the Indian Act remains monumental to the history of discriminatory federal policy. Thus, to understand the present situation of women under the Indian Act, it is helpful to look at how that policy developed and how Victorian notions were transformed into fundamental policy principles that continue to affect the lives of Aboriginal women today (RCAP, 1996 IV: 1).

The rules and regulations that were applied to Aboriginal women's lives by government officials were infinite and at the expense of these women. They were unable to vote in band elections and if they married an Indian man from another band they lost membership in their home communities. If an Aboriginal woman married out by wedding a non-Indian man, she lost Indian status, membership in her home community and the right to transmit Indian status to the children of that marriage (RCAP Final Report, 1996:11). If an Aboriginal woman married an Indian man who became enfranchised, she lost status, membership, treaty payments and related rights and the right to inherit the enfranchised husband's lands when he died (RCAP Final Report, 1996:11).

The 1876 Indian Act consolidated and expanded previous Indian legislation, carrying forward the provisions that put Indian women at a disadvantage compared to Indian men. J.R. Miller (In RCAP, 1996 IV: 14-15) wrote:

The Indian Act's tracing of Indian descent and identity through the father was the unthinking application of European patrilineal assumptions by a patriarchal society...Although most of the provisions that discriminated against women were simply carried forward from the earlier legislation...in 1884, an amendment permitted the wife of an Indian man who held reserve land by location ticket to receive one-third of her husband's estate, if he died without a will. But the amendment stated that the widow might receive it only if she was living with him at the time of death and if federal authorities determine "she has good moral character". This amendment applied standards to women that were not applied to men.

The high incidence of sexual violence experienced by Aboriginal women and children, is an additional indicator of the general social health conditions in Aboriginal communities in Saskatchewan. Colonization has been the source of diminutive status for Aboriginal women. Paternalism now pervades Aboriginal communities. In some Aboriginal communities this paternalistic view has been reinforced by Christian Churches (RCAP, 1996 IV: 9). "The Catholic Church in particular, takes stances that promote homophobia and support the idea of a sexually subservient woman" (RCAP, 1996 IV: 11). The role of religious institutions and government can

be directly linked to the increase of sexual violence in Aboriginal communities in Saskatchewan and the origins of generations of victims of abuse.

As stated by Linda Day (In RCAP, 1996 IV: 13):

One of [our] concerns is the lack of education on the virus and the lack of support, care and treatment for those individuals who are living with AIDS. Often entire families are shunned, rejected, and even attacked in communities when other members learn a family has AIDS. At a time when the individual and their families most need support and compassion, the individual cannot even return home to receive proper care and treatment. Fear based on ignorance has meant that people who are living with AIDS are denied the right to live and die with dignity in their own communities.

This issue needs to be addressed with care and compassion and most of all with speed. Further proposals for action, to assist people with HIV/AIDS and for the suitable collective response, must come from within Aboriginal nations and communities. If the ideas initiate education measures to prevent the spread of the infection among high-risk groups elsewhere, they will fail to take into account Aboriginal sensibilities and social realities (RCAP, 1996 IV: 15). This is true of all health and social welfare issues, but particularly issues that are culturally or socially sensitive.

Chrisjohn (1991:173) argues:

As a tool of assimilation, the residential school system failed, but it was successful in causing irrevocable damage to Aboriginal culture. Its damaging impact has had serious consequences. Children that were taken from their families and communities and held captive within these schools are still suffering the consequences of those actions. Parental care and guidance were lost and was replaced by institutionalized childcare characterizes by authoritarianism, often to the point of physical, psychological, and sexual abuse.

The cases of sexual abuse of Aboriginal children in Aboriginal communities in Saskatchewan, are reaching crisis proportions. This form of violence has been the legacy of colonialism as well.

Family violence is a particularly alarming manifestation of the erosion of traditional norms of interpersonal respect. As RCAP (1996 IV: 3) reports: "Many women spoke to us of fear for the safety of their children and themselves and the need for places of refuge. In some communities,

especially smaller ones, it can be hard for a woman and her children to find a safe haven.”

Aboriginal women want to see their leaders and communities take a stand of zero-tolerance against family violence. They also see a great need for more culturally appropriate counseling programs and services for both the perpetrator and the victim (RCAP, Final Report, and 1996:3).

2.4 Sex, Sexuality and HIV/AIDS

Sexual behavior in its social, economic and political context is the real challenge of the AIDS crisis. Decisions about sexual behavior cannot be separated from the wider social and cultural influences that inform human behavior. HIV/AIDS is not merely a medical issue. It raises the fundamental issues of equality between the sexes. An unequal power dynamic between women and men results in a debilitating double standard for male and female sexuality.

As La Rocque (1994:4) points out: “One of the central questions we need to address is this: we know there has been violence by white men against Aboriginal women, but what do we make of violence by Aboriginal men against Aboriginal women and children?” Accepting the familiar underlying accounts for this violence is not enough. La Rocque (1994:4) holds:

Too often the standard answer or reason given is that Aboriginal “offenders” were themselves abused and/or victims of society. There is no question that this answer may be partly true for some of the abusers, especially the young. However, it is hardly a complete answer and certainly should not be treated as the only or final answer to this problem.

It does not suffice it to say that Aboriginal men did not become violent towards Aboriginal women until the advent of European contact. In pre-contact and contact times, missionaries as well as Aboriginal people themselves have made reference to the use of violence by Aboriginal men toward Aboriginal women (La Rocque, 199:4). La Rocque (1994:4) contends: “It should not be assumed that matriarchies necessarily prevented men from exhibiting oppressive behavior toward women. There were individuals who acted against the best ideals of their cultures. Even today, all the emphasis on Mother Earth has not translated into full equality and safety of women.”

There is no doubt, however, that European colonization exacerbated the extent, nature or potential for violence that existed in original Aboriginal cultures. Neither is it too difficult to understand how Aboriginal men may have internalized the white male devaluation of women (La Rocque, 1994:12). As La Rocque (1994:13) notes: “Deprived of their ancestral homes...men began to move into areas that had previously been the province of women, adopting some of the white attitudes toward women and treating them as inferiors rather than equals.” The roles performed by Aboriginal women and Aboriginal men were no longer of equal importance to the well-being of their communities. “Clear divisions of labor along gender lines existed, [but] women’s and men’s work was equally valued...Everyone in the camp worked hard and everyone had a specific role...” (Martha Flaherty, RCAP, 1996 IV: 6).

Marlyn Kane (In RCAP, 1996 IV: 5) states:

At the beginning, when the “others” first came here, we held our rightful positions in our societies, and held the respect due us by men, because that’s the way things were then, when we were following our ways. At that time, the European woman was considered an appendage to her husband, his possession. Contact with that...and the imposition of his ways on our people, resulted in our being assimilated into those ways. We forgot our women’s responsibilities and the men forgot theirs.

In order to understand the effect that these changes have had on Aboriginal women, Winona Stevenson (In RCAP, 1996 IV: 5) offers these words:

...The deconstruction of our colonization will shed considerable light on why our communities are so troubled today and why Aboriginal women are at the bottom of Canada’s socio-economic ladder...[O]ur re-education will serve to bring more people home, to encourage our youth and lost ones to safely reconnect with their pasts and communities.

Aboriginal women need to begin to deal with these issues and as Stevenson (1996:5) concludes: “Once our beliefs become founded on more secure bases, individual confidence, self-esteem and pride will grow.”

La Rocque (1994:3) suggests that one only has to consider the “racist/sexist views of the “Indian” male as a violent “savage” and the Aboriginal female as a debased, sexually loose

“squaw”.” These stereotypes have done nothing but perpetuate the sense of superiority that Europeans felt over Aboriginal people in Saskatchewan. As a result La Rocque (1994:4) argues: “Aboriginal internalization of racist/macho views of Aboriginal men and women has contributed to violence generally and to sexual abuse specifically.” Erroneous cultural explanations have created enormous confusion for Aboriginal people with respect to a number of issues that affect them on a daily basis. La Rocque (1994:5) stresses:

Besides the problem of typecasting Aboriginal cultures into a static list of “traits,” 500 years of colonial history are being whitewashed into mere “cultural differences,” Social conditions arising from societal negligence and policies have been explained away as “cultural.” Problems having to do with racism and sexism have been blamed on Aboriginal culture. When cultural justifications are used on behalf of the sexually violent, we are seeing a gross distortion of the notion of “culture” and of Aboriginal peoples.

As La Rocque (1994:5) astutely points out: “Men assault, cultures do not. Rape and violence against women were met with quick justice in original cultures. And if there is any culture that condones the oppression of women it should be confronted to change.” Aboriginal women who have been raped or sexually abused at an early age rarely escape an inevitable lifetime of devastation. La Rocque (1994:9) describes Aboriginal women as suffering from “post-traumatic stress syndrome, which can be seen in the level of female violence, alcoholism and extent of incarceration.” Aboriginal women today are over-represented in each of these institutions in society. La Rocque (1994:3) indicates:

A complex of white North American cultural myths, as expressed in literature and popular culture, has perpetuated racist/sexist stereotypes about Aboriginal women. A direct relationship between racist/sexist stereotypes and violence can be seen, for example, in the dehumanizing portrayal of Aboriginal women as “squaws”, which renders all Aboriginal female persons vulnerable to physical, verbal and sexual violence.

Sexist and racist attitudes toward Aboriginal women have never been totally discarded in Canadian society. La Rocque (1994:3) maintains: “One of the many consequences of racism is that over time racial stereotypes and social rejection may be internalized by the colonized group.

The internalization process is one of the most problematic legacies of long-term colonization.” This has proven to be especially evident in the lives of Aboriginal women in Saskatchewan. One would only have to take a walk along the “stroll” in any city in Saskatchewan to see that the majority of the working girls there are very young and are Aboriginal.

La Rocque (1994:3) describes Howard’s concept of internalization, in his book, *Prison of Grass* (1975):

By this he meant that as a result of disintegrative processes inherent in colonization, Aboriginal peoples have subconsciously judged themselves against the standards of white society, often adopting what he called the White Ideal. Part of this process entails “internalizing” or believing-swallowing the standards, judgments, expectations and portrayals of the dominant white world. Many other Aboriginal writers have pointed to the causes and consequences of having struggled with externally imposed images about themselves and the policies that resulted from them. The result was/is often shame and rejection not only of the self, but also of the similar other, i.e., other Aboriginal people.

At present, many young Aboriginal women in Saskatchewan state that they are not comfortable and that they do not deserve anything better than the street, where most of their friends and some of their relatives are. La Rocque (1994:3-4) acknowledges:

Since *Prison of Grass* was written things have changed in Aboriginal communities. A lot more Aboriginal people are aware of the whys and wherefores of their position in Canadian society. As more Aboriginal people grow in political awareness, they are less prone to judge themselves or act by outside standards. However, the damage has been extensive, and the problem of internalization does still exist. It is still of value to study how Aboriginal internalization of racist/sexist stereotypes may be at work in the area of violence.

Since colonization, Aboriginal women in Saskatchewan have suffered from the actions and attitudes of European society, as well as members of their own communities. For La Rocque (1994:3):

Colonization and sexism go hand in hand. Racism has provided justification for the subjugation of Aboriginal peoples. While all Aboriginal people are subjected to racism, women further suffer from sexism. Racism breeds hatred of Aboriginal peoples; sexism breeds hatred of women. For Aboriginal women, racism and sexism constitute a package experience. We cannot speak of sexual violence without at once addressing the effects of racism/sexism. Sexual violence is related to

racism in that racism sets up or strengthens a situation where Aboriginal women are viewed and treated as sex objects. The objectification of women perpetuates sexual violence. Aboriginal women have been objectified not only as women, but also as Indian women. The term used to indicate this double objectification was and is “squaw.”

Acoose (1995: 29) relates: “I shamefully accepted that I was not only different but inferior. Consequently, I learned to passively accept and internalize the easy squaw, Indian-whore, dirty Indian, and drunken Indian stereotypes that subsequently imprisoned me, and all Indigenous peoples, regardless of our historical, economic, cultural, spiritual, political, and geographic differences.” Along with the stereotype of Aboriginal women as “squaws” is their association with sexual promiscuity. Aboriginal victims of sexual abuse face all the same obstacles that come with living in a small community. There is a lack of privacy. Fear of further humiliation, through community gossip and the fear of ostracism and intimidation from supporters of the perpetrator, are serious issues that Aboriginal women must also face. Often a victim is confronted with disbelief, anger and family denial. Secrecy is expected and enforced. There is in effect censorship against those who would report sexual assault or even other forms of violence. If the victim does succeed in sending her assailant to prison she knows that she may quite possibly have to deal with quick retaliation. Sexual offenders can get out of prison in a matter of weeks or months. The offenders often go right back into the communities where they can continue to violate and intimidate women.

La Rocque (1994:7) stresses:

North American popular culture feeds off of the objectification and degradation of women. Women are presented as sexual playthings that must conform to male needs. Stereotypes of female sexuality are concocted as a rationalization for violence. It is about male maintenance of power, but it is a conscious and deliberate form of power, not one that is necessarily caused by “abuse” or other traumas. Obviously power brings all sorts of advantages. It has been in the interests of men to keep women down. Society supports all this with its tolerance of violence against women.

Women who have been affected the most by this degradation and objectification are women from minority communities. The most obvious in western Canada are women in Aboriginal communities, including Saskatchewan. La Rocque (1994:7) testifies, "Rape in any culture and by any standard is warfare against women. And the degree to which any community tolerates sexual violence is an indication of the continuation of this warfare against women." Sexual violence comes in many forms and under divergent circumstances, from rape to forced prostitution. Sexual abuse and sexual assault are not foreign to growing numbers of Aboriginal women in Saskatchewan. As La Rocque (1994:8) highlights:

...Many of the stories of sexual abuse reveal that Aboriginal women were often attacked as teenagers. Teenage girls with little or no sex education in an environment conducive to alcohol abuse and violence are particularly vulnerable to adult male sexual seductions/attacks... There is growing documentation that following sexual assault, teenagers turn to substance abuse, prostitution, self-mutilation and/or suicide. This is not to mention that they can get pregnant and/or contract sexually transmitted diseases. The suicide rate is five times the national average in the 15-24 age group among Aboriginal youth.

There are too many circumstances under which Aboriginal women in Saskatchewan remain subordinate to other women and men. Razack (2002:55) argues that:

In much of anglophone canadian fiction, Indigenous women are misrepresented in images that perpetuate racist and sexist stereotypes. Stereotypic images of Indian princesses, squaw drudges, suffering helpless victims, tawny temptresses, or loose squaws falsify our realities and suggest in a subliminal way that those stereotypic images are us. As a consequence, those images foster cultural attitudes that encourage sexual, physical, verbal, or psychological violence against Indigenous women. Stereotypic images also function as sentinels that guard and protect the white eurocanadian-christian-patriarchy (and now to a limited extent the same kind of matriarchy) against any threatening disturbances that might upset the status quo.

Colonization has played a major role in the subservience of Aboriginal women. Razack (2002:65) continues: "Within the colonizer's cultural context, images like the romantic Indian princess, the easy squaw, and the hopeless, suffering victim, are constructed to distort the reality of Indigenous women and justify social, political, economic, and spiritual oppression."

As Absolon, Herbert & MacDonald (Lynne, 1996:2) contend, numerous forces were at work to ensure the subordination of Aboriginal women:

...Capitalism (mercantilism), the church, the state, and the military. All these forces systematically created women's subservience to men. For example, European colonizers intended to accumulate capital through the production and circulation of commodities. Fur was the main attraction to Canada, and Aboriginal women were especially essential to the fur traders. The Europeans used the presence and influence of Aboriginal women to penetrate new territories and secure new markets. Aboriginal women were also sexually commodified.

Women were purchased through a system of exchange, where they were bought with alcohol and other European goods. Kathleen Barry (1984:70) in her article "Female Sexual Slavery" argues, "The traffic in women, like the traffic in drugs or black market babies, depends upon a market...the demand for sexual service is most significant where men congregate in large groups separated from home and family."

The discussion of women and sexuality has not changed dramatically since the eighteenth and nineteenth centuries. Foucault (1984:208) argues, "Sex is a whole series of different tactics that combined in varying proportions, the objective of disciplining the body and that of regulating populations." As such, sex and sexuality are political, economic and social issues that are grounded in power relations. Squire (1993:152) describes these power relations as being, "expressed through the scrutiny, domination, control and exertion of authority over the body, especially women's bodies." In some cultures women do not have the permission to talk about sex with men or to negotiate safer sex practices. To do so may have serious repercussions, ranging from stigma association to fear of violence or abandonment.

Despite this, many HIV/AIDS prevention programs expect women to assume responsibility for the prevention of both pregnancy and sexually transmitted diseases, in a context in which they have limited control over when, with whom and how they engage in sexual activity. As Mariasy and Thomas (1990:18) contend, "some women fear that if they insist upon condom use or even ask their partners to use a condom, they will endanger their relationship, perhaps even lose their

partner. And in losing their partner, they may lose a relationship that confers status, emotional and perhaps financial support.” The way in which women understand risk, negotiate sexual relationships and safer sex will reflect the impact that HIV/AIDS has on them. Easton (1992:15) indicates that the HIV/AIDS models for safer sex “have often not been useful to women, because they reflect male experiences of sexuality and power.”

The privacy of the bedroom is no longer sacrosanct. Foucault (1984:314) suggests that since the eighteenth century, “sex was driven out of hiding and constrained to lead a discursive existence.” Sex and sexuality have become common topics of discussion in the private and public spheres of contemporary society, especially since the advent of HIV/AIDS. Conrad (1989:52) claims that, “this connection between intimacy and sexuality amplifies our anxieties, and creates fears that one sexual act may bring forth a lifetime of pollution and ultimately death.” As a contagion, AIDS brings to the forefront the fear of large-scale epidemics that have been a scourge of the past. HIV infection cuts across class, race and gender. Foucault (1984:319) describes the marginalization of groups as “the setting apart of the “unnatural” and “as a specific dimension in the field of sexuality.” The discourse surrounding AIDS and the marginalized people who contract the disease adds to its stigma potential. Showalter (1990:200) maintains that the reaction to HIV/AIDS has been formed by, “its association with a threatening sexuality and with other despised and marginalized groups in our culture.” HIV/AIDS represents a very contemporary challenge. It carries with it issues of homophobia, cultural alienation, drug use and sexual behavior. All of these issues are rarely dealt with comfortably at a societal level.

Society continues to be divided along the lines of race/ethnicity gender and class. The treatment of members of marginalized groups with HIV/AIDS is a clear representation of their ascribed status in society. Just as everyone in society should receive the same opportunities in life, all HIV/AIDS victims should be offered the same quality of prevention and care. If one is to study the problem of HIV infection and AIDS it is essential to study the cultural practices that contribute to its spread in a given society. The key to controlling the AIDS crisis for Aboriginal

women in Saskatchewan lies in the modification of sexual behavior and control of intravenous drug use and the modification of these behaviors. Human behavior is rooted in the social and economic factors of individual lives. As awareness of the spread of the virus grows the critical limitations of the power of many women in their personal relationships are becoming increasingly crucial. The rooted and widespread beliefs about the passive nature of female sexuality combine with many individuals' sexual relationships are the most personal and intimate part of their lives and are predicated on and reflect society's most fundamental norms.^x

Notes

viii. In the review of HIV/AIDS the literature does focus primarily on epidemiological sources. As well the theoretical and cultural analyses of the infection are drawn on only partially in order to advance the argument that HIV/AIDS was initially constructed primarily as "a White gay male disease." While there certainly was a strong emphasis on gay men in the representation of the infection in the early 1980s, there was also a focus on the racialized pattern of the disease. Indeed, early theories of the viral origin of HIV/AIDS invoked decidedly racist and colonial imagery. Given that a major tenet of this thesis is that colonialism established social contexts that exacerbate the risks of HIV/AIDS, a discussion of how colonialism informed dominant North American and European ideas about the infection should be included. Christopher C. Taylor. (1990). "AIDS and the pathogenesis of metaphor." Douglas A. Feldman. (Ed.), Culture and AIDS. (pp.55-65). New York: Prager offers a superlative position with which to begin.

ix. HIV/AIDS and tuberculosis are comparable in the sense that what has caused both of them to become so apparent in Aboriginal communities in Canada is the direct result of the compounding effects of colonization. HIV/AIDS is an infectious disease that is spread primarily through the practice of unsafe sexual activity. Tuberculosis is an infectious disease that can be transmitted from one person to another through the air that they breathe and through casual contact with the infected person.

x. There is a great deal of information in thesis about the history of the Indian Act and how it has affected the lives of Aboriginal women in Saskatchewan. It is difficult to understand what is happening to Aboriginal women in the present if you are not aware of had happened to them in the past. There would be no framework to work within and informed comparisons could not even be attempted.

3.0 METHODOLOGY

3.1 Introduction

In this chapter, information generated from the profiling of twenty-two Aboriginal women from Saskatchewan is presented. Although there is a great deal of written information including studies and surveys on HIV/AIDS, not much of it focuses on the specific problems of Aboriginal women on and off reserve.

3.2 Profile of the Respondents

Twenty-two respondents from Saskatchewan were selected and profiled through the use of feminist ethnography and personal history.^{xi} This research utilizes a semi-structured interview format as its method of data collection. The women were profiled through the use of demographics and semi-structured and open-ended questions. The questions focused primarily on how sexually transmitted diseases, specifically HIV/AIDS and/or Hepatitis C, had affected their lives and the lives of their families.

All of the twenty-two Aboriginal profiled were from Saskatchewan and lived primarily in Prince Albert, Saskatoon, and Regina. Some of the women came from as far north as La Ronge and some as far south as Maple Creek. The profiles were conducted under a variety of settings that included the STD Clinic in Prince Albert, The Pine Grove Institute for Women in Prince Albert, The Prince Albert Penitentiary, the University of Saskatchewan and the homes of the respondents in Prince Albert and Saskatoon. The objectives of this research were to obtain information on the type, amount and availability of knowledge that Aboriginal women in Saskatchewan have concerning HIV/AIDS prevention and the spread of the disease. A discussion of the extent of high risk behaviors within this population, sexual practices, substance abuse, colonial- determined and generated roles and traditions that constitute barriers to behavioral change, well-being, and recovery are major issues. The influence of attitudinal, lifestyle, socioeconomic, and cultural factors that prevent the progression and diffusion of HIV/AIDS are also examined.

The methodology for this research involves a combination of feminist ethnography and personal history.^{xi} Qualitative research was the most suitable method for exploring and explaining the lack of knowledge, with respect to Aboriginal women and HIV/AIDS and/or Hepatitis C and for achieving the objectives of this research. This research has utilized a semi-structured interview format as the method of data collection, because it allowed for more flexibility while interviewing the women about their lives and past and present experiences.

Once the fieldwork was concluded, the data were prepared for analysis. The profiles were transcribed verbatim. Health Canada statistics from across Canada show that there is an increasing number of Aboriginal women who have contracted HIV/AIDS and Hepatitis C. The data obtained from these women completely validate, uphold, and extend Health Canada's current statistics on Aboriginal women and HIV/AIDS, specific to Saskatchewan.

3.3 Feminist Ethnography

In this research, I employed the method of feminist ethnography in an attempt to avoid the historical and contemporary exploitation and marginalization of Aboriginal women in Canadian scholarship.^{xii} As stated by Millen (1997:10):

...any research may be considered feminist, which incorporates sensitivity to the role of gender within society and the differential experiences of males and females, and also incorporates a critical approach to the methodology and epistemology within which it is placed, within the public domain of sociology. Feminist research so defined, provides us with a tool for critiquing practice as well as content, for examining how we make knowledge, as well as what that knowledge says about the world.

No feminist methodology expresses parameters that state that the only way to achieve accurate feminist research is through qualitative means. Researchers in feminist methodologies have also discussed the possibility that a qualitative means of accumulating information is preferred or more suitable to exploring feminist research, than quantitative means. The collective reason being that qualitative methods focus more accurately on the gathering of in-depth information about individual experiences, than generalizing experiences within a larger group of people. If the focus

of a particular inquiry is discovering the multifaceted aspects of women's lives, qualitative research more effectively meets those goals (Millen, 1997). The goal of this research was just that. Through the use of in-depth interviews with Aboriginal women from Saskatchewan, the researcher was able to openly discuss how HIV/AIDS and Hepatitis C had affected their experiences and their lives. In doing so, these women were afforded the opportunity to express, in their own words, what life had been like for them. As a result their voices, which had remained silent for far too long, became validated and revealed as significant to other members of Canadian society. Millen (1997:10) points out:

It is possible for a feminist to conduct research using any sort of methodological paradigm and to critique the ways in which this knowledge is incorporated into the public domain: the essential issue is of the hierarchy of validity of knowledge, with numerical or quantitative results generated by a more positivistic model being considered somehow "more valid" and "more objective" than experiential or qualitative accounts...What is valid knowledge? Is objectivity an attainable or even desirable value?

In this case, subjectivity was a desirable value and a qualitative method of research is just as capable as a quantitative method, in obtaining valid information about the effects of HIV/AIDS on Aboriginal women in Saskatchewan. On the other hand, using a feminist research methodology where the function of the ethnographer is viewed as an "objective" voice is prevailing in research methodologies. This can then be used to expand all aspects of knowledge, including the practical, political, social, critical, historical, and theoretical to develop shared interactions that would be essential for establishing productive feminist research (Millen, 1997) Harding (1987) writes about the emancipatory aspect of feminist research and advocates a feminist research methodology for women and by women, that provides explanations about their experiences that they can use to understand themselves and their socio-political worlds.

HIV/AIDS research in general has supported this methodological approach. In the area of HIV prevention, involving research subjects in the research process is obligatory in order to increase participation rates in difficult to access communities and to increase the likelihood that research results will have any impact (Allman, Myers and Cockerill 1997). Historically in Canada

marginalized groups, who were the first to recognize and experience harm inherent in explicit policies, have signaled some of the most important changes to ethical codes. Hurtig (2000:5) argues: “In fact, for many feminist ethnographers, ethnography - with its emphasis on recovering “local knowledge”, its methodological flexibility, and its interactive, dialogic orientation - has seemed particularly suitable to the egalitarian, reciprocal, and inter-subjective principles of feminist research.”

Other feminist methodologists have responded to both the celebrations and critiques of feminist research. Rather, what is important is that feminist theoretical frameworks and research ethics inform how particular research methods are used (Hurtig, 2000). One way to do this is to design ethnographic research as participatory research. Participatory methodologies can be incorporated into ethnographic research that allows feminist ethnographers to focus on the cultural construction of gender, race, class, and sexuality and to use their results to develop programs and services designed to modify the basic foundations of inequality (Hurtig, 2000).

Feminist epistemology specifies what women’s knowledge is and how it may be distinguished from the knowledge that dominates men’s knowledge. As feminists have reconstructed epistemology in order to incorporate women’s voices, they have illustrated the inherent connection between women’s knowledge of the world and their construction of realities within that world. “Feminist epistemology illustrates the multiplicity of women’s voices while integrating their knowledge and experiences. Once this door is unlocked a better understanding of women’s lives can occur and the end of the oppression may be plausible” (Harding, 1991:5).

3.4 Personal Histories

Personal histories can draw the lives of Aboriginal women out of obscurity, repair historical records, and provide an opportunity for other women to identify with them. Research needs to stress the importance of Aboriginal women as representatives of their culture (both colonist-destructive and post-colonial regenerative) and preservers of their traditions and values. Personal histories can be examined qualitatively and can contain information that is unlikely to be found in

written records. They may not be found in written records because much of Aboriginal peoples' history has been passed on from generation to generation, through narratives. It is just recently that these narratives have been put to paper, so that future generations of Aboriginal children will not lose the significance of the history of their ancestors. Many Aboriginal women in Saskatchewan have never had the opportunity to tell their own stories. Aboriginal women need to be encouraged and provided opportunities to speak for themselves. The purpose of this research on HIV/AIDS is to create a written record of Aboriginal women's lives, from their perspectives and in their own words. Personal histories contribute to social justice, facilitate the understanding among social classes, and explore the meaning of events in the eyes of Aboriginal women.

In her paper titled "The Pursuit in Oral History," Eileen Clark (1999:2) writes: "Oral history has been hailed as a means of redressing the class, race, and gender biases of traditional history based on written records. It can be an important tool in recording social change, especially from the viewpoint of disadvantaged or subordinate groups." Personal histories can study issues of importance to marginalized groups in a way that makes women's voices and concerns central. In doing so, the methodology itself draws upon feminist debates about appropriate ways to conduct research. Personal histories have been viewed as being motivated by the politics of emotion and as too idiosyncratic to be taken seriously as academic knowledge (Sangster, 1994). However, personal histories present a strong challenge to the traditional history of Aboriginal women in Saskatchewan.

Writers disagree about the extent of similarity that is desirable between interviewer and interviewee in terms of ascribed statuses like class, gender, or ethnicity, while a measure of conformity can encourage frankness. Anderson and Jack (1991:110-111) indicate, "There is more agreement over the need for interviewers to acknowledge class and gender differences in styles of talking." Minister (1991) points out that women as informants are disadvantaged by a masculine communication style that is the dominant paradigm in social science interviewing. She believes that men traditionally talk about topics like work that reflect what they do, while women

focus on personal and relationship issues that show who they are. Unless a suitable communication frame is used, interviews with women will miss important aspects of their lives and provide unreliable information. This communication framework not only shapes the words that are used, but also takes into account the non-verbal communication used by women. Silences and omissions may be more telling than words in women's stories (Sangster, 1994).

In an attempt to provide Aboriginal women in Saskatchewan with the opportunity to express the impact that HIV/AIDS has had on their lives and to explore avenues of social change, this research was conducted in collaboration with Aboriginal women. The purpose of this research was to ascertain the effects of HIV/AIDS on Aboriginal women. This was accomplished through personal interviews with Aboriginal women under various social settings including the participants' homes, STD Clinics, the University of Saskatchewan, the Pine Grove Institute for Women, and the Prince Albert Penitentiary in Prince Albert, Saskatchewan. This thesis research identifies reoccurring themes in Aboriginal women's life histories from childhood to the present and through their precarious lifestyles that included alcohol and drug abuse, prostitution, violence, and in number of cases prison.

3.5 The Study Sample

In order to obtain a detailed analysis of the subject matter a target of twenty-two complete in-depth unstructured interviews with Aboriginal women from Saskatchewan were conducted. Initially, a target group of twelve to fifteen Aboriginal women from the age groups: 16-19, 20-29, 30-39, and 40+, as well as from urban and reserve populations in Saskatchewan, was sought. However, after working in the field and realizing how difficult it would be to obtain such a restricted group of Aboriginal women, the parameters changed. It was not difficult to find Aboriginal women who were willing to take part in the research. Instead, difficulties arose in getting those women to follow through with the interviews once they had committed themselves. The participation of many of the women in the research was unreliable because of their unstable living conditions as well as their continuing substance abuse. The final group of interviewees was

twenty-two. The group consisted of Aboriginal women who had prostituted at a very young age, abused intravenous drugs, and/or contracted Hepatitis C, HIV or had full-blown AIDS.

There were a number of avenues available to gain access to Aboriginal women who were willing to share their life experiences, for the purpose of this research. I contacted AIDS Saskatoon, which offers services and information to persons living with HIV/AIDS. The Persons Living With AIDS (PLWA) Network and the All Nations Hope Network were very helpful. They assist people with HIV/AIDS in coping with their life-changing experiences. I spent a great deal of time volunteering at the PLWA. As a result, I was able to develop friendships with some of the Aboriginal women there. The PLWA Network also put me in contact with the doctor that took care of most of their HIV/AIDS patients, Dr. Williams. He works at the Royal University Hospital in Saskatoon in infectious disease control. Dr. Williams has clinics at RUH twice a week for people who have contracted HIV or have full-blown AIDS. He examined my proposal and became very interested. Dr. Williams' nurse contacted patients and then contacted me as to when they would be in Saskatoon for the bi-weekly clinics.

The STD Clinic in Saskatoon was approached, but they were not very cooperative and wanted me to pay each woman \$20. An Aboriginal Elder from the Piapot Reserve openly discussed the effects of colonialism and the marginalization of Aboriginal women in Saskatchewan. She also offered her thoughts on the effects of HIV/AIDS in Aboriginal communities. The Head Nurse at the Prince Albert Correctional Center established an anonymous AIDS testing program for Aboriginal people in and around Prince Albert and gave me a great deal of assistance. All of the possible avenues of knowledge were not exhausted and were changed and augmented as the research progressed.

The intention of this research was to obtain information from Aboriginal women, who have been described in Health Canada HIV/AIDS statistics as having a higher risk potential for HIV infection. This study included administering to the target group questions concerning general health status, substance use, the existence of sexual, psychological or physical abuse, HIV/AIDS-

related knowledge, attitudes and behaviors towards sex and sexuality, and Aboriginal women's own perceived risk of HIV infection. It also involved questions concerning the impact of HIV/AIDS on their lives and the lives of their families. This research covered a variety of social (such as poor housing, lack of employment) and psychological (such as attitudes towards sex and sexuality) variables that affect the life experiences of Aboriginal women in Saskatchewan.

The majority of the women were heterosexual and engaged in vaginal sex for the most part. A number of them had had multiple partners through prostitution and engaged in unprotected sexual activity, on a regular basis. Approximately 99% of the women had had a sexually transmitted disease and of these 75% had a history of more than one infection (Health Canada, 1999a).

3.6 Data Collection and Analysis

The data were obtained from the narratives (personal histories) and the in-depth interviews (ethnographic studies) of twenty-two Aboriginal women in Saskatchewan. The data are being used to support or discredit the hypotheses presented in this thesis. Aboriginal women in Saskatchewan have been marginalized and oppressed in the AIDS crisis, in relatively the same manner as they have been socially segregated and disenfranchised in Canadian society since colonization. Moreover, the ability of Aboriginal women to educate themselves about the prevention and spread of HIV/AIDS and Hepatitis C has been gravely restricted by their lack of access to services and programs. The data are being supplemented with statistics from quarterly surveillance updates on AIDS in Canada and HIV/AIDS Epi Updates, from the Laboratory Centre for Disease Control (LCDC) at Health Canada. It is mostly nominal-level data that have been presented through descriptive analyses.

3.7 Conclusions

Feminist methodologies can be helpful in understanding the life experiences of Aboriginal women. Feminist inquiry takes human emancipation as the goal of social scientific study, and claims that knowledge must be used for the construction of more egalitarian societies, that are free of oppression for both men and women. Knowledge must be genuinely inclusive and take

gender, race, and class together as part of the complexity of human experience. Feminist research has unmasked the biases in conventional studies, and has shown how these studies result in inadequate accounts of the lives of women. Looking at the lives of Aboriginal women in Saskatchewan through the lenses of feminist knowledge seems apropos for this research. The following chapter analyzes the results of this research and what the implications are for Aboriginal women in Saskatchewan.

Notes

xi. Gordon Marshall. *The Concise Oxford Dictionary of Sociology* (Oxford University Press: New York, 1994) p.158. Ethnography is a term usually applied to the acts both of observing directly the behaviour of a social group and producing a written description thereof. It is sometimes also referred to as fieldwork. The principal technique of ethnographic research is participant observation. Personal histories involve listening to a person's own account of their life experiences and placing their own exact words on the page. The term ethnography is also defined in the Appendices of the thesis under the title of *Definition of Terms*.

xii. The use of feminist methodology is appropriate for this research. However, it must be made clear how the issues of "voice" fit into the analysis. Like anything that emerges in a research encounter, "voice" is not an unproblematic concept. It emerges under specific circumstances and it reveals as much about the context of the research encounter as it does about the topic under discussion. In most literature on feminist methodology, "voice" is interpreted to be the product of an intersubjective exchange; this kind of intersubjectivity is characterized by a pre-negotiated balance of power. Researchers and participants work together to create opportunities for various voices to emerge. In feminist methodology, "voice" is something complex. It requires that the context, meaning, overlapping sentiments, discontinuities, and contradictions appearing in these words be analyzed. In other words, "voice" is more than an assigned placement of precise words; it is a critical engagement with the meaning of those words and the experiential context that gave rise to those words. How do the women's voices reverberate with each other? Where are the similarities and the differences? What are the sources and meanings of these similarities and differences? What do the women's voices tell us not only about the women's lives (which is the most important thing) but also (and secondarily) about the research encounter? These concepts could be elaborated on in this research.

xiii. Feminist ethnography is not only used to reveal the exploitation and marginalization of Aboriginal women due to their gender. It is also effective in crosscutting the socioeconomic stratification within society that encompasses race and class as well.

4.0 PRESENTATION AND ANALYSES OF RESEARCH DATA

4.1 Introduction

Using excerpts from the personal histories of the twenty-two Saskatchewan Aboriginal women profiled in this research, this chapter will present and analyze the data accumulated to their well-being. To fully discern what these women had been through the researcher felt that it was necessary that their precise words be placed upon the page through the use of a feminist methodology. In the presentation of these data, qualitative analysis is used to highlight the ideas and observations of the Aboriginal women in Saskatchewan who were profiled. It is the aspiration of the researcher to present as much of the women's own words as possible and to extend an avenue for their words to be disclosed.

4.2 Demographic Information

Health Canada (1998b: 57) reports: "Although there are limits to the information available on the HIV epidemic (the simultaneous occurrence in a human community of a great many cases of a specific disease) among Aboriginal people, it is clear that some Aboriginal communities are at increased risk of HIV infection, because of their low socioeconomic status, poor health, and high rates of sexually transmitted diseases." The majority of the respondents in this research supported themselves and their children through prostitution. Many had never completed Grade 12, had been incarcerated more than once, had no permanent address, abused alcohol and/or intravenous drugs, had contracted one or more sexually transmitted disease, had contracted HIV/AIDS and/or Hepatitis C, and had been sexually, physically, emotionally, and/or spiritually abused.

Health Canada (1998b: 57-58) maintains that:

Heterosexual sex accounts for the majority of Aboriginal female AIDS cases. Aboriginal AIDS cases are more likely to be younger, to be women and to be attributed to intravenous drug use than non-Aboriginal AIDS cases. Aboriginal people are over-represented in groups at high risk for HIV infection, including injection drug users, clientele using inner-city services, men who have sex with men and prison inmates.

The Aboriginal women profiled in this study are primary examples of the Aboriginal women that Health Canada describes in their statistics and that live on and off reserve in Saskatchewan. The Aboriginal Nurses' Association of Canada (1996:7), in an article titled *HIV/AIDS and its Impact on Aboriginal Women in Canada*, points out that:

The current definitions of AIDS in the medical community have excluded some infections that are common to women and as a result, many cases of HIV among women have not been recorded. Chronic vaginal yeast infections and gynecological disorders like invasive carcinoma of the cervix are both found only in women however, physicians may not consider HIV infection to be one of the causal factors. As a result, women may not get proper diagnosis regarding HIV infection, at the onset of disease. Because they are not presenting a clinical picture that is absolutely characteristic of HIV infections it may take a while for women to be diagnosed. Part of the problem may be that there are no studies examining the natural progression of the disease in women, as there have been for men.

Bias due to perceptions of risk, along with the failure to recognize symptoms of HIV/AIDS in Aboriginal women, can and have resulted in delayed diagnosis and delayed treatment. Taylor, Bar, and Jurado (1998:1) in their article titled "*AIDS Epidemic An Increasing Concern Among Aboriginal Women in Canada*," suggest that:

If HIV/AIDS programs are not targeted to the specific needs of Aboriginal women, the incidence of HIV/AIDS among Aboriginal women in Canada will inevitably continue. Thus, there is an urgent need to enhance the educational level of Aboriginal women in every aspect, but especially in those areas that could empower Aboriginal women to participate in the development of effective, holistic, and gender appropriate strategies and programs.

Yet, accurate data representing the seriousness of the crisis in the Aboriginal community in Saskatchewan remain lacking, to the injury of Aboriginal women not only in Saskatchewan but in the remainder of Canada as well. In her article titled "*AIDS Epidemic Advancing in Canada's Aboriginal Community*," Arlo Yuzicapi Fayant (1998:1) argues that "being targeted as an infectious race gets people crazy. We're not looking forward to being the scapegoats of the new millennium, but we need our people to stop the denial." The collection of more exact data on the effects of HIV/AIDS and/or Hepatitis C on Aboriginal people in general, and Aboriginal women

more precisely, can serve numerous purposes. The data can reveal the undistorted extent of the crisis and render known facts that can then be used in the education, prevention, and the treatment of these diseases, with respect to Aboriginal women who are affected now and in the future.

At the outset the respondents were asked how they wished to be referred to for this research. The date as well as where the profiling took place were recorded. The complete demographics of the profiling are presented below, using the actual numbers and percentages of the women involved. The researcher used simple frequency distributions that most adequately reproduced the demographics of the profiling.

4.2.1 Location of Interviews

Fifteen of the respondents were interviewed at the Pine Grove Institute for Women and the STD Clinic in Prince Albert, Saskatchewan (See Table 4.2.1).

Table 4.2.1 Location of Interviews:		
Place	Number in Sample	Percentage of Sample
Home of Interviewee	4	(18)
University of Saskatchewan	1	(4.5)
STD Clinic, Prince Albert, SK.	2	(9.0)
Prince Albert Penitentiary, Prince Albert, SK.	1	(4.5)
King George Hotel, Saskatoon, SK.	1	(4.5)
Pine Grove Institute for Women, Prince Albert, SK.	13	(59)
Total	22	(100)

This research reveals that there are a disproportionate number of Aboriginal women with HIV/AIDS and Hepatitis C that are incarcerated or have been incarcerated, at some point in their lives. ^{xiii} At the Pine Grove Institute for Women in Prince Albert, the Warden and the Director of

Health Services were very supportive after being apprised of the intentions of the researcher. The Director of Health Services took the researcher through the prison and explained the various aspects of its functions, including where the inmates lived, ate, worked, improved their education, had visits with their families, could exercise, and where they could practice traditional and spiritual Aboriginal ceremonies, if they so wished. The researcher was also introduced to a number of the Aboriginal inmates themselves. The Director of Health Services at Pine Grove, after having discussed the purpose of the profiles with the researcher, explained to the inmates what was being asked of them. No demands were placed upon the women by the staff or by the researcher to co-operate. Once their permission to participate was attained, the Director of Health Services established a schedule with the day and time that each of the inmates was available for profiling. The staff made the availability of the inmates flexible enough that the researcher was able to perform various consecutive interviews.

4.2.2 Age Range of Respondents

The Saskatchewan Aboriginal women profiled in this research explain by example the foregoing statements concerning HIV/AIDS in Canada. Health Canada (2001b) reports that the proportion of females and the proportion of the less than 30 year olds among reported Aboriginal AIDS cases are higher (22.7%) than among non-Aboriginal AIDS cases (7.9%). In the number of reported HIV tests in Canada from 1998-2000, only 19.7 % of them were non-Aboriginal females, whereas 46.6% of them were Aboriginal females. There are also a higher proportion of female Aboriginal AIDS cases that have IDU as an exposure category compared to non-Aboriginal cases (34.3% vs. 5.9%). The majority of the respondents were between the ages of 25-30 years (See Table 4.2.2). Some of the respondents were tested through the STD Clinic or their doctors' offices on a regular basis, usually every three months.

Age	Number in Sample	Percentage of Sample
20-25 Years	4	(18)
25-30 Years	8	(36)
30-35 Years	4	(18)
35-40 Years	4	(18)
40-45 Years	0	(0.0)
45-50 Years	1	(5.0)
55-60 Years	0	(0.0)
60-65 Years	1	(5.0)
Total	22	(100)

Ninety percent of the respondents are in the childbearing age group of 20-40 years, with only ten percent over the age of 40 years. Health Canada (2001d) further holds that persons with HIV/AIDS do not in actuality show symptoms of the disease for as long as 7-10 years after contracting it. Taking this into account, it is fair to say that many of the respondents in fact contracted HIV as young as 13 years of age and predominantly through the use of intravenous drugs and/or prostitution.^{xiv}

Anikwacas began prostituting when she was eleven years old, after her mother overdosed and her father was placed in a federal penitentiary. At fifteen years of age she turned to prostitution to pay for her aunt's intravenous drug use. Amisk was introduced to intravenous drugs when she was seventeen years old and shared rigs (needles and syringes) with her partner. He was thirty-five years old and had already contracted Hepatitis C. Dove was raped at the age of seventeen, and had full-blown AIDS. Dove (2000:13-14) described her disbelief when she was diagnosed:

Like I thought I would never get AIDS and here I ended up I had AIDS. I never realized what AIDS could do to you and I never thought I would meet someone that had AIDS or be close to someone who had AIDS. But the doctors are looking into that trying to find out who gave me AIDS. I gave them a list of people and they are checking them all out. There is probably a guy out there giving other people AIDS and he doesn't even know he has it.

Nicole had been diagnosed with Hepatitis C for over two years and had been arrested eighteen times for prostitution. She was only twenty-three years old at the time of her interview. Pipiciw

had been a prostitute for more than fourteen years. She had contracted HIV and Hepatitis C six years earlier at only 22 years of age.

4.2.3 Marital Status of Respondents

The marital status of the respondents was described as a variety of relationships (See Table 4.2.3). Just over a quarter of the respondents had been in a common-law relationship at least once in their lives. Four of the respondents were married and did not have a legal divorce yet; they had moved on to a new common-law relationship.

Table 4.2.3. Marital Status of Respondents:		
Marital Status	Number in the Sample	Percentage of Sample
Married	4	(18)
Common-law	9	(41)
Single	6	(27)
Divorced	3	(14)
Total	22	(100)

A number of the respondents had never been married but had lived common-law, one for as long as eighteen years. Once a relationship dissolved both participants were free to move on to other relationships, without any legal constraints or filial responsibilities. Three of the respondents had lived common-law with as many as four different partners. Eighty-six percent of the women maintained that their priority was their children, even if it meant raising them as a single parent. For ninety-five percent of the respondents, the father of the children moved on without committing any psychological or financial support, not long after the children were born. In large part it can be argued that these issues were reflected in the lifestyles of these women, who felt that their only recourse was prostitution.

Maskwa (2000:1) had lived common-law with the same man for eighteen years and when she was asked why she never married she replied, "Because I like it that way." Pipiciw was married for nine years and her husband had beaten her so badly that she was hospitalized more than once. She never divorced him, but was living in a new common-law relationship. Tiffany was twenty-

eight years old and stated that she had so many common-law relationships that she could not even remember them. Mistatim had just been married at the Prince Albert Penitentiary thirty-five days prior to her interview. At the time of her wedding, her husband was in the Prince Albert Penitentiary for robbery with violence. Her three brothers were also there and were serving time for robbery. Her mother was unable to attend the wedding ceremony at the Prince Albert Penitentiary, because she was doing time in another corrections facility for killing her father.

4.2.4 Number of Respondents' Children

Anikwacas' mother overdosed when she was just three years old and she found it very difficult to deal with her mother's condition. As well, her father had been in and out of the penitentiary since she was very young. Anikwacas (2000:4) confessed, "I was eleven when I hit the street and I started bumming around and not working or whatever." She began prostituting when she was fifteen. When asked if she had ever had her children tested for HIV/AIDS and/or Hepatitis C, Anikwacas (2000:6) replied, "Yeah they are fine. When I had Hep. C they had to get shots and everything but that was about it. I have never had them tested for the Hep. C."

Table 4.2.4 Number of Respondents' Children:		
Number of Children	Number of Sample	Percentage of Sample
Zero	5	(23)
One	2	(9.0)
Two	2	(9.0)
Three	6	(27)
Four	3	(14)
Five	1	(5.0)
Six	3	(14)
Total	22	(100)

The respondents varied a great deal in the number of children that they had (See Table 4.2.4), how they were being raised, and who was raising them.^{xv} As well some of the children in the same family had different fathers. The research findings revealed that just under a quarter of the respondents had no children. The majority of the women had three children. The number of women with four and six children represented a very small segment of the respondents. Putting

this information into perspective, the research revealed that Aboriginal women are having sex at an earlier age and are becoming pregnant more often than their non-Aboriginal counterparts. If Aboriginal women are not using condoms to prevent unwanted pregnancies, then they are not using them to avoid contracting HIV/AIDS, Hepatitis C or any other sexually transmitted disease.

Makwa (1999:4) stated:

When I was about 23 I just had my third boy and the ex-boyfriend was running around with everybody. I asked him to move out and then I had my boys with me. Then I got into the cocaine addiction and hooking and that kind of stuff. So I asked the boys' fathers to take the children, because I didn't want them in that kind of environment. Because I was going down and I was losing everything fast. So that this is why they ended up where they are.

Moswa (2000:4-5) had Hepatitis C for just over a year when we spoke and she described her relationship with her three children:

I'm open with my kids and my kids knew I had a drug problem. When I'm going out to drink I tell them I'm going out to drink. With my youngest sister she says I'm going out for coffee to my nephew, but I practically raised my nephew because he was always dumped off on me. He would give me this look like yeah she won't be back tonight. Now he lies to her like crazy but she brought it on herself. If you lie to your kids they're going to lie right back to you. My children and I have talked about the AIDS virus. We have a very small amount of time together so when we are together ...no I haven't told them I have Hep. C yet.

Moswa had not been able to see her children for a while because she had checked herself into a methadone clinic and in the meantime had been incarcerated.

Kakakiw (2000) was a twenty-six year-old corrections worker at the Prince Albert Penitentiary, and did not have any children but had had two abortions in the preceding four years. Kakakiw (2000:9) discussed the reasoning in lieu of one of her abortions, "Prior to La Ronge I had already become pregnant with his (Curtis's) child and I was still drinking at that point. I knew there was no way that I was going to bring a child into this world that did not have a healthy chance to begin with." Pipiciw has had HIV and Hepatitis C for roughly six years, and had kept her illness a secret except for a few people. She had two children, a seven and an eight-year old,

who were taken care of by her mother-in-law. She had been married for nine years but never divorced and lived with her present common-law. Pipiciw (2000:11-12) contended:

I think it's you know when I'm in fixing houses where they (children) are running around and everybody is fixing and they are telling their kids go in the other room we are busy. The kids know what they are doing, because they are just the next generation of junkies. They learn what they see and that's sad.

Even though she had had the opportunity to spend time with her children, they continued to reside with their fathers on a permanent basis. Amisk was married and had six children, who ranged in age from 8 years to 19 years and she has had Hepatitis C for nearly eighteen years. Amisk's life had been one of sexual abuse, rape, and incarceration. She had contracted Hepatitis C from a man who was eighteen years her senior and she was determined to make the lives of her children more "normal" than what her childhood had been.

Due to colonialism and the residential school system, many Aboriginal women in Saskatchewan were unable to fully take part in their traditions, culture, and language. Consequently they found themselves at a loss in the domain of parenting skills. Insufficient parenting skills have gone back as far as three generations for some of these women. Yet Canadian society continues to demand that Aboriginal women retain the pertinent knowledge to raise their children as generations of women before them had. Many of the respondents had their children removed and made permanent wards of the state or put into foster care. Some of them had extended family members that looked after their children, while they were incarcerated or when they worked on the street. Some of the women admitted to using alcohol and/or intravenous drugs when they were pregnant and most of them had their children tested for HIV/AIDS and/or Hepatitis C after they were born.

The respondents' mothers, mothers-in-law, cousins (on and off reserve), the children's fathers, other relatives or older children often performed the role of caretaker to the younger children. Some of the children were left with extended family members when their mothers were working the street and/or when they were incarcerated. If that was not possible the children were put into

foster care, put up for adoption, or became permanent wards of the state. Some of the women used alcohol and/or drugs while they were pregnant or shortly after the children were born. Many of them did not have financial, emotional, or any other type of support from the children's fathers. Most of them were aware of the need to have their children tested for HIV/AIDS and/or Hepatitis C.

Apisimos (2000:3) presented the most typical reply, "No my kids are all good, because I just got Hepatitis C. I had my kids before I got it (HIV/AIDS/Hepatitis C) so they're okay. The doctor did take blood tests and stuff like that on my kids every time I did have a kid." Only a very small proportion of the women admitted to using alcohol and/or drugs while they were pregnant. Ciask (2000:11) stated, "I was going out there (on the streets) looking for help to get off my drugs. That was when I was pregnant with my daughter. Like I used drugs through my whole pregnancy and there is nothing wrong with her. She's as healthy as can be." A number of the children had a great deal of difficulty accepting the idea that their mothers' lives would be cut short and many of them felt cheated.

A number of the respondents stated that the worst part of having HIV/AIDS and/or Hepatitis C was that they did not want their children to see them when they reached the end stage of their disease or worse yet, have their children be responsible for their care. Many of the women had talked about the effects of their disease on their children. Minos (2000:4) had three children and had contracted Hepatitis C and revealed, "I get scared when I think about my children. Who am I going to get to look after them if I get really sick? I worry a lot." Prostitution and too many years of life on the street have not given these women the tools or the opportunity to raise their children responsibly. Amisk (2000:5) has had Hepatitis C since she was seventeen years of age and stated:

When I started learning I started getting scared for my children. For a long time I hid my razors and toothbrushes and I was fearful about kissing them. That's a hard thing not to do as a mother, not to kiss your children on the lips. Even with the herpes when I'd go to kiss them I had to be careful. That's a hard thing to do. Nobody thinks of those things. I never thought of those things before I found out about this disease. It just drove me mad there for a while.

Many of the respondents' children were too young to fully comprehend or even accept the idea that their mothers might die from contracting HIV/AIDS and/or Hepatitis C. On the other hand, many of them had lived in a state of constant fear and blamed their mothers for continuing to abuse drugs and alcohol.

4.2.5 Residence of Saskatchewan Respondents

The majority of the respondents lived in the north and north central areas of Saskatchewan, including La Ronge, Meadow Lake, and Prince Albert; the main reason given was that they lived closer to their home reserves (See Table 4.2.5). The fact that there are a large number of reserves in the northern portion of Saskatchewan is due in large part to the lasting effects of colonialism on Aboriginal people. The state saw the north as the most suitable area of the province to relocate larger numbers of Aboriginal people, on land that had the poorest resources and where they could be assimilated with the least measure of censure. However, these circumstances have continued to change over time as more and more Aboriginal people, especially women, have relocated to large urban centers. Yet there remains a great deal of migration back and forth from the reserve to the city. As already highlighted in this thesis, slightly more than half of the respondents lived in northern and north central Saskatchewan in La Ronge, Meadow Lake, and Prince Albert. Less than a quarter of the respondents lived in central and north central Saskatchewan, in Saskatoon and Duck Lake respectively.

Place of Residence in Saskatchewan	Number in Sample	Percentage of Sample
La Ronge	1	(5.0)
Meadow Lake	1	(5.0)
Duck Lake	1	(5.0)
Prince Albert	8	(36)
Saskatoon	4	(18)
Regina	5	(23)
Moose Jaw	1	(5.0)
Maple Creek	1	(5.0)
Total	22	(100)

A third of the respondents lived in southern Saskatchewan in Regina, Moose Jaw, and Maple Creek. A few of the women lived in central Saskatchewan in Saskatoon, while others lived in southern Saskatchewan, which included Regina, Moose Jaw, and Maple Creek. These are all larger urban areas that were not far from their home reserve and yet close enough to earn money prostituting and to obtain intravenous drugs.

The living arrangements of the respondents varied a great deal. Some of the women lived with their children and common-law partner and others lived by themselves, because their children had been removed by social services. Most of the women did not remain at the same address for any length of time, due in large part to the fact that they were short on funds. Angel had gone through four changes of address by the time her profile was completed. She had lived in a low-rental apartment on the west side of Saskatoon but became behind in rent. So she moved in with some friends in the same vicinity as her apartment. Angel only resided there for about a week, because she and her friends were evicted from the house that they had been living in. From there, she proceeded to Regina to live with a cousin, but came back to Saskatoon a week later. Again she had no place to stay, so she went to the YWCA in Saskatoon and remained there for approximately two weeks. After Christmas she was able to find another low rental apartment on the west side of Saskatoon and it was there that she was eventually interviewed. Angel's story was not that notably different from several of the other respondents.

Mahkesis grew up on the Crooked River Reserve located about 27 kilometers north of La Ronge, but she had lived in Prince Albert for a number of years. Mahkesis (2000:13) described how life on her reserve had not changed:

There is just as much fixing as there is in Prince Albert if not more. Even myself going up there, I know there is a lot of promiscuity going from one partner to the other. I was like that. I was a prostitute. I don't know how many men are out there infecting their wives now. The guy that gave it to me did he switch the needle? He said he was going to take down as many as possible. Whoever fixed with him had to carry their needles in their hand all the time or else they got it. I know once it (HIV) hits La Ronge its like it's going to spread like wild fire, because of all the teen pregnancies and promiscuity around there. I know what it's like

over there.

Marie has had Hepatitis C for roughly six years and resided in Regina. Marie (2000:5) described how she received assistance from public health staff in coping with her disease: “They come out once a week or else they drive around at night and exchange needles. They have a time and where they are going to be and you just go there. They hand out condoms too. They hand out little pamphlets with bad date sheets in there for the girls that work on the streets.” The bad date sheets were used when a prostitute had a bad experience with a john. Public health reported it and then let the girls working the street know that that particular guy was out there and to watch out for him.

Most of the urban Aboriginal women in this research took part in prostitution and alcohol and/or intravenous drug use, due in part to the reality that these vices were more common in the larger urban areas than on reserve. Since the majority of the respondents were profiled at the Pine Grove Institute for Women in Prince Albert, it appears that the sample deliberately focused on women from northern Saskatchewan instead of the remainder of the province, but that was not the intent of the researcher. The women profiled included those women who were and who had been incarcerated in the Prince Albert Correctional System, but had lived in the southern and central areas of Saskatchewan as well as the north.

4.2.6 Occupation of Respondents

Some of the women did not readily admit to taking part in prostitution, but did reveal their involvement when asked directly. As a result, the most prominent occupation of the respondents was prostitution (See Table 4.2.6). Maskwa is an Elder who has worked in Corrections in Saskatchewan with Aboriginal women and Kakakiw is a Corrections worker at the Prince Albert Penitentiary. A few of the respondents specified their occupation as housewife, one respondent stated that she was a labourer and one of them was unemployed. Sixteen of the women were or had been prostitutes, which they stated was due in most part to the fact that it required a short

period of time to perform and the monetary value was the most profitable. The rationale for choosing a life of prostitution was more than economic.

Occupation	Number in Sample	Percentage of Sample
Prostitute	16	(73)
Housewife	2	(9.0)
Laborer	1	(5.0)
Elder	1	(5.0)
Corrections Officer	1	(5.0)
Unemployed	1	(5.0)
Total	22	(100)

There were other mitigating factors, including the cycle of alcohol and/or intravenous drug use as well as the sexual, physical, emotional, and spiritual abuse that they faced at home. Most of the women had prostituted from a very early age. If not forced into it they turned to the street for the love and affection that they did not receive at home. Mistatim candidly admitted that her occupation was that of a “hooker” and a drug dealer. Cahcakiw (2000:6) revealed:

I ended up on the street when I was twelve years old. My mother sold me to a guy. This guy showed up at her house one day and my sister went outside and asked what he was doing there and what he wanted. She came running in and she was pretty upset because that guy wouldn't take her. Both of them were grouchy, because they were withdrawing and they didn't have anything to do (cocaine). They didn't have no money or anything...so my mom came up to me and started talking to me about it, she started to get really violent and mad so I said okay I'd go. So I went.

Many of the respondents left home at a very young age. They did so to distance themselves from what was happening at home, only to discover that life on the street was not any better and in most instances worse. Anikwacas (2000:3-4) explained how she began prostituting herself:

My family life was not good at all. My Mom overdosed when I was like three years old and she's still in a coma in the hospital in Regina. Yeah she's like a vegetable and she's in long term care so that really bothers me every day. It gives me a lot of pain and I try to hide from it and I try to run from it. Everybody kind of expects me to be able to deal with it because it's been so long. But not once has my family ever taken the time to say how do you feel about your Mom? Never, so I keep all that in and I'm trying to figure out how to grow from it and let it go but I can't.

She was an only child and her father had been incarcerated numerous times. Anikwacas (2000:3-

4) continued:

I have an aunt... she tried to look after me for a while, but that was when I was going through my teenage years. I was about thirteen and I just got totally crazy. Nobody could keep me and that's when I started hanging out on the street all the time. I was about eleven when I hit the street and I started bumming around and not working or whatever Yeah I started when I was about fifteen.

After listening to the personal histories of the respondents it was not difficult to understand why they had no self-worth, self-confidence, self-respect or any hope that they were just as deserving as the rest of humanity to live a decent and happy life. These women/girls had aunts, sisters, and mothers who were already working on the street as prostitutes or drug dealers and who were addicted to alcohol and/or intravenous drugs. They were not preferred role models for ten and eleven-year-old girls, who ran away looking for the love that they did not get at home.

4.2.7 Respondents' Level of Education

Only one-third of the women profiled completed Grade 12 (See Table 4.2.7). For many of the women, having children at a very young age and being responsible for those children did not make education an option. The level of education achieved by the Aboriginal women profiled varied remarkably. Less than a quarter of the respondents reached Grade 8, just over a quarter of them reached Grade 9, very few achieved Grade 10 and Grade 11, and approximately a third of them achieved a Grade 12 education.

Table 4.2.7 Respondents' Level of Education:		
Grade Level Completed	Number in Sample	Percentage of Sample
<Grade 8	1	(5.0)
Grade 8	3	(14)
Grade 9	6	(27)
Grade 10	2	(9.0)
Grade 11	2	(9.0)
Grade 12	7	(32)
Post-secondary	1	(5.0)
Total	22	(100)

Ninety percent of the women also stated that a higher education was not plausible, because they were required at home to assist in raising their younger siblings. All of the respondents had a dysfunctional and unstable family life, so they gravitated towards their friends who were already on the street. Moswa (2000:2) has had HIV and Hepatitis C for six years and described her situation at home:

My alcoholic father, from 3-16 years of age sexually abused me. It was a family secret that nobody wanted to talk about. My mother ignored all the signs because she was in denial pretty much all the time. My dad worked 9-5 and he was home most of the time when I got home from school, which wasn't a very good situation and that's just the way it happened. When I told my mother she believed me and she was the one who decided that she should press charges, because she was already divorced from him by then. The day before we were to go to court was when my dad died and sometimes I think he committed suicide, but no one would ever tell me.

More than half of the respondents also acknowledged that they were not interested in completing Grade 12, since past history had shown them that it would not have improved their future anyway.

As a result of colonialism, the church, and the residential school system Aboriginal women in Saskatchewan have been compelled to live a life that has been prescribed for them, through the Indian Act and under the guise of assimilation. As stated earlier in this thesis, approximately one-third of the respondents had attended residential school. Two of the women had completed Grade 12 while they were there, while others ran away after just a short period of time. The remainder of the respondents had parents or grandparents who had attended residential school. Many Aboriginal families were torn apart as a result of the residential school system in Saskatchewan. Maskwa (2000:4-5) disclosed:

I was about twelve or thirteen when I arrived at Lebret. I was in my teens when I finally left Lebret. Over the years the treatment got better, so I ended up staying there and getting my grade 12 there. The boys had half of the school and we had half of the school, so we saw our brother seldom. It was hard in those days, it was back in the early fifties and my dad would drive by team and sleigh in the wintertime, but I don't remember him coming to see us in the summertime or the fall or the

spring. It was just in the wintertime because he could drive on the lake.

What happened to Maskwa (2000:5-6) at the Lebret Residential School, continued to influence all aspects of her life:

I never got my self-esteem back until I was around forty and being proud of who I was and what I did and my teachings to my children and stuff like that. I was never a very affectionate person to my children. I didn't know how to tell them that I loved them or give them a hug, so they missed out on all of that. When I first tried to kiss my son's cheeks or give him a hug he didn't know how to accept the gesture. What has made a difference is going to the ceremonies and finding out what we're all about and sweat lodges and going to Sundance and stuff like that that gave me an awakening of my own. I was about forty-five. It gave me a sense of worth and I am just as good as everybody else.

In large part that was why Maskwa has continued to work in women's corrections for eighteen years. ^{xvi}She conducts traditional ceremonies such as fasts, sweats, circles, and smudges where the inmates were encouraged to take part. Maskwa (2000:18) talked about why so many young Aboriginal women were turning to prostitution, alcohol, and drugs:

I think a lot has to do with their home lives, but it also has to do with education. A lot of these young women drop out, because they are alone in the classroom with no other Aboriginal person there or they have no push to go. Their mothers and fathers are alcoholics or drug addicts or whatnot and they have to learn how to look after themselves when they are really young, at eight or nine years old. That is how come they end up in Pine Grove. Ninety-seven percent I would say of the inmates in Pine Grove are Aboriginal.

Maskwa maintained that if there was a positive aspect to be found in her stay at the Lebret Residential School it was that she did complete her Grade 12.

4.2.8 Respondents' Religion

Approximately one-third of the respondents stated their religion was Roman Catholic (See Table 4.2.8). Another fourteen percent stated that their religion was a combination of Roman Catholic and Native spirituality. The Anglican religion was a close third with the respondents. This was not unexpected considering the entrenched influences of colonialism and missionaries on Aboriginal communities in Canada.

Table 4.2.8 Respondents' Religion:		
Religion	Number in Sample	Percentage of Sample
Roman Catholic	7	(32)
Roman Catholic & Native Spirituality	3	(14)
Native Spirituality	2	(9.0)
Anglican	5	(23)
Pentecostal	1	(5.0)
Mormon	1	(5.0)
No Specific	3	(14)
Total	22	(100)

In the past two decades, there has been resurgence as well as an acceptance of Native spirituality, traditions, and customs in the form of ceremonies, sweats, circles, and sundances. This is especially evident in the treatment of Aboriginal women, who are attempting to heal from alcohol and/or drug addictions and in some instances, a life of crime.

4.2.9 Languages Respondents Spoke at Home

Over 65 percent of the respondents spoke only English at home and in public even though their parents, grandparents, and Elders spoke a Native dialect (See Table 4.2.9).

Table 4.2.9 Languages Respondents Spoke at Home:		
Language	Number in Sample	Number in percentage
English	15	(68)
Cree & English	6	(27)
Chipewyan	1	(5.0)
Total	22	(100)

For most of the respondents the English language had helped them “fit in” with their peers and did not make them stand out as someone “different” from the norm.

4.2.10 Sexually Transmitted Diseases (STDs) That Respondents Had Acquired

As most of the respondents admittedly took part in sexual activity at an early age and generally through prostitution, they had all suffered from a sexually transmitted disease (See Table 4.2.10). The high incidence of STDs in this population is of most concern, because the same risk behaviours for STDs also apply to HIV (Health Canada, 1998e).

Table 4.2.10 Sexually Transmitted Diseases (STDs) That Respondents Had Acquired:		
Type of Disease	Number in Sample	Percentage of Sample
Hepatitis C	13	(59)
HIV/AIDS	7	(32)
Chlamydia	13	(59)
Venereal Disease	2	(9.0)
Gonorrhea	6	(27)
Syphilis	2	(9.0)
Herpes	1	(5.0)
Genital Warts	2	(9.0)
Trichomonis	2	(9.0)
Total	22	(100)

The findings of this research revealed that, the most common STDs were HIV, Hepatitis C, and chlamydia. Approximately one-third of the respondents were HIV-infected and one of them had full-blown AIDS. Just over one half of respondents had Hepatitis C and had chlamydia at least once. Approximately a third of them had contracted both HIV/AIDS and gonorrhea. Venereal disease, syphilis, genital warts, and trichomonas had appeared in a few of the respondents in different combinations. The main route of transmission for STDs is the same as HIV/AIDS and Hepatitis C, through unprotected anal, vaginal, or oral sexual activity. Some STDs can also be spread through intravenous drug use, by sharing used or unclean needles or syringes and from mother to child during childbirth. The women's knowledge concerning the risk factors for contracting HIV/AIDS, Hepatitis C, and other STDs varied widely. The availability of knowledge varied as well as its accuracy and was compounded by the effects of poverty, violence, intravenous drug use, and alcoholism.

Wacask was twenty-four years old, has had HIV and Hepatitis C, and has also suffered from gonorrhea, chlamydia, and trichomonas. When asked why she felt she had to be tested for HIV, Wacask (2000:13) replied:

Because the guy I was going with was always disinfecting stuff and always wore gloves doing dishes and he never ever gained one pound. He phoned me and he told me, "I'm waiting for my tests to come back".

He phoned me and said, "We are going to get married right?" And I said yeah. "Through sickness and health?" he asked. And I said yeah is there something you're not telling me? He said yeah, I have AIDS and I just broke down. He said he had full-blown AIDS for four years and I just hung up.

When questioned about where she obtained information concerning HIV/AIDS, Hepatitis C, and other STDs Wacask (2000:12) stated:

I know that you can't get it from kissing and hugging. I was educated about it because in school I was educated about it. In Meadow Lake there was a community nurse that came out and said a lot about it, when I was I think in about grade six. I got educated. So I knew all the rights and wrongs and how it affected hugs. If you have open cuts you have to put a band-aid on it. She told us about it.

Wacask also pointed out that she had looked in the library at Pine Grove, in an attempt to educate herself about HIV/AIDS and Hepatitis C. Mahkesis was diagnosed with HIV four years earlier at the STD Clinic in Prince Albert. Mahkesis also described how the STD Clinic in Prince Albert and its counsellors had helped her to better understand HIV/AIDS and how to take care of herself. They had also supplied her with free condoms and fresh needles and syringes. Pipiciw (2000:7-8) has had HIV and Hepatitis C for roughly six years and when asked where she got her information about HIV/AIDS and Hepatitis C, she replied:

When I was in Vancouver I was a heroin addict and I was doing a lot of cocaine. When I got it (HIV and Hepatitis C) I just moved here (Regina) anyway, because everyone around me was dropping like flies all the time. So that's why I guess I associate it so much with death. So I never really educated myself about it before I had it. They always gave out condom with things to tell you what to do if you want to talk about AIDS or whatever and it's got the phone numbers on the back and stuff. I'm just taking the condoms out and putting that back or throwing it in the garbage. We just wanted the condoms. After I realized I had it then that's when I tried to educate myself, but I don't really have the patience to learn everything, just what I need to know.

Most of the women obtained information about HIV/AIDS and Hepatitis C during incarceration, through STD Clinics in the nearest urban center, and some from their doctors or specialists. Ciask (2000:7) has had Hepatitis C for approximately seven years and revealed a very unorthodox treatment for HIV/AIDS:

I know that that have been known to do it though, like tiny bits of it at a

time to kill the virus and all that. I said to a friend of mine, what are you trying to do... kill yourself? She said no, I'm trying to kill the virus. I said it doesn't matter how much you put in eventually it all adds up and it's going to knock you right out of your socks. She said well if it does it does, I'm dying anyway.

Some of the women held false hopes that a cure for HIV/AIDS or Hepatitis C was in the foreseeable future. They felt that if they could just keep themselves healthy long enough they could benefit from that cure. Ciask (2000:7-8) continued:

It doesn't bother me so much having it (Hepatitis C), it is knowing that they are going to come up with a cure for it. I am pretty sure with all of the dreaming I get, that they are going to come up with a cure for Hep. C. The public health nurse that comes here, she was saying that there was some kind of hope already for HIV or Hep. C. About it now I mean it's in your system and once it gets diagnosed early surely it would be early enough to catch it.

The very thought that members of the health care profession in Saskatchewan are telling Aboriginal women such falsehoods (a cure for HIV/AIDS and Hepatitis C is imminent) is recklessly detrimental to the health of all Aboriginal communities. These are the same Aboriginal communities that do not perceive HIV/AIDS and Hepatitis C as a serious threat that needs to be dealt with at the collective level, as soon as possible.

4.2.11 Respondents' Alcohol Consumption

In this thesis, just over a third of the respondents were found to drink minimally, moderately, or heavily (See Table 4.2.11).

Table 4.2.11 Respondents' Alcohol Consumption:		
Amount of Beer at one Sitting/Per day	Number in Sample	Percentage of Sample
Minimum < 6 Beer	8	(36)
Moderate 6 Beer	7	(32)
Maximum > 12 Beer	7	(32)
Total	22	(100)

They all drank for basically the same reason, its availability at home and on the street. They also drank to fit in and to numb the overwhelming feelings of shame and guilt that invaded every

aspect of their lives. Many of the respondents stated that alcohol was readily available at home and on the street. Alcohol was also consumed in combination with intravenous drugs.

4.2.12 Respondents' Drug Use

Most of the respondents used some form of drug and continued to do so on a regular basis.

Table 4.2.12 Respondents' Drug Use:		
Name of Drug	Number in Sample	Percentage of Sample
Ritalin	10	(45)
Ritalin & Talwin	7	(32)
Morphine	12	(54)
Cocaine	13	(59)
Dilaudid	4	(18)
Heroin	6	(27)
Marijuana	7	(32)
Valium	1	(5.0)
Talwin	1	(5.0)
Tylenol # 3	1	(5.0)
Total	22	(100)

The drugs were most often used in conjunction with alcohol. The most commonly used drugs were cocaine and morphine (See Table 4.2.12). Ritalin and Talwin (T's and R's) were used in combination and were often referred to as "poor man's heroin." Marijuana was frequently used as well. Heroin was only available to those who could afford it with cash or through other means (prostitution). The rationale behind the use of drugs was much the same as it was for drinking alcohol, although the drugs were purchased with the revenue from prostitution and were used to sustain the women's bravado to sell themselves. Each of the respondents described this conduct as a vicious cycle that was inescapably difficult to break, once they started working on the street.

4.2.13 Alcohol and/or Drug Treatment of Respondents

More of the women went through treatment for drugs and/or alcohol as did not (See Table 4.2.13). Some of them went through a treatment program for alcohol and/or drugs more than once.

Table 4.2.13 Alcohol and/or Drug Treatment of Respondents:		
Yes/No	Number in Sample	Percentage of Sample
Yes-Once	9	(41)
More than once	4	(18)
No	9	(41)
Total	22	(100)

Of the women who did attend treatment, most did so as a duty required of their probation or a court order and not through any choice of their own.

4.2.14 Crimes for Which Respondents Had Been Incarcerated

Ninety-percent of the respondents had been incarcerated at least once in their lives, the majority for prostitution. Minor charges included shoplifting, fraud, breach of probation, break and enter, failing to appear, drunkenness, not paying a fine, uttering threats, fighting, and the possession of narcotics. The more severe charges for which the respondents were incarcerated included trafficking of narcotics, obstruction of justice, possession of a firearm, aggravated assault, and robbery with violence, unlawful confinement, and escaped from facility (See Table 4.2.14).

Table 4.2.14 Crimes For Which Respondents Had Been Incarcerated:		
Offence	Number in Sample	Percentage of Sample
Shoplifting	8	(36)
Break & Enter	4	(18)
Robbery with Violence	2	(9.0)
Unlawful Confinement	1	(5.0)
Trafficking Narcotics	3	(14)
Prostitution	9	(41)
Assault	7	(32)
Drunkenness	1	(5.0)
Fighting	2	(9.0)
Failing to Appear	3	(14)
Breach of Probation	4	(18)
Possession of Firearm	1	(5.0)
Uttering Threats	2	(9.0)
Obstruction of Justice	1	(5.0)
Not Paying Fine	2	(9.0)
Fraud	1	(5.0)
Possession	1	(5.0)
Escaped Facility	1	(5.0)

Wapos was incarcerated in Pine Grove for two years less a day for aggravated assault. Her boyfriend was going to beat her up so she slashed his neck before he could do her any harm.

Wapos (2000:3-5) described the circumstances:

Like this guy that I'm in here for, he didn't tell me he had Hep. C and he grabbed my needle and I grabbed his needle by accident. I realized I grabbed his needle because his needle was different from mine. When I finished fixing I looked at the needle and I threw it down. I said "shit why the fuck don't you keep your fucking stuff in your own fucking space?" He said, "Ah shit I'm sorry". I said "you better not have nothing or I'll fucking find out". He didn't say nothing then and when I grabbed his needle that's when he told me. I went and got a blood test and the test came back positive for Hep. C...He didn't care and he was dirty about

his fixing. I would watch his needles after that and I'd say watch where you're throwing your needles. We were fixing one weekend and he just pushed things too far and he started hitting me and stuff and I grabbed a knife. I know its crazy thinking, but I just went up behind him and I slashed him right around his neck. He tried to pull the knife away from me and I cut his finger and then I hit him on the face and I hit him on the head and he fell down. He lived and I got thrown in here (Pine Grove).

Mistatim indicated that she had been incarcerated pretty much every year, since she was 12 years old. She had spent time in Kilbourn Hall (Saskatoon) and other youth detention centers in Saskatchewan. She had also done time in provincial jails for breaking and entering, robbery with violence, and unlawful confinement. At the time of the interview, she was serving two years for her first federal offence (at the Prince Albert Penitentiary) trafficking in narcotics. Mistatim (2000:9-10) discussed some of the circumstances of her latest arrest:

When I got busted and came to the pen I had three grams of coke on me. They searched me, but I swallowed it so they didn't have any evidence and so that I had it for later. You wrap it three different times; the bundles are wrapped three different times. You put about a gram and a half in a little baggie and tie it up. Then you wrap it again in another plastic bag and then a third time in another plastic baggie. Then you swallow it. I always wrapped it carefully. I used to walk around like that most of the time. I used to carry a lot of my drugs on me like that in case I got busted or someone tried to steal them from me. Then you take them out and use them when you need them.

Mahkesis (2000:2-3) offered an example of the violence that permeated the lives of each of the respondents:

A friend of mine had come into town and she had about \$4,000.00. So I went downtown and got my niece Stephanie to baby-sit my baby, Gary. I had kicked Glen (ex-boyfriend) out about a half an hour before that. He was in the living room and I walked by him to the kitchen and all of a sudden a great big ashtray zoomed by my head and just about hit my baby. So I threw him out. We went downtown to pick up some beer and just when we got there she was saying come on lets go..."I'll buy you guys a quick double". I said sure and I sat down and took my three sips and that was it. Then I had to wait for a cab to get home. By then all this shit is going on at home. I guess he (Glenn) must have been watching. He went back and forced himself in there and took my baby and started walking down the street with him. About five minutes later my then son-in-law Raymond walked in. Stephanie was crying and said that Glenn just took Gary away and I couldn't do nothing about it. So Wheat (ex-son-in-law) went running down 8th Street (Saskatoon), caught up with Glenn and got my baby back and brought him home. The baby had been

put to bed and we were sitting around drinking when all of a sudden Glenn kicked the door down and he had a butcher knife. My son-in-law was very short but very tough and he was only seventeen. This guy that gave me HIV (Glenn) was about six foot one maybe. They got into a scuffle and somehow Glenn ended up stabbing himself. My niece phoned the cops while they were fighting. One cop came along and he said, "Whose blood is that?" Like it was all over my niece Stephanie. She said Glenn's. They told her I guess and she told me later, to go for an HIV test because he was suspected of having HIV.

Mahkesis had a tendency toward violence herself. She had choked a woman until she could not breathe, because she had stolen a \$4.00 brush that her daughter had given her. She had beaten three other women who had stolen from her or did not pay her money back. She had also repeatedly hit a woman's head on the cement floor of a jail cell because they had a disagreement. Many of the respondents continued to take part in a cycle of violence that had been forged in previous generations.

4.2.15 Victimization of Respondents

Ninety-five percent of the respondents have suffered from some form of abuse: sexual, physical, emotional or spiritual. The abuse took place either at home or on the street.

Table 4.2.15 Victimization of Respondents:		
Type of Abuse	Number in Sample	Percentage of Sample
Sexual Abuse	19	(86)
Physical Abuse	21	(95)
Emotional Abuse	21	(95)
Violence	20	(91)
Total	22	(100)

Family members, including their fathers, grandfathers, uncles, foster-fathers, ex-boyfriends, and common laws, as well as johns violated the respondents (See Table 4.2.15). Furthermore, many of the respondents witnessed the abuse of others at some point in their lives and over a long period of time. These women suffered a whole range of abuse, including rape, beatings with a weapon, hospitalization for broken bones, and intimidation, resulting in a cycle of violence for most of them.

4.2.15.1 Sexual Abuse

This research revealed that eighty-six percent of the respondents had been sexually abused. This was not unexpected, considering that the main occupation of the respondents was prostitution. This research reveals that they were violated by family members, ex-boyfriends, ex-common-law partners, as well as by johns. Mistatim had been a 'hooker' and a drug dealer and has had HIV for nearly three years. Her cousin sexually abused her at five years of age, her stepfather (her mother's ex-boyfriend) abused her at nine years of age and her biological father abused her when she was 12 years old. Mistatim (2000:6) described the violation by her father:

My mom and dad were both heavy drinkers. One night we were all sharing the same bed. I was about 12 years old and my mom and dad had been drinking heavily. During the night my mom got up to go to the bathroom and then my dad reached over and started fondling me. I screamed and my mom came. I told her what happened and she just said, "Oh he didn't know what he was doing because he was drunk." Two months later my mom killed my dad in a drunken rage. Ever since, my mom has thrown it in my face saying, "I killed him for you" and "you owe me." The only time I hear from her is when she needs something. If I say no, she reminds me that she killed my dad for me. I didn't want her to kill him.

Amisk had been raped twice, once by a person that she knew in the AA program and again by a man in Prince Albert last August. Amisk (2000:10) described what she experienced as a child:

I was very angry and by the time I was eleven I was dead, a walking dead. I used to write poems like I would scream inside and nobody was hearing me. I ran away from a youth center because I was raped. After a year or so I went to look for my mom. I ended up in Regina where I didn't know anybody. I slept under the steps of a parkade and I got robbed and raped by an Asian guy. I remember the girl at the station said go to the YW they'll take you in. I went there and they ratted out on me. I got put in the Dojack Youth Center, in Regina and when they took me back my worker could only say why did you run away? Nobody asked me what happened.

Anikwacas (2000:11) was sexually abused by her older cousins and described her past:

If they are going to do the rat to you that's part of it, they want to hurt you. That happened to me this trick didn't want to wear a condom when I insisted I got the crap beat out of me and I got raped for a couple of hours...I just got myself numb to it after three years. It was very brutal. I got left way out in a field at six o'clock in the morning and I had to walk two miles to the nearest place. I took off out of the city after that for a

couple of months and went back to the reserve (Piapot Reserve). I couldn't talk to anybody about that, nobody cared. I phoned home and I said I was raped last night and I was taken out of town and beaten up and everything. Oh really you shouldn't talk about that kind of stuff, they told me. I charged him and everything. They found him and when it came time to go to court I couldn't do it. After they let him out he was driving around the streets looking for me again and I would just take off and hide until he was gone.

This research has shown that there are a disproportionate number of Aboriginal women in Saskatchewan who have experienced sexual assault. This information alone underlines the very real threat of HIV/AIDS and Hepatitis C spreading even further in the Aboriginal community, as a direct result of sexual violence against Aboriginal women.

4.2.15.2 Physical Abuse

Ninety-five percent of the respondents had been physically abused. Makwa (1999:6-7) disclosed her experiences with her pimp, who happened to be a bill collector for the Grim Reapers (an outlaw motorcycle gang that was absorbed by the Hells Angels motorcycle gang in 1997. They take part in money laundering, intimidation, assault, attempted murder, fraud, loan-sharking, extortion, prostitution, the trafficking of illegal weapons and drugs, including cocaine, marijuana, and ecstasy, in both Canada and the United States):

Yah, my ex-boyfriend the pimp that I worked under, he was also a bill collector for the Grim Reapers. Boy he was a mean guy. Oh Jesus, I got scars all over. I got four inches on the neck here because I opened the door. He was too drunk and he got mad because I could do it and he couldn't. So he got a knife and got me on the back of the neck. It was like three o'clock in the morning and he was drinking and he was getting mean, beating the crap out of me. Then he went into the bedroom to go get the pipe. So I ran out the door and I kept going. It was hard because I would go to Saskatoon and he followed me. I went to PA and he followed me. Then I moved to Regina. He followed me there as well. So now I am living in Moose Jaw.

Most of the respondents had a "pimp" while they were taking part in prostitution. These "pimps" preyed on the women's vulnerability and offered them support, love, and a way to get them back on their feet. Makwa (1999:7-8) revealed:

I went to court (for break and enter) and that's where I met the pimp guy. He says, "oh you are M", he says, "Come on let's go for a drink". I said

“okay get me out of here “ because I didn’t want to be in court. So we met and went for a couple of beer and everything and I said I just lost my apartment and my boys had just gone where they went and I needed some place and I need income. This person just happened to be a bill collector and a pimp on the stroll. I said, “okay I tell you what I need, money, and I need a pimp”. I said, “If I can do this of course you would get your piece”. You pay a hundred bucks a day on that stroll when you stand on the corner, even if you don’t get anything you still pay a hundred bucks a day. If you don’t get it then it goes on the next dole tomorrow and so on. Then I told him “okay you’ll get a hundred bucks yourself a day and then I get the rest”. Pretty soon we got together doing cocaine and pretty soon he started to get all the money. If I had a quarter on me he thought I was trying to call my boyfriend or something like that and he’d beat the shit out of me for holding out, for holding onto a quarter, twenty-five cents.

The majority of the respondents had suffered some form of physical abuse at home or on the street. Again, abuse was committed by family members, pimps, ex-boyfriends and/or by johns. Many of the women also admitted that physical abuse was difficult to deal with not only through the actions of others, but also in their own personal actions toward others. The violence that many of the respondents admittedly displayed with regard to others is a primary example of the cyclical aspect of abuse.

4.2.15.3 Emotional Abuse

Ninety-five percent of the respondents had also suffered some form of emotional abuse. Apisimosi (2000:3) had recently found out that she had Hepatitis C and explained the emotional roller coaster that she went through with her ex-common law:

I think I got it through my ex-common law through sexual intercourse and we did share needles and stuff like that. I was wondering why he was always going to take hepatitis shots or something like that. I’d ask him “do you got Hep?” and he’d say “oh no I just took shots”. I was like you don’t take them unless you need them. Well just in case I do get it he said, to prevent it. He’d tell me that and I never bothered to check into it myself and now I ended up with it.

Nicole (2000:4-5) had been in Saskatchewan’s social system since the age of fourteen and described her turmoil:

I had a boyfriend then and I was in a foster home and he introduced me to the street, because he was a pimp. He introduced me to the big city and to doing tricks and stuff like that. I am trying to break the cycle, because I am

twenty-three now and I can't keep living like this. I haven't been in a relationship lately because I'm so fucked up in the head. It's just like I don't know where I belong and that's why I always get high because it heals the pain. It also helps me forget that no one cares about me. It seems like the only time anyone cares about me is when I'm in jail. I have been thinking about suicide lately, because I am sick of this life of being homeless and everybody just using me for my drugs and my money and my body.

For most of the respondents emotional anguish was a common theme and an ordinary happenstance in most aspects of their lives.

4.3 Responses to the Semi-Structured and Open-ended Questions

Each of the Aboriginal women from Saskatchewan who are profiled in this research was asked to answer semi-structured and open-ended questions. The women were very forthcoming with their answers and the researcher was able to establish rapport quite easily. The following are excerpts from the answers that some of the respondents shared with the researcher.

4.3.1 Disease and Diagnosis

The Aboriginal women profiled had been diagnosed with HIV/AIDS and/or Hepatitis C for as short as 1-2 days and for as long as twenty-one years. The effects of being diagnosed with HIV/AIDS and/or Hepatitis C were devastating for all of them. The circumstances of their lives at the time that they were diagnosed and where they were tested varied. Wapos was diagnosed with Hepatitis C in August 1999, at the STD Clinic in Regina. She disclosed that she had been living and working on the streets of Regina at the time. Wapos (2000:6-7) specified:

The reason why I ended up on the street was my family wasn't involved in the things I was getting involved in, like pimps and pushers. What started me was my sister was already into that when I came to the city. She was already working the street and everything, but she didn't hang around with the pimps. She would just make her money and then she would go and buy it (drugs). I kept telling her to quit using. She quit so long and then she started going out with this guy from the street and he got her right back into it. I would go visit her and we would take off on her old man and leave him with the kids. She would want to buy six so I would chip in with her and I would get my cut out of it. I started to like six myself and I had to give her too much money, so I started doing it myself. I started fixing and I started to get to know all the drug dealers.

Wacask has had HIV and Hepatitis C for approximately a year and was diagnosed while she was incarcerated at Pine Grove. When asked about the circumstances of her life at the time, Wacask (2000:2) replied, "I turned my life around. I had quit doing needles and I started staying home with my kids. Then when I came here I decided to go for the test to be on the safe side and it came back positive." Wacask felt a great deal of animosity towards her ex-boyfriend's family, who knew that their son had HIV and Hepatitis C and had never told her about his condition.

Eighty-five percent of the respondents had lived with HIV/AIDS and/or Hepatitis C for one to three years. Ten of the respondents had Hepatitis C only. Five of the women had HIV only and five women had HIV and Hepatitis C. The average age range of the women with HIV/AIDS and/or Hepatitis C was 24-28 years of age. The average age range of the women with Hepatitis C was 23-39 years of age. The women with HIV only ranged in age between 27-42 years. Angel (1999:1) was 34 years old and had the following to say: "I have been living with HIV for three years...I was living out in Burnaby, British Columbia and I was an intravenous drug user. I was doing coke and heroin and I was hanging out at crack houses and sharing "rigs" and got an infected needle."

Mistatim (2000:2-3) has had HIV for approximately four years and related how she contracted the disease:

It was probably through unsafe sex. There were more times than I can remember when I didn't use a condom when I was turning tricks or just having sex with a boyfriend. I didn't like the feel of a condom so I didn't always use one. There was a certain guy that I had sex with. He had just had an argument with his girlfriend, and he was a good friend of mine so we spent some time together. He had HIV and I knew he had HIV. He didn't try to hide it. He wanted to use a condom, because he wanted to protect me. I knew that he had HIV, but I didn't want him to think that I didn't trust him and care about him or make him feel like he was different because he had the virus.

Tiffany (2001:8) was twelve years old when she started working on the street, has had HIV and Hepatitis C for two and a half years, and described why she got into prostitution:

Because she [her mother] threw me out and I didn't know what to do. I seen girls do it and I asked them how you go about it. So I met this black

guy and he told me how much to charge and what to do and all of that. Then I did that and made lots of money. He wasn't there to protect me. If he did you know like I didn't see him driving or sitting or parking. He should be taking license plate numbers but he didn't, he just stayed at a nightclub drinking and trying to pick up other girls.

Pipiciw (2000:4) has had HIV and Hepatitis C for six years and revealed, "I was living in Vancouver where their HIV is so high that almost everybody has it and being a junkie well...In Vancouver like you would just do it anyway because you just needed your fix. It didn't matter whose needle you used." Pipiciw (2000:4) continued, "I came back to Regina from Vancouver after seeing people I knew get really sick or die from HIV and I thought maybe I should take a test and I came back to have the test."

Most of the respondents were unaware of having contracted HIV/AIDS or Hepatitis C and did not get tested on a regular basis, even though their personal behaviours were precarious. Many of them had been living and working on the street and using alcohol and/or drugs, when they became infected. They had also begun a life of prostitution at a very young age, which included unprotected sex and intravenous drug use. Many were diagnosed when they started to show symptoms of disease or when they were incarcerated. After being incarcerated, many of the respondents were checked through an STD Clinic on a regular basis, usually every three months, which was mandatory after release.

4.3.2 Illness and Personal Relationships

Seventy-five percent of the respondents had experienced both positive as well as negative responses to their illness, by both family and friends. Anikwacas was a prostitute who worked the streets of Regina since she was just fifteen years old. Anikwacas (2000:8-9) described how her life had changed on and off reserve since being diagnosed with Hepatitis C:

O yeah my family they're cool but to a point. I live a double life. Like my reserve life is a girl that does gardening and stuff. Then I get to Regina and I'm this street person that just doesn't give a shit, you know. My family stays on reserve. They are aware of it (two sides) because they don't even say nothing about that. Not once have they. They don't even care, that's what I think. Just my kokum, my grandma, she is

always on my case over needles all the time. She doesn't know everything about it, but she knows. That's the only one.

Anikwacas (2000:6-7) described how she felt it would be for young women with HIV/AIDS and/or Hepatitis C on reserve:

I think there would be a lot of shame and guilt and I don't know if I would be able to go home with that. I don't know. I don't think anybody in the community would ever understand. A lot of these girls that hit the streets never come back home just because of the fact that they've been out there and a lot of people make it hard for them to come back.

Anikwacas's mother overdosed and had been in a vegetative state since Anikwacas was three years old and her father continued to be a regular inmate at the Prince Albert Penitentiary. The only stability that she ever had came from her grandparents on reserve. Mistatim indicated that it was very difficult for her to establish relationships and that the only important person in her life had been her eighty-three year old grandmother, who had just recently passed away. With respect to other family members Mistatim (2000:5) declared, "My brothers know I have HIV and I have seen them in here. My youngest brother was discharged two days ago. All of them were at my wedding here but they don't keep in touch with me, because my Mom killed their Dad, my Dad."

Pipiciw (2000:2-3) was a 28-year-old ex-prostitute and noted:

My mother is blind to the things that I do or who I am or what I am. Because I look so healthy she doesn't believe that I have AIDS and its six years now. With my Hepatitis she said okay, I might have that and I go over there and she's sterilizing dishes. I can't take food out of the same plates as they (family) do. When I went there for Christmas one time they were eating chips and dip and they wouldn't even let me dip my chip in the dip, because they were scared they could get something.

Eleven of the respondents made a point of mentioning that they felt betrayed by both family and friends. Approximately a third of the women had the full support of their families while others did not. Seventy-five percent of the women made it clear that their families and friends did not necessarily understand their disease and tended to alienate them, out of ignorance and fear. It was difficult for most of the respondents to establish any form of lasting relationships, due in large

part to their disease, their lifestyle and their personal histories. Many also acknowledged that they felt they had to invariably guard against the actions of others so that they would not be hurt. For most of the respondents, having HIV/AIDS and/or Hepatitis C had not brought them closer to their families and friends, instead they were left feeling even more isolated.

4.3.3 Respondents' Own Knowledge about HIV/AIDS and/or Hepatitis C

Ninety-five percent of the Aboriginal women profiled took part in a lifestyle that made it necessary for them to have some knowledge with regard to Hepatitis C and/or HIV/AIDS. Some of the respondents gleaned the knowledge that they did have, through STD Clinics, outreach workers, and doctors, but most of them were educated through a life of incarceration. A number of the women obtained information firsthand working on the street, which was seen as indispensable to survival. When asked whether she used condoms and practiced unsafe sex, Wapakosis (2000:6) replied, "No. Well I'm pretty much with my boyfriend like I go around but I don't sleep around. When I do go with guys it's not sexually, I mark them in. Sexually, if I was going to be I'd be safe. I'm safe that way." Wapakosis (2000:6) admitted that there were places to secure information about HIV/AIDS and/or Hepatitis C, but it was not necessarily what she or other prostitutes wanted to know:

Yeah, but you kind of avoid that topic though. You don't just sit around and talk about AIDS when you are out there. People don't talk about it. It's a disease that kills you and face it man, nobody wants to know anybody who has it and it's scary. Just to find being able to talk about it and say look I have AIDS. If you have had Hep.C maybe it would be easier for them to say, because I always hear a lot of people saying that Hep.C is no different. It is gradually going to go up to graduate to AIDS, the way you are going about with that needle and I still try to use it. So no I don't care. I didn't care to get it so if I get it maybe I deserve it.

Wapakosis's attitude was much the same as a number of the respondents, who lacked any sense of self-worth, and felt that they did not deserve anything better or that they had it coming. Minos (2000:6-7) obtained knowledge concerning HIV/AIDS and Hepatitis C, from the counsellors at the STD Clinic in Prince Albert:

I know it can kill you. HIV and AIDS is one disease. HIV develops into AIDS and it has certain stages. I read a lot about it but I don't know how a person would feel. I guess it would be the same thing as Hep. C for me. I think it's the first stage of AIDS the first stage of getting it or having it. I get scared and I think about it a lot. Marlene (counsellor) helped me through a lot and she has been very supportive. She tells me a lot and I owe my life to her.

When questioned about her knowledge pertaining to HIV/AIDS and/or Hepatitis C, Apisimos (2000:4) observed:

For Hepatitis C there are little pamphlets in the nurse's office here. I read about Hep C after I found out I got it. There wasn't too much on how it can be sexually transmitted except maybe if I consumed a lot of whatever you know what you call it (semen). And I have so and we shared rigs together.

Apisimos also pointed out that the only information that she was able to obtain about HIV/AIDS and/or Hepatitis C was from the health nurses at Pine Grove when she was incarcerated.

Seventy-five percent of the respondents in this research obtained information about HIV/AIDS and/or Hepatitis C during incarceration or at the nearest STD Clinic in Saskatchewan. It was evident that even though the women had been diagnosed with one of these diseases and made clear the risks of their continued behavior, they still had unsafe sex and used intravenous drugs. There is no doubt that this could be described as an addictive demeanor, but for these women it was more than that. For them it was a lifestyle that began on the street, to escape their home environment and then it graduated to alcohol, intravenous drug use, prostitution, and incarceration and for some, ended with contracting HIV/AIDS and/or Hepatitis C. This vicious cycle was something that nearly all of the respondents had spent most of their lives trying to break.

4.3.4 Knowledge of Others with HIV/AIDS and Hepatitis C

Ninety-five percent of the respondents know someone who has been incarcerated or who has worked the street, and who has had HIV/AIDS and/or Hepatitis C. These were Saskatchewan Aboriginal women who had lived the same lifestyles as themselves. Apisimos (2000:4) had just

recently found out that she had Hepatitis C and pointed out, “There are two girls in here that got HIV.” Wapakosis (2000:5) was a twenty-six-year-old ex-prostitute, who had just found out that she had HIV and she stressed, “Just by listening to what is happening on the street and the way that they pass on needles. Oh yeah, it happens that they have it.” Mistatim (2000:7) was a twenty-seven-year-old hooker and drug dealer and maintained:

I have a girlfriend who has HIV she’s in full-blown AIDS. She just had a baby and after that they found out she was sick. She’s really sick and she has a brand new baby. She got HIV through unsafe sex and drugs, I think. Now she has a tiny little baby that won’t have a mother.

A number of the respondents were unsure of how HIV/AIDS and/or Hepatitis C are contracted. Cahcakiw (2000:8), a twenty-three-year-old ex-prostitute, was one of eight children, and also had two younger sisters and a brother that had Hepatitis C she indicated, “They got it through intravenous drugs and I think they were sharing among each other. My older sister, the one that is my half-sister, she’s got full-blown AIDS right now and she’s got Hepatitis C and she’s got herpes and stuff like that.” Apisimosi (2000:4) was asked if she knew how HIV/AIDS and/or Hepatitis C could be contracted she responded: “Yes I do, needle sharing, sexually transmitted diseases, and contact of the blood and you can get Hep C from using a spoon of another person that has Hep C. I’m sure that you can get HIV that way too.”

Once they recognized that they had contracted HIV/AIDS and/or Hepatitis C, the majority of the respondents not only understood but also admitted that their behaviours and attitudes, concerning their sexual activity and their use of intravenous drugs, were careless.

4.3.5 Worst Aspect of Disease and Support System

Seventy-five percent of the respondents established that the personal aspect of their disease was the worst-case scenario. They saw the medical aspect as not as ominous, because they could deal with the symptoms and many had made peace with the fact that they were ill. It was much more difficult for them to deal with the feelings of guilt, humiliation, and abandonment

in their personal relationships. For Pipiciw (2000:9-10) the worst part of having HIV and Hepatitis C was:

Personally, I'm just trying to keep it a secret, because I'm sure a lot of people wouldn't understand. A lot of people would push me away or they would just kind of cut me down or there would be ugly rumors stuff like that, just the secretiveness of it. Nobody is educated enough to give you a hug and say heh it's okay. You would be a leper or something. You know what I mean? I just wish I could tell some people because maybe they would understand some of the things about me. I find that I have to be very secretive about it and in a place like this (Pine Grove) it is very hard because rumors are just going. Some people that know me and know that I have it are saying you know Pipiciw has AIDS. Don't tell anybody and it just goes around.

The fact that Pipiciw felt that she had to keep her illness concealed made her feel totally isolated with no one to share her thoughts and her fears with. Pipiciw (2000:10) continued:

I spend a lot of time alone in here (Pine Grove) because a lot of people don't want to get close to me. I find that I don't want to get close to anyone either. There are also needles and drugs in here too but nobody will fix with me. That doesn't matter because I'll get out and do my own, but it's a lot of things like that. Everybody just kind of keeps me at a distance and friends don't want to get too close. I'm not having a sexual relationship with anyone in here. I did years ago. Now I don't but if I did somebody would probably go up to the girl and say heh she's got AIDS. I don't try to put anybody in that position. It's all just the secretiveness of the whole thing.

Apisimosi (2000:9-10) stated that the worst aspect of having Hepatitis C for her was medical: "because the fact that I have it and you know a lot of people would be like holy cow we can't have that or no we can't do this and we can't do that. But I'm hoping it will go away. I want to have another kid. I want to have another baby. I want a baby boy." Apisimosi also made it clear that her family loved her for who she was and not what she did.

Makwa (1999:14) described the worst part of having HIV for her:

Everybody is going to die. No that doesn't bother me. The worst part for me would be being sick and having my children have to change my diapers and that kind of stuff. That would be the worst part for me. People know that I am positive and some of them may shun me, but like I say that's fine that's okay I don't need them in my life.

Makwa concluded by saying that she sometimes wondered whether the side effects of the drugs that she was taking, were worth the way that they made her feel. She realized that the drugs were not a cure but hoped that they would extend her life. Mistatim (2000:8) revealed that she has had difficulty with both the medical and the personal aspects of her illness, “The worst part is worrying about being sick having blood tests done and waiting to see if my viral load was high or low. I know when I do drugs [cocaine and heroin] my viral load always went up, but I used anyway. I worry if I will be able to have children.” Mistatim (2000:4-5) continued:

The worst part has been with my friends and the way that they have treated me. They are supposed to stand by you when you need them and I don't want any of that fucking false compassion shit or pity. My so-called friends will talk to me and as soon as I walk away they start laughing or something. If I ask them what's going on and what they are laughing about, I get called that “fucking HIV bitch” or you don't know what you are talking about “you AIDS bitch”. That really hurts because they are supposed to be my friends. Those people that called me a “fucking HIV bitch.” I got even with them. I broke into their place and stole their money and their drugs. They couldn't do anything about it because they were dealing too.

Cahcakiw (2000:10) had much the same story as the others with HIV and Hepatitis C, but described her thinking from a different point of view:

Living with it mentally I am going crazy. Personally I would say it is a challenge for me all the time. What bothers me the most is the fact that there's little bugs eating me up inside. I heard on the news that there was going to be a cure, but it is going to take thirty years and that's shocking. Then they show people with AIDS in the hospital and oh my god do they look sick when like it's their time to go. That was on this program on TV. I couldn't sit and watch it. When someone comes to talk to me about living with AIDS, I can't handle it and I just start to cry and I wonder if I'll ever accept it. Yet, in a way I did accept it because I am still living. I am only twenty-six years old and I am already dying.

All of the respondents expressed their thoughts, concerning the worst aspect of their disease, from both a medical and a personal standpoint. Seventy-five percent of them decided that the personal aspect of their disease was more devastating. For some, it was personal because of how it affected their relationships with family and friends. In most instances the respondents were left with feelings of loss and alienation, due to a lack of understanding among significant others about

their illness. Each one of the respondents shared the same fear of reaching the end stage of their disease and of death.

As stated earlier approximately a third of the respondents had the support of family and friends if they happened to live close by. Assistance was also made available through AIDS Saskatoon, AIDS Regina and AIDS Prince Albert, The Persons Living With AIDS Network, and the All Nations Hope Network. STD Clinics in the major cities had assisted most of them with education concerning the prevention of HIV/AIDS and Hepatitis C, needle exchange programs, condoms, and any other needs that they may have had. Some of them did not have a support system of any kind. Cahcahiw (2000:14) described her support system:

Yeah I have a lot of family members that do support me. I wouldn't say mostly me but it just feels like it. Most of my family members support me because I've tried so hard to make a normal life. I've tried so hard to quit drugs. I've tried so hard to take care of my son and I have tried everything. I had my own place that I was really proud of. A lot of my relatives, when I was living alone with my son, they would come in every day to see me. They were so happy for me because of the lifestyle that I lived. Because of the lifestyle that I'm living now I quit drugs and stuff like that for a while and I just started using again, because I lost my home and I came here [Pine Grove]. I lost just about everything I had and everything to look forward to out there, except my son is still out there. A lot of people around me like my relatives, my aunties, and uncles they all help me and they all come over and they all talk to me about it and they always come back.

Apisimosi (2000:10-11) related:

I was always loved ever since I was a little girl and I'm happy for that. I'm glad I'm not like some of the girls that don't have anybody. There are times when I do feel like I don't have anybody, but that's just me that's what I think anyway. Since I've been here [Pine Grove] being institutionalized has made me think a lot clearer and think about what I want in my life instead of all the negativity. I want positive thoughts and positive feelings towards life now. I feel bad that I do have it but I guess it's something that just happens, especially living a life as a prostitute and a drug user. Also the STD Clinic in Regina has a needle exchange and they have a van that drives around giving out clean needles and condoms and information on things.

All of the respondents stated that they did not want to die and that they were especially afraid because there was no cure for HIV/AIDS and/or Hepatitis C at the time. Wapos (2000:9) has had Hepatitis C for just over a year and pointed out:

My support system is spiritual. I always keep that in mind. I always keep the God of my understanding in mind and I imagine what he would do. That is to not put anyone at risk and I wouldn't put anybody at risk. All that matters is what he sees and that's it. That's my support. I tried to tell my friends about it, but they started talking about me right away and they went and told everybody else. Then everybody started to make fun of me. So, I got away from them and I keep admitting; it so what to everybody and they leave me alone.

Nicole admitted that she had no specific support but she went to AIDS Saskatoon and the STD Clinic in Saskatoon to pick up fresh needles. Nicole (2000:9) described how she dealt with having Hepatitis C: "Well I don't look after my Hepatitis C.... it's just when I come in here [Pine Grove]. I really do clean up myself when I'm in here, but when I get out it seems like the same things happen all over again. You know what I mean?"

The adequacy of the support system, that each of the respondents had, seemed to vary a great deal in relation to their personal circumstances at the time. When she was asked where she obtained support, Pipiciw (2000:12-13) pointed out:

Well I go to AIDS Regina and All Nations Hope. All I do there is just grab condoms and needles and sometimes I sit down and talk. They know me pretty good. I don't know it's just when I'm using a lot and losing a lot of weight and stuff I just hate going in there, because they are going Pipiciw you look like shit. It's just so hard to hear it because I have totally refused treatment. Nothing at all. They keep telling me there are new drugs Pipiciw there are always things and I don't want to hear it. I don't want to even prolong it. Why should I? It wasn't like my life was all that great anyway. It doesn't really bother me but it is my choice.

When asked about her support system Minos (2000:4-5) replied:

My whole family lives in Sandy Lake. We don't hide anything from each other. My brother, my baby brother and my sister they both have it too. My brother just started using needles, my baby brother so, he just got it recently and he doesn't know how to handle it so I talk to him. I feel like I'm the cause of their Hep. C though. Having it around I was the one that brought it to the house. I was the one that more or less introduced them to the needles. I showed them in a way and I talked about it, saying oh I

get really high. I don't feel good about that. I never forced them to do it but I still feel responsible by talking about the drugs.

It was very difficult for Minos to deal with the fact that she had contracted Hepatitis C. Yet, due in part to her lack of self-esteem, shame and guilt, she still felt responsible for both her sister and her brother contracting it as well. Even when Minos was reminded that she did not make them use the drugs, she still felt some degree of responsibility. It was understandable that most of the respondents did not want to have their lives cut short by a disease that they knew they could have prevented. They were especially fearful because there still is no cure for HIV/AIDS and/or Hepatitis C.

4.3.6 Own Knowledge of HIV/AIDS and/or Hepatitis C

Ninety-five percent of the respondents had some idea where they could obtain information concerning HIV/AIDS and/or Hepatitis C. Many learned about the diseases while they were incarcerated and through seminars held by the Health Nurse there. Others gained knowledge through STD Clinics, drop-in centers, and some through their doctor. Amisk (2000:5-6) had Hepatitis C for eighteen years and went through a more traditional route for information and the treatment of her disease. Here is what she had to say:

I go here and on my reserve, Wineyapi. I started going to sweats, because they knew that it was probably my Hep and they started giving me medicine that helps rejuvenate me. One Elder in town he will give me medicine straight. Right now I have one Elder because I was given the opportunity to maybe heal up my Hep, but I sort of destroyed it by drinking.

When Apisimosi (2000:4) was asked where she was able to obtain information about Hepatitis C, she replied:

For Hepatitis C there are little pamphlets in the nurse's office here [Pine Grove]. I read about Hep C after I found out I got it. There wasn't too much on how it can be sexually transmitted, except maybe if I consumed a lot of whatever you know what you call it [semen]...HIV I read all the information about that and I was very scared and every time I did take a test for HIV or AIDS or something like that I'd be nervous and scared because of the life that I live.

Marie (2000:4) has had Hepatitis C for six years and stated that, “In Regina like they have nurses come around and they hand out pamphlets and they have a rig exchange, where I exchange my dirty needles and they give us little pamphlets and all that.” Dove (2000:7) had contracted HIV from being raped and had this to say: “There is a community nurse in Prince Albert, Marlene. She said that any time I needed anything she would come and talk to me or any member of my family. It’s working out all right I guess.” Mistatim (2000:7) has had HIV for three years and commented:

I didn’t know anything. The only way I found out was when I was in prison. I used to see signs up about AIDS in outreach clinics, but I never read them. I didn’t want to know. I was afraid to get tested. I used to go to the STD clinics and sell drugs to the prostitutes there, but I never read anything about HIV or AIDS.”

Mistatim (2000:7) stated later:

Yeah I guess I should have known better. When I was out on the streets, when I was 14 years old the johns didn’t want you to use condoms. If you wanted to turn a trick and make money you had no choice but to do what the johns wanted. Yeah, I guess I knew about unsafe sex and sharing needles.

Mistatim’s story is much the same as the majority of the respondents profiled in this research. The respondents stated that they did not want to know about HIV/AIDS or Hepatitis C when they were working on the street because they were still using intravenous drugs and in many cases practicing unsafe sex. The fear was there that they could contract HIV/AIDS and/or Hepatitis C but by consciously choosing not to learn more about the diseases helped them feel like it was less of a threat.

4.3.7 Prevention, Invincibility and Violence

Ninety-nine percent of the respondents agreed that the best method to prevent HIV/AIDS and/or Hepatitis C from being passed on to younger Aboriginal women was through safe sex and intravenous drug use education from someone who had been there. That would be someone who had already abused alcohol and intravenous drugs, turned to prostitution, and ended up incarcerated, to tell them what it was really like on the street. Makwa (1999:16) maintained that

the most important way to prevent Aboriginal youth from contracting HIV/AIDS and Hepatitis C was through “Information, straight up information.”^{xvii} Makwa (1999:16) continued:

I would like to take it into the schools because they are starting. I started when I was twelve. Sex that kind of stuff. I would like to take it to the schools, but like I say there would be all sorts of opposition. The parents would be keeping their children away from the schools, if we were going to have any kind of education class like that. They would take them out of the schools. But like they need information, they gotta know.

Makwa (1999:17) also discussed the sense of invincibility that Aboriginal kids have, “It will never happen to me. That was the way I was thinking too. I’m too smart it will never happen to me.”

When conducting this research, Aboriginal youth’s feelings of invincibility were a common thread in the lives and experiences of all of the Aboriginal women who were profiled. At least half of them could remember a friend or they themselves feeling, “it could never happen to me”.

Apisimos (2000:12-13) also discussed whether Aboriginal kids felt invincible:

Sometimes kids do. I didn’t actually. I wanted a baby. I thought I’m in love with this guy and I want to keep him in my life. I did hang onto him. He was not the father of my first. The father of my first is not the father of my last three. The father of my first was very abusive. The last licking I got was with a bat on my head, arms, neck, back, and the back of my legs. Good thing it wasn’t my face though, that I protect all the time.

Apisimos (2000:11) described her thoughts about Aboriginal teens, “They should stay off the streets and stay away from needles and stay away from people that use, keep going to school and learn more about better things in life, than trying to follow friends who try to act cool and quit school, grab a brain more or less. It is not a life.” When asked about sex education in schools,

Apisimos (2000:11-12) replied:

I think maybe they should do more, because more and more young girls are starting to get pregnant at a young age. Like I was young. I was thirteen when I had my (now nine-year old) daughter. My family was there. My mother was mad but then she shook it off. She’d rather me have it than have an abortion. I really was considering having an abortion. If they start sex at a young age I think they should at least tell their parents, well you know I’m having sex now instead of just doing it.

My mom let us have sex at an early age. She let us move in together and then all of a sudden I got knocked up and I was like what am I going to tell my mom? My mom was kind of mad and she said, but you are going to take after it, but she ended up taking care of her anyway.

Cahcakiw (2000:15-16) discussed the violence that some prostitutes face if they insist on the use of a condom:

Some of them get raped. It happens all the time. Some of my friends that are out there on the street have been raped because of that, because the man didn't want to use a condom or the men didn't want to pay them. I know this one lady who was raped three times. It was either wear it or go I made that clear. I have been raised to fight and fight back. So if they don't want it I can put up a fight for a couple of hours. If they don't want to wear a condom they don't have to, but they aren't going to get anything out of me if they don't. I make that clear. So no I don't have any problems with men wearing condoms. If they don't want to wear it they don't get anything.

Ninety percent of the respondents stressed the invincibility that today's Aboriginal youth feel. They also stated that they were well aware of that feeling of invincibility because they had felt the same way. Anikwacas could not emphasize enough that young Aboriginal women had to be prepared for life on the street, because she herself had paid such a high price. Ninety percent of the respondents faced violence in their everyday lives for any number of reasons. Mahkesis (2000:16) has had HIV for four-years and stated, "Well it's like if you know your husband is cheating on you and you ask him to wear a condom he is going to beat the shit out of you, because he is going to say who the fuck have you been fooling around with? That's the first thing he's going to think. It's a vicious cycle." Mistatim (2000:11-12) pointed out:

When I was younger I didn't think anything would happen to me either, but it did and it was also my choice. I chose to have unsafe sex and to use drugs it was my decision. I have no one to blame. I did it myself. It's hard young Native girls face violence if they do wear a condom. Their boyfriends would think that they are fooling around and that they're not special. They may have slept around but their girlfriends have to be true to them. Men don't like wearing a condom. It also depends on how they approach their partner. You don't say I'm not going to have sex with you if you don't wear a condom. For one thing they'd get beat up by their boyfriends. The boyfriends don't like the feel of a condom. They don't want to say just a minute I have to put a condom on. It's not "macho" enough for them and they always have to be in control.

Violence associated with insisting on wearing a condom with a boyfriend or a john, was a very prevalent theme in the lives of each one of the Aboriginal women profiled in this research. They discussed violence as if it was something that they had been forced to deal with everyday of their lives and most of them had.

4.3.8 Anonymity

Another shared theme in this research was the conflicting need for or against anonymous testing for HIV/AIDS and/or Hepatitis C. Mistatim (2000:12) stated: “Yeah I suppose it is important to be tested. I have talked to some of my girlfriends about going and getting tested, but they don’t. They are too afraid so they don’t go.” Mahkesis (2000:17) agreed that HIV/AIDS testing was very important, but also stated that where the testing took place was also important:

Someplace like the walk-in clinic upstairs, just in case they just want to go and see a doctor. Instead of here [STD Clinic] because they know where you are going. I used to try and hide my face if that door was closed and they were with other patients and somebody came in. I used to try and hide my face.

Minos (2000:10) has had Hepatitis C for three years and argued that it was not that important for anonymous HIV/AIDS testing because:

Everyone will know and is going to find out, so why should it be anonymous? You should just go ahead and tell them your name because your name is there anyway. Who are you trying to cover for? You can’t cover yourself, you can’t cover your blood and people do find out. Like me I couldn’t hide that I had Hep. C. I had to tell people. It doesn’t bother me at all. You are only being safe for yourself and others. I not only think about myself I think about the people around me. You can’t hide yourself.

Apisimos (2000:13) provided a somewhat different perspective on anonymity with respect to testing for HIV/AIDS and Hepatitis C, “It is kind of hard for me because I’d like to know who has it and I am sure that anyone else would like to know who has it too. What if that person has it and doesn’t say nothing to anybody about it and keeps on giving their disease to other people?”

Wapos (2000:12) stressed:

Yeah, because it gives the ones that are afraid of having their identity exposed. It gives them a sense of security and they can do it privately. Yeah because I have been anonymously tested since 1991 and I have been keeping up with it for every three months, because I knew the lifestyle I was leading. In 1991, I was with a guy and I wanted to make sure. I don't know that if he loved me or not before finding out. We broke up in 1995 and that's when I started going every three months because I started fixing. I didn't realize how many people had it until I started talking about it more. I found out that lots of people have Hep. C. I couldn't believe how many people. I also think that HIV is on the rise for Aboriginal people, because back then I only knew one person with HIV and I started to ask around and there were about nine people and nine people in Regina that's a lot. Those nine people can do a lot of damage if they don't take precautions.

Nicole (2000:11) pointed out the importance of anonymous HIV/AIDS and Hepatitis C testing for her:

Because I think it is your business if you have the disease and if you want someone else to know about it you'll tell them that yourself. Why let everybody know you have it when you don't want them to know? People who don't care about you and know that you have it are just going to say, that bitch has HIV.

Nicole also contended that more people would actually go and get tested for HIV/AIDS and Hepatitis C if they knew that the person being tested and the results of the tests were kept anonymous.

All of the respondents felt that the anonymity of HIV/AIDS and Hepatitis C testing was essential in getting women to just follow through with testing for themselves. The exposure of HIV or Hepatitis C status can and does have serious consequences for Aboriginal women with HIV/AIDS and/or Hepatitis C and their families. For the safety, security, and peace of mind of Aboriginal women with HIV/AIDS or Hepatitis C in Saskatchewan, it is essential that they have control over the disclosure of their own status. They must also be assured of the confidentiality of their medical history.

4.3.9 Best Person to Educate Others on Prevention

Marie (2000:8) argued that the best person to educate Aboriginal women in the prevention of HIV/AIDS and Hepatitis C would be:

A person who does have AIDS or Hep. C so that they can tell them how it is. Well, AIDS is the most important thing nowadays and everybody is afraid to have it. An Aboriginal with HIV or Hep. C would be better, because then they can see that Natives can get it too. Anybody can get it. In Vancouver I hear that there's a lot of Aboriginals that have AIDS there. I never want to go there. A doctor or nurse for the medical part yeah, but someone who has it has the experience.

The best person to educate Aboriginal women about HIV/AIDS and Hepatitis C, according to Ciask (2000:15) was, "Both a doctor and a nurse, because they both know about it and if a doctor isn't available then the nurse can take over." Ciask (2000:15) also stated that education does not depend solely on medical personnel: Pipiciw (2000:15-16) had a view similar to Ciask's:

Probably someone that is positive and probably the ones that have been prostitutes and IV users, the ones that have lived it. You can look at somebody like you and you can say are you HIV positive? You don't have time for that. You would understand because you study this and you can still empathize and feel for them. I think those would be the easiest ones. But then it would be hard, because if you see me on the street I wouldn't want to go around doing this. I would rather go around and do the things I was doing. It is really hard to find an IV user that's a prostitute to slow down to do interviews.

Nicole (2000:12) stressed the need for more counselling, "Like how to deal with their suicidal thoughts, their emotional thoughts that they are going through, if people could only understand them more. You can't get much in here [Pine Grove] but out there you could look." Accessing numerous avenues of knowledge according to the women profiled in this research, can best serve Aboriginal women in future. Minos (2000:12) was asked if there was enough available information on HIV/AIDS and Hepatitis C:

There is but people don't know and are too shy to pick up that information pamphlet or whatever. They think that they are too good for it or a lot of people fight who they are and what they have. There is ignorance and some people stay away from me and stuff like that. I grew up with this girl and I don't know she just shut me out that was it. She just said I don't want anything to do with you anymore. I said well fine then no skin off my ass. I am going to keep living my life. She said whatever life you have left. I said you weren't that much of a friend.

The stigma linked with HIV/AIDS makes it difficult for not only the person who has contracted the disease, but those associated with that person as well. HIV/AIDS-related stigma can persist

even in the face of education about the disease. The result for people with HIV/AIDS and/or Hepatitis C is that they are treated differently based on the attitudes and ignorance of others. Pipiciw (2000:16-17) offered her thoughts about HIV/AIDS and Hepatitis C and Aboriginal women: “When I get talked to on the street by the street nurses and stuff I just go yeah okay and I walk away. It’s not enough to make me just sit up and listen. There’s nothing being done that really just makes you want to do something about it and to be more careful, like make tricks wear condoms. There is no reason that I have that I should change.”

The principal argument for the most appropriate person to educate Aboriginal women with HIV/AIDS and/or Hepatitis C was that it should be someone who had been there and who knew just what they were going through, although some of the women had different views. Angel (1999:14) made it clear that:

For the Natives I think they should have doctors going out and speaking along with Elders. For Aboriginals they have their separate cultures and they only take what they need and messages they need from Elders. A doctor or a nurse and myself would be the best to go out speaking, someone who can tell their medical history. What I told my children is when the time comes I am refusing to take the medication, because of the side effects of the cocktails and stuff. I refuse to be on medication and I won’t be carrying this medication around with me all the time, everywhere I go. I would have to take 10 to 20 pills a day. I told them just respect my wishes and I told them I just want to go peacefully and not to be like a guinea pig. That is the way I feel about it. I told them we will talk about it a couple years down the line and I’ll see if I still feel this way.

Wapakosis (2000:10-11) related that it should be:

People who have it pretty much and who are taking care of themselves to this day. Someone they will listen to, someone who is convincing, I don’t know. I think it would have to be someone who has gone through it. I don’t know I’m just sitting here listening to you ask me these questions and I’m scared to know myself. I think the important thing is to have someone to convince them to be careful, that’s important.

Amisk (2000:18-19) had Hepatitis C and indicated:

Doctors, lawyers, Indian Chiefs, correction workers, and social workers, if I could get a big group of them together my agenda would include a prostitute (one who is still on the street), a pimp or a drug dealer (one who was still into it), and I would have a recovering one as well. I would

involve all of them. I started doing grade five education before I even got off the street, because it angered me so much when people would come up and get their cameras out and say, this is a PROSTITUTE! That was sick. People who are still living these dysfunctional lives are the ones you want to talk to and the ones you want to learn from, because those are the people you are going to end up taking care of. If you want to find out how to help a junkie, a drunk, a hooker or a pimp or the youth you have to go to them. How do you go to them? You give yourself the opportunity to have someone come to you that's the way it has to be done.

The comments made by the respondents were numerous as well as diverse and reflected the differences in the women's opinions as well as their lifestyles. The respondents concurred that the most effective way of preventing other young Aboriginal women from following in their footsteps would be to have someone, who had and/or was currently dealing with HIV/AIDS or Hepatitis C, talk with them. Amisk (2000:14-16) had worked with the STD Clinic in Prince Albert and contended:

I think young Aboriginal girls should be made to attend health class or sex education class where condoms should be made available. The other thing too is the parents. I have been to so many schools with kids who are really bright and the parents don't have a clue because they are in denial. My daughter comes home from school with information on HIV and I have to correct it. The other thing is it is not only a gay disease anymore. Women, especially young women, have to know that. The first time I told my story in front of a group of people I just got up there and told it real quickly and sat down. Then this fellow who was really good looking and a couple years older than me got up and started talking. He said I'm a heterosexual male. I don't use drugs. I party and I smoke dope. I found out two years ago that I'm HIV positive. I figured I had it about six months. I only recently found out that I've had it since 1994 and I've been with I figure a minimum of fifty women, no condom and fifty women. I'm thinking a minimum of fifty women. If we think in Saskatchewan alone one guy and fifty women who were one night stands. A woman can't tell and if she isn't a prostitute or a junkie the doctor is not going to think well you should have an HIV test. Unless she's a hooker he's just going to give her stuff for a vaginal infection and send her on her way. These women are going to have children and they are going to be with other men.

Amisk also mentioned the utmost importance of young Aboriginal women achieving a healthy sense of self-respect and self-esteem which considering the lifestyle of most of the respondents

was often fleeting and short-lived. Anikwacas (2000:9-10) related that prevention should include needle exchange programs and sex education in schools but that:

They don't go far enough. They teach how to put a condom on if you don't want to get pregnant, but I never heard that you put a condom on so that you won't get AIDS. I never heard that until I started hitting the street and stuff and then you learn why safe sex is so important as part of that life.

More than half of the respondents felt that the prevention and education programs that targeted school children should have begun at a much younger age than it was. Deciding on just what age that should be had proven to be a very arduous task for many of them. Ciask (2000:11) has had Hepatitis C for seven years and when discussing preventative measure held that:

The best way is for someone like myself, that's been around the streets and drugs and knows how it's spread and that. Someone that would teach the younger generation and talk to them before they get into doing it. Yeah, before they even think of going on the street or getting into marijuana and then abuse it to bigger stuff. Look what happened to me, I started with marijuana then I had also been drinking and then I started into needles. I did that once at my reserve and the Elders and the aunties asked me to talk to the younger generation, the younger kids that want to come to the city and live the life that I lived. I told them that it was no life to live and you are playing Russian roulette with your life if you do that. Then they asked me, well how did you get your money? I said I prostituted and I stated that it doesn't stop a man from going out and selling his body too.

Ciask continued by saying that she went out to the streets looking for help to get off of her drugs and ended up getting pregnant with her daughter. She used drugs all the way through her pregnancy. Mistatim (2000:10) was in the Prince Albert Penitentiary for drug trafficking and indicated as well:

It is important to have someone who has lived on the street, done tricks, done drugs, someone who has been there, to talk to them. Yeah a person like me that can honestly say what it is really like out there. Someone who doesn't know would not make any influence on kids out there, kids who think it is fun and glamorous to hook, sell, and use drugs and carry around weapons.

This same theme ran through each and every one of the personal stories shared by the Aboriginal women from Saskatchewan who were profiled. All of the respondents stated that it was extremely

important to teach sex education in schools and at home, especially with respect to condom use and safe sexual activity.

The data procured through profiling these twenty-two Aboriginal women in Saskatchewan overwhelmingly support Health Canada's statistics concerning HIV/AIDS. In his article in the *Globe and Mail* (2000:1) entitled *Natives hit hard by HIV infections: study*, Andre Picard argues:

Not only are Aboriginal people getting infected in large numbers, but almost one-third of them are diagnosed with HIV-AIDS before the age of 30 (double the rate of the general population), an indication that they are getting infected young increasing the likelihood of epidemic spread of the disease. Aboriginal members also have on average higher rates of incarceration, intravenous drug use, alcoholism, and poverty (which pushes people into the sex and drug trades) all of which are risk factors for HIV infection.

These facts as well as the psychosocial and socioeconomic dimensions of the prevention, care, treatment, and support for Aboriginal women with HIV/AIDS create a potential for serious injustice that is detrimental to the health and well-being of all Aboriginal communities in Saskatchewan.

The responses of the Aboriginal women profiled offered in this research, augment the data that are revealed in Health Canada statistics. On average the respondents had been living with HIV/AIDS for approximately three years. What was going on in the lives of the women at the time of their diagnosis and where they were tested, varied on a personal basis. Many of them experienced both positive as well as negative responses to their illness by family and friends. Whether due to a lack of understanding, fear, or ignorance Aboriginal women with HIV/AIDS suffer rebuke at all levels of society.

The lifestyle of the Aboriginal women profiled made it necessary for them to obtain some degree of knowledge about HIV/AIDS. However, HIV/AIDS was not a topic that was easily and openly discussed at the street level. Information regarding HIV/AIDS was essentially obtained during incarceration, which was also where many of them were diagnosed. A greater number of Aboriginal women established that the personal aspect of their disease was their worst-case

scenario. They saw the medical aspect as not as ominous, because they could deal with the symptoms and many had already resigned themselves to the fact that they would die sooner than they thought. It was much more difficult to deal with the feelings of shame, guilt, humiliation, and abandonment in their personal relationships.

The consensus was that to prevent HIV/AIDS from being passed on to young Aboriginal women there should be more accessible and realistic information about the sex trade and intravenous drug use. The best person to educate other Aboriginal women about HIV/AIDS would be someone who had lived it. There was also a need for more counselling, especially for those women who were still on the street. The sense of invincibility that most Aboriginal youth feel today was comprehensible and collective. Anonymity was stressed as a necessary to get young Aboriginal women to feel comfortable enough to just get tested. Each of the respondents stressed the importance of the availability of HIV/AIDS and/or Hepatitis C information prior to contracting the diseases, free needle exchange and condom supplies, and education on prevention.

Every one of the respondents profiled in this research raised consequential issues that had shaped their lives and that should be brought to the attention of all of Canadian society. These were issues that the remainder of Canadian society may find incomprehensible. It is critical that future education and prevention initiatives contain an awareness of the prevalence of HIV/AIDS and Hepatitis C in the Aboriginal community in Saskatchewan. By addressing the issues of HIV/AIDS and Hepatitis C and the impact that it has had on Aboriginal women in Saskatchewan, Aboriginal women themselves have begun to reduce the chances of infection among women in their own communities. It should be kept in mind that this is only a small fraction of the personal histories shared by these courageous women. These are personal histories that many of the Aboriginal women profiled were eager to have someone listen to and take seriously.

A new approach to AIDS education, anti-AIDS practices and recovery in Aboriginal communities in Saskatchewan is crucial. AIDS education must take into account the importance of understanding individual communities - the history, the parenting, beliefs, traditions, practices,

oppression, class and gender, and social and political issues. Aboriginal communities claim the highest prevalence of many of the social ills facing Canadian society, including sexually transmitted diseases, teenage pregnancies, alcohol, drug, and gambling addictions and unemployment.

Notes

^{xiv.} While the focus of this research is on HIV/AIDS, Hepatitis C has also played a significant role in the lives of Aboriginal women. Unfortunately there has not been a discussion of Hepatitis C; paralleling that of HIV/AIDS, is offered. It is not the intent of the researcher to portray both conditions as identical because they are not identical. In the interests of this research HIV/AIDS is a sexually transmitted disease that is transmitted from one person to another through unsafe sexually activity (oral, vaginal, and anal), transfusion of blood or blood products, the mother to the fetus during childbirth, and the use of syringes or needles that have been used by an HIV-infected person. The co-infection with Hepatitis C virus and the human immunodeficiency virus is significant because persons infected with both viruses may have an aggravated clinical course related to the presence of the other. In particular, the immune suppression caused by HIV may exacerbate the progression of liver disease due to Hepatitis C infection. The treatment of each infection may also be complicated by the presence of the other infection. The number of co-infected HIV-HCV individuals is considerable because the modes of transmission for the two viruses overlap to a significant degree. Both HCV and HIV may be acquired through intravenous drug use and blood transfusions. With respect to Hepatitis C, the most common exposures are through intravenous drug use. A discussion regarding how these clinical conditions are medically as well as experientially similar and different would no doubt enhance this research. Hepatitis C has a very different social history than HIV/AIDS and it was not the intent of the researcher to refer to them as one entity.

^{xv.} I recognize that more than half of the respondents that took part in this research were incarcerated, but I had hoped that I had explained that I was not **only** looking for Aboriginal women who were incarcerated. The Aboriginal women that I met through the STD Clinics, the PLWA, the ALL Nations Hope Network, and Dr. Williams had also been incarcerated at some point in their lives or had just gotten out of a corrections facility. So no I do not feel that the sample is skewed even though thirteen of the women were actually interviewed at the Pine Grove Institute for Women in Prince Albert.

^{xvi.} In this research “prostitution” is used to refer to the provision of sexual favours for financial rewards. It has nearly always involved the prostitution of women to men, although male prostitution is not uncommon.

^{xvii.} None of the Aboriginal women in this research had multiple births.

^{xviii.} I realize that through my descriptions of Maskwa as an Elder from the Duck Lake area, and who worked with Aboriginal women in the Pine Grove Institute for Women in Prince Albert, yielded some obvious clues as to her identity. However, Maskwa was not concerned about preserving her anonymity in this research. Maskwa stated that she truly enjoyed the work that she was doing and that her work included revealing herself to others.

^{xix.} There are not any outstanding avenues to reach at risk Aboriginal youth on the street, but Saskatoon does have the White Buffalo Lodge for Aboriginal youth and Egadz is in touch with young Aboriginal prostitutes at the street level and they have an opportunity to encourage “safer” behaviours and attitudes (condoms, needle-exchange).

5.0 IMPLICATIONS AND RECOMMENDATIONS

5.1 Introduction

Anyone can become infected with HIV/AIDS and Hepatitis C. It does not matter about a person's background or race or whether they have sex with men or with women. Because the disease does not discriminate it is not somebody else's problem. AIDS is not a 'gay disease', a 'city disease' or a 'white disease'. HIV/AIDS and Hepatitis C are already in the Aboriginal community in Saskatchewan. This chapter looks at the implications of the data produced, through profiling twenty-two Saskatchewan Aboriginal women. It also offers some practical recommendations in dealing with the increasing number of young Aboriginal women who are contracting HIV/AIDS and Hepatitis C in Saskatchewan.

In Saskatchewan Aboriginal communities, "The cumulative effect of HIV/AIDS-related stigma and discrimination is to objectify, marginalize, and exclude people with HIV/AIDS. Those who were already objectified, marginalized, and excluded are pushed even further from a recognition of shared humanity and from the support of human society" (de Bruyn 1998:11). Such is the case for Aboriginal women in Saskatchewan. Aboriginal women in Saskatchewan are at increased risk of HIV and Hepatitis C infection for various reasons. High rates of STDs and intravenous drug use, as well as other health and social issues, increase the vulnerability to HIV/AIDS and Hepatitis C within this sub-group. These risks are compounded by the over-representation of young Aboriginal women in corrections facilities and among those who are using outreach services such as needle exchange and clinics, that provide support for HIV and Hepatitis C infected women. In addition, the collective transient movement of Aboriginal women in Saskatchewan between urban centers and reserve communities has brought the risk of HIV/AIDS and Hepatitis C to even the most isolated Aboriginal communities (Health Canada, 1998b: 3).

There are major social, political, economic, and cultural changes currently underway in many Aboriginal communities in Saskatchewan. A type of cultural revitalization is taking place, bringing increasing respect and utilization of the traditional ways and beliefs of Aboriginal people. This resurrection has taken many forms, including the demonstrated recognition of Elders and traditional healers within the Aboriginal community itself. Even now the process of healing has begun for women in Aboriginal communities.ⁱ Many of them have started to confront the long-term problems faced by Aboriginal women in Saskatchewan, which include the psychological impact of colonization, racism, poverty, marginalization, and now HIV/AIDS and Hepatitis C.

Taken together these factors have resulted in Aboriginal people in general, and Aboriginal women more specifically, having the poorest overall health and socioeconomic status of any identifiable group in Saskatchewan. HIV/AIDS and Hepatitis C and the responses to these diseases are not merely a medical issue; instead they are simultaneously economic, social, cultural, political, and more importantly spiritual issues (RCAP, 1996 IV: 4).^{xviii}

The Aboriginal community in Canada and in Saskatchewan has had more than its fair share of health crises. Just in the last century tuberculosis and influenza killed thousands of Aboriginal people, while decades before that smallpox ravished entire Aboriginal communities. HIV/AIDS and Hepatitis C are seen and understood as yet another example of the conceivable annihilation of even more Aboriginal people, and entire Aboriginal communities (RCAP, 1996:4).

HIV/AIDS and/or Hepatitis C have presented Aboriginal people in Canada with a formidable task. Initially, so few cases were detected that this led some in the Aboriginal community to assume that these diseases had 'passed them by'. Even though there is a consciousness of HIV/AIDS and Hepatitis C in the Aboriginal community, some remain reluctant to concede that they are actually a threat, especially if that community is isolated. A thorough and appropriate response to these diseases is still nonexistent. HIV/AIDS and Hepatitis C rates for Aboriginal women continue to rise; yet denial and intolerance remain prominent, with respect to those living

with these diseases. This intolerance has taken a variety of forms, including Aboriginal women living with HIV/AIDS and Hepatitis C being forced to stay away from their home communities, being ostracized, and facing discrimination by both family and friends.

There are numerous factors that exacerbate the incidence of HIV/AIDS and Hepatitis C among Aboriginal women in Saskatchewan. High rates of sexually transmitted diseases are a major factor in the increasing number of young Aboriginal women contracting HIV/AIDS and Hepatitis C, because HIV/AIDS is more easily contracted and transmitted in the presence of other STDs. A disproportionate number of Aboriginal women continue to experience sexual assault. There is an overwhelming lack of self-esteem evident in many young Aboriginal women, the source of which is embedded in racism, abuse, and poverty. This has translated into an unwillingness or inability to affirm themselves in sexual relationships. Mobility between urban and reserve communities is recurrent and in most cases Aboriginal reserve communities can make collaborative health education and prevention strategies extremely difficult. High-risk behaviors such as unprotected sex and needle sharing can take place in one location, but may or may not be divulged to partners in the home community. With the prevalence of intravenous drug use and the high HIV/AIDS and Hepatitis C transmission rates that exist among intravenous drug users in urban centers, the possibility of transmission via this route cannot be underestimated.

Although the availability of anonymous HIV/AIDS and Hepatitis C testing sites has evolved in the past decade, there still remains considerable reluctance by young Aboriginal women who are at risk, to get tested. Even where testing is anonymous, the possibility of their community finding out is a significant barrier for many women. In part, this fear is also related to the attitudes of community members towards HIV/AIDS and Hepatitis C and those who have been infected. Living with the fear of the negative consequences of getting tested heightens the risks of that community that much more.

5.2 Identifying the problem

The limited epidemiological data available indicate that in general rates of reported AIDS cases and HIV and Hepatitis C infection rates are similar in Aboriginal and non-Aboriginal populations in Saskatchewan. However, some studies in inner cities and corrections facilities demonstrate higher HIV and Hepatitis C infection rates among Aboriginal women than in non-Aboriginal women, under similar circumstances. There are almost no data on HIV and Hepatitis C infection rates in reserve communities, although specific information indicates that the number of infected people is growing. Evidence does suggest that the crisis is still affecting Aboriginal women in inner city areas. Yet, high mobility between the inner city and rural and reserve communities brings the risk of HIV/AIDS and Hepatitis C to even the most secluded community.

High rates of other sexually transmitted diseases and high rates of substance abuse, including intravenous drug use, facilitate the transmission of HIV/AIDS and Hepatitis C among Aboriginal people. These risks are compounded by the over-representation of Aboriginal people in some inner city populations, where rates of HIV and Hepatitis C infection are relatively high and risk behaviors, such as needle sharing and unprotected sexual activity, are prevalent.

Although the threat of HIV/AIDS and Hepatitis C to Aboriginal populations in Saskatchewan is clear, community-based groups have repeatedly stressed that many Aboriginal women face barriers in accessing HIV/AIDS and Hepatitis C prevention, education, care, treatment, and support programs and services, regardless of their location (on or off reserve). Problems of access are caused by various factors, including a lack of services, particularly in remote and rural reserve communities. Off-reserve services are not suitable or sensitive to Aboriginal women's needs, language or culture. There is a reluctance to use services such as HIV/AIDS and Hepatitis C testing or treatment, because of the fear that confidentiality will not be maintained. Some Aboriginal women living with HIV/AIDS and Hepatitis C face impediments to care and support in their home communities. Often denial and the fear of HIV/AIDS and Hepatitis C prevent the actual development of these services as well as a supportive environment.

HIV/AIDS and Hepatitis C prevention and education initiatives are still not widely available in reserve communities in Saskatchewan. Many respondents felt there was still a great deal of resistance in reserve communities to implementing them, due in part to the ignorance and fear that still surrounds HIV/AIDS. Existing activities tend to focus on general HIV/AIDS and Hepatitis C awareness. Prevention efforts in reserve communities need to be augmented with an increased emphasis on risk behavior and attitudes, skills and resources for behavior change, risk reduction, and social and economic environments that support healthy choices. The number of Aboriginal women in Saskatchewan living with HIV/AIDS and Hepatitis C continues to rise, and has the potential to become even more critical. More emphasis on collaborative research is needed to fully comprehend the nature of the HIV/AIDS and Hepatitis C crises within Aboriginal populations, and to respond with appropriate interventions as well as evaluate progress. General HIV/AIDS and Hepatitis C programs and services must also give greater priority to Aboriginal women's issues and needs.

5.3 Implications

The testing procedure for HIV/AIDS and Hepatitis C allows the individual confidentiality and also provides a general description of those who are testing positive for HIV/AIDS and Hepatitis C. This proffers a general idea of who is getting infected and what the major risks are; however, it is based on self-reported information and as a result, some questions go unanswered. Ethnicity remains a large unknown, as most data from Health Canada's Updates and Surveillance Series are usually a lower estimate of HIV and Hepatitis C infection rates. The incidence of Hepatitis C and HIV/AIDS in Aboriginal women in Saskatchewan is undeniably increasing. This is worsened by the fact that cocaine is the drug of choice and that it is mainly used intravenously. Given this information, it is imperative that Aboriginal communities look at harm reduction strategies for those already using intravenous drugs and recognize that the prevention of alcohol and drug abuse is essential to slowing down the spread of HIV/AIDS and Hepatitis C. It is important that each

person infected protect him/herself by making positive and healthy life choices to reduce their risk of infection.^{xix}

The spread of HIV/AIDS and Hepatitis C is not solely influenced by intravenous drug use or unprotected sex. Social and economic factors also increase the chance of becoming infected. Low levels of education and high levels of unemployment and poverty must be addressed, if the spread of HIV/AIDS and Hepatitis C is to be reduced. Compared with persons who acquire HIV and Hepatitis C infection through other modes of transmission, the number of Aboriginal women infected through heterosexual transmission is also escalating. Heightened awareness of these trends and concerns about other STDs and unwelcome pregnancies, among adolescent Aboriginal girls, will result in enhanced efforts to promote safer-sex behaviors. These behaviors include the postponement of sexual activity among youths, decreasing the number of sexual partners, restricting sexual contact to a mutually monogamous relationship with an uninfected partner, and the consistent and correct use of condoms during intercourse.^{xx} The promotion of these changes in behavior is influenced by community norms and Health Canada has attempted to expand its efforts in assisting local health professionals in planning HIV/AIDS and Hepatitis C prevention programs at the community level.

The reality of an increasing number of young Aboriginal women in Saskatchewan, living with HIV/AIDS and Hepatitis C, requires a more effective development of education and prevention programs in affected Aboriginal communities. Effective HIV/AIDS and Hepatitis C strategies must no longer only be about HIV/AIDS and Hepatitis C prevention and education, they must also be about improving and enhancing the quality of life of Aboriginal women and their families, living with HIV/AIDS and Hepatitis C.

Both Aboriginal and non-Aboriginal women who live with HIV and/or Hepatitis C infection often experience stigma and prejudice. However, there are issues facing Aboriginal women living with HIV/AIDS and Hepatitis C that are unique. The existing social, economic, political, and cultural inequities reinforced through colonialism and the attitudes of racism and animosity faced

by many of the respondents, make living with HIV/AIDS and Hepatitis C that much more difficult. It is therefore, impossible to look at the immediate needs of an Aboriginal woman living with HIV/AIDS and/or Hepatitis C without looking at the broader social, economic, and cultural issues faced by the Aboriginal community as a whole.

There are innumerable factors that shape the overall inferior health status of the Aboriginal population in Saskatchewan. They include high rates of poverty and unemployment, housing shortages and overcrowding, lower rates of health care utilization, cultural and language barriers, a lack of support services and counselling, discrimination and racism, and most significantly, the psychological impact of colonization (including residential schools and cultural assimilation). These factors have had an immediate and negative impact on Aboriginal women who are living with or have been affected by HIV/AIDS and Hepatitis C. Even at a minimum, these problems have negatively impacted the quality of life of Aboriginal women living with HIV/AIDS and Hepatitis C. They have also contributed to a rapid deterioration of Aboriginal women's health that also lessens their life expectancy.

Considerable disparities in health status between Aboriginal communities and the balance of Canadian society remain. Tuberculosis and Hepatitis C rates in some northern Saskatchewan communities are higher than the national average. The prevalence of infectious diseases in Aboriginal communities make the risks faced by persons with an already weakened immune system that much greater. Without improvements in health care and education, the long-term effects for Aboriginal women in most areas in Saskatchewan remains dismal (Health Canada, 1998e: 59-60).

This research has addressed the impact of gender, race/ethnicity, and poverty on the respondent's ability to access health care, by separating these topics into artificially distinct sections. However, the effects of gender, race/ethnicity, and poverty are inherently connected. The medical and public health fields have historically invoked gender as a way to normalize biological differences, thereby overlooking Aboriginal women in Saskatchewan, who are at risk

of HIV/AIDS and/or Hepatitis C. An example of this is the role of the power dynamics in condom negotiation between women and men during sexual intercourse. Furthermore, women's health concerns have traditionally been seen as reproductive health issues and nothing more. From being almost absent from the AIDS crisis in the 1980s Aboriginal women infected with HIV now number in the hundreds, with more and more becoming infected each year. In Saskatchewan, health professionals are trying to comprehend why a virus that infects both men and women is increasingly affecting Aboriginal women in such a disproportionate manner.

5.4 Recommendations

While recent therapeutic advances have caused AIDS deaths to drop, there remain significant gendered differences in who is living with and dying from AIDS-related causes. HIV-positive women face a wide range of barriers to care and these barriers are deeply embedded in the very structures to which women turn for assistance. Health Canada (1998e: 25) argues, "In the area of HIV prevention research, particularly involving research subjects in the research process is essential, in order to increase participation rates in difficult to access communities and to increase the likelihood that research results will have any impact." Studies under consideration should identify that Aboriginal women in Saskatchewan have participated, so that conclusions can be drawn that reflect the personal experiences of Aboriginal women. Qualitative studies are needed that will provide valuable data on the individual experiences of Aboriginal women living with HIV/AIDS and/or Hepatitis C. Cultural practices that affect the design and delivery of programs need to be considered, including the prospective role of Elders and traditional Aboriginal medicine (Health Canada, 1998e: 25). Wider attention to understanding the effectiveness of traditional perceptions of health and healing in the prevention of substance abuse, the social development of youth, and gender relations is required.

There are numerous proposals that can be explored that would assist Aboriginal women in Saskatchewan in making positive and healthier lifestyle choices, with regard to HIV and Hepatitis C infection. Even the smallest change in behavior and/or attitudes can result in dramatically

decreasing the number of Aboriginal women contracting HIV/AIDS and/or Hepatitis C in Saskatchewan.

A holistic and culturally appropriate strategy against HIV/AIDS and Hepatitis C that will meet the explicit needs of Aboriginal women in Saskatchewan must be developed. Partnerships between local health professionals and on and off reserve Aboriginal communities should be assured. Aboriginal women will need to be given funding and moral encouragement to establish their own HIV/AIDS and Hepatitis C prevention and education agenda. In doing so, more beneficial approaches for reaching Aboriginal women living on reserve or in urban centers can be realized. If Aboriginal women are knowledgeable about HIV/AIDS and Hepatitis C, it will reflect back on the rest of the community.

There are some key principles that need to be taken into account, when proposing an agenda specific to the needs of Aboriginal women in Saskatchewan, with HIV/AIDS and Hepatitis C. Respect for Aboriginal women and their families and community autonomy and diversity regardless of status, residency, gender or sexual orientation must be maintained. It must be community-based in design, development, and delivery and include direct participation by both male and female Aboriginal youth and Aboriginal Elders/spiritual advisors. It must also respect and promote positive Aboriginal traditional history and values. It should involve Aboriginal women who are living with and affected by HIV/AIDS and Hepatitis C and go beyond religious, geographic, political, and socioeconomic restraints. It must utilize an Aboriginal community-based evaluation process and acknowledge and respect an Aboriginal woman's choice of programs and services. It should also respect their right to privacy and freedom to make decisions, concerning their own healing and care. Finally, it has to provide the opportunity and encouragement for Aboriginal communities in Saskatchewan to maintain adequate support that is safe and secure for Aboriginal women living with and affected by HIV/AIDS and Hepatitis C (Ontario Aboriginal HIV/AIDS Strategy, 1993:10-11).

Recommendations include moving beyond education and prevention strategies to

providing care and treatment to Aboriginal women with HIV/AIDS and/or Hepatitis C; ensuring that Saskatchewan Aboriginal AIDS Service Organizations are adequately staffed; providing funding for Aboriginal women specific Healing Centers to ensure access to traditional healing; educating Elders and including Aboriginal historical concepts of health and sexuality; educating community leaders to become positive role models that would promote the acceptance of alternative lifestyles; addressing the economic issues of poverty among Aboriginal women living with HIV and AIDS; providing funding for hospices for them; encouraging advocacy with Aboriginal volunteers in local AIDS Service Organizations in Saskatchewan and providing Aboriginal women-specific media; identifying substance abuse and unprotected sexual activity as high-risk behaviors for HIV/AIDS and Hepatitis C.

Spirituality should be a predominant aspect of the HIV/AIDS and Hepatitis C healing agenda for Aboriginal women. Completed studies on the impact of HIV/AIDS and Hepatitis C on Aboriginal women need to be made available and every effort must be taken to promote assistance, based on the results of that research. Priority must be given to the research of Aboriginal youth and women in order to identify exact barriers to safer sexual activity and to the prevention of intravenous drug use. The issue of perinatal transmission must be addressed, with particular attention paid to understanding behaviors and attitudes that would reduce the transmission of HIV/AIDS and Hepatitis C to the fetus. Research addressing the social determinants and risk factors associated with Aboriginal women contracting HIV/AIDS and Hepatitis C are seriously deficient.

As a wide-ranging research agenda, qualitative and quantitative research addressing the following must be undertaken: attitudes and behaviors towards condom use, age of sexual debut, number of sexual partners, STD control, sex education, prostitution, sexual orientation and sexual abuse. Young Aboriginal women in Saskatchewan should be viewed in terms of their self-esteem, identity, sexuality, peer influences, and generational relationships. There is very little published literature on research that is specific to Aboriginal women in Aboriginal communities. Most of

the programs and services that have received funding, have not been evaluated and as a result, there is no tangible measure of their value.

Aboriginal women with HIV/AIDS and Hepatitis C are overwhelmingly poor and consequently face a more complex scope of impediments to health care. It is well recognized that the social magnitude of gender has been overlooked in shaping an individual's health care utilization and results. Additionally, inequities in the health outcomes of many Aboriginal people have been well documented, and attitudes about HIV/AIDS among Aboriginal people have been affected by a prolonged history of discriminatory practices. It is critical that the ongoing structural abuses of the Aboriginal population in Saskatchewan be dealt with. The correlation between these abuses and the ability of Aboriginal women to access health care is a major factor in the denial of quality health care for HIV and Hepatitis C-positive Aboriginal women (RCAP, 1996 III: 2).

More culturally appropriate education and prevention, with a focus on risk behavior and attitudes is also needed off reserve. Better coordination, cooperation, and resource sharing between all levels of government, the mainstream Aboriginal community and HIV/AIDS and Hepatitis C organizations would help guarantee resources are used efficiently and effectively, to meet the needs of Aboriginal women in Saskatchewan. These cooperative efforts could build on existing experience with HIV/AIDS and Hepatitis C prevention. As such, they would enhance the Aboriginal community's capacity for prevention programming and support the development of targeted Aboriginal-specific services and resources. These would help ensure that programs and services are sensitive to Aboriginal culture and involve Aboriginal leaders and organizations in their development and execution. This will also make certain that all partners know about and can obtain existing culturally appropriate resources and services, according to need.

While recent therapeutic advances have caused AIDS deaths to drop, there remain significant gendered differences in who is living with and dying of AIDS-related causes. Recent analyses reveal that the current relationship of HIV-positive Aboriginal women in Saskatchewan to health

care services is intricately connected to historic and current institutionalized racism and sexism; the providers, who administering care to HIV-positive Aboriginal women; past and persistent HIV-related discrimination, coercive practices, and breaches of privacy and confidentiality. The pervasive and ongoing alienation of Aboriginal women in Saskatchewan from medical structures is the context within which women with HIV/AIDS and Hepatitis C attempt to access the health care system.

HIV and Hepatitis C-positive Aboriginal women have suffered with regard to the recent restructuring of health care programs, under managed care services. Numerous studies and Health Canada statistics have shown that approximately one-third of low income patients in managed care programs report that they have no regular doctor, half go to emergency rooms for care, and approximately ten percent report not receiving needed care at all (Health Canada, 1998e: 15). With regard to the overall structure of the health care system, the factors most frequently cited by the respondents as impediments to their ability to receive adequate care, were financial costs, long waits, lack of child care, the difficulty of getting to the location of service providers, and a lack of coordinated and comprehensive care. Some women with HIV/AIDS reported encountering language discrimination while trying to see providers, along with breaches of their confidentiality. The respondents reported their health care workers' lack of knowledge to be the most prominent barrier to services. Many of the respondents felt that their health care providers had limited information or were misinformed about treating people with HIV/AIDS and Hepatitis C. During this research, approximately one third of the women stated that they were actually giving information to their doctors about the effects of their disease. All of the respondents who had been incarcerated had been diagnosed and provided with information. Women with HIV/AIDS and Hepatitis C were at risk of terminating or failing to obtain care if their providers did not intelligibly and compassionately discuss their health problems and give them competent care.

A very crucial issue for many of the respondents was the ability of their health care providers to maintain their confidentiality and privacy. Many women reported difficulty in obtaining confidential care and were quick to point out that this often prevented them from using the services and resources that they needed. HIV and Hepatitis C- positive Aboriginal women repeatedly raised concerns over their personal safety, if health care providers were required to notify their partners of their HIV/AIDS status. The factors that determine access to care also determine to a significant degree who lives and who dies with AIDS. The deep roots of health care inequities must be explored and in turn, a comprehensive response must be developed to address the severe impediments to care that HIV-positive Aboriginal women face, in attempting to maintain their health. While the scope of this research is limited to identifying the multiple barriers that inhibit Saskatchewan Aboriginal women's access to care, this assessment highlights the urgent need to both devise sustained policy and engage in advocacy efforts. Only in so doing, can the health care of all Aboriginal women living with HIV/AIDS and Hepatitis C be fostered and the deadly denial inherent in women's health care can be confronted.

Currently, one of the most urgent needs for Aboriginal women in Saskatchewan is to establish more specific HIV/AIDS and Hepatitis C programs and services. The division of responsibility for on-reserve and off-reserve services, between federal and provincial governments, has led to barriers in accessing HIV/AIDS funding and crucially needed services for Aboriginal women (Health Canada 1998e). The need for improved involvement by all levels of government both on and off reserve, is made clear by the increasing number of Aboriginal women each year that are being infected with HIV/AIDS and Hepatitis C. Better overall information sharing and the coordination of programs and services, using a more collaborative effort, is crucial to effectiveness. To ensure that such efforts meet the needs of Aboriginal women in Saskatchewan with HIV/AIDS and Hepatitis C, their communities must be viewed as equal partners in program development. In order to be effective, HIV/AIDS and Hepatitis C programs and services must also give greater priority to the explicit concerns of Aboriginal women.

Even though it is illegal to use certain drugs, it is not illegal for people to protect themselves while using them. Although clean needle exchange programs exist in some cities, clean rigs for addicts should be made more widely available both on and off reserve. Service providers in the addiction community must recognize HIV/AIDS and Hepatitis C as some of the most important issues that intravenous drug users have to confront. On site testing and culturally appropriate counselling in treatment and drop-in centers, would go a long way to ensuring that addicted persons do not get overlooked when HIV/AIDS and Hepatitis C issues are being discussed. Governments and other agencies must respond in a more effectual manner, to HIV/AIDS and Hepatitis C in Aboriginal communities, by ensuring that resources and services are culturally appropriate with access to counselling and testing.

Indisputably the most efficient way to fully comprehend how Aboriginal women have been affected by HIV/AIDS and Hepatitis C and what programs and services would improve their chances of not contracting infection, would be to involve Aboriginal women. This research has overwhelmingly revealed that the best person to talk to young Aboriginal women in Saskatchewan, about the risks of HIV and Hepatitis C infection, is an Aboriginal woman who has been there and has lived the experience. It also exposed the fact that most of the infected women felt that they had no choice but to lead a life of prostitution, in order to survive. Contracting HIV/AIDS and Hepatitis C involves high-risk behavior and the inability to make healthy life choices. As a result of prostituting themselves and a lack of self-respect, many of the respondents admitted to taking part in unprotected sexual activity. These factors are key and must be kept in mind in order to establish effective education and prevention programs for Aboriginal women in Saskatchewan.

Notes

^{xx} The role of Elders in Aboriginal communities has always been an important one. All of the respondents felt that Elders could also play an important role in the prevention of HIV/AIDS in Aboriginal youth because Elders are held in such high regard.

^{xxi} HIV/AIDS and Hepatitis C are not merely medical issues for Aboriginal people because they involve all the social consequences of colonization including poverty, racism, and dislocation from their cultures, traditions, and belief systems.

^{xxii} According to the Aboriginal women in this research needle exchange programs are not offered in reserve communities. In some smaller urban centres needle exchange programs are still not provided.

^{xxiii} The prevention of HIV/AIDS and Hepatitis C through unsafe sex is possible through abstinence, but for the respondents who took part in prostitution it was not a viable option.

6.0 CONCLUSIONS

In Saskatchewan, Aboriginal women represent people with unique cultural, social, ethical, and geographical differences from mainstream society. This research is one of only a few efforts to understand the potential harm of HIV and Hepatitis C infection for Aboriginal women, in their own communities in Saskatchewan.

Health Canada (1998e: 58) maintains:

What differentiates discrimination against Aboriginal people living with or affected by HIV/AIDS is the *history of oppression and social disintegration* that has been meted out to Aboriginal, Metis, and Inuit in Canada. This history has resulted in a maze of interconnected spiritual, communal, social, economic, and political problems that strain the resources, the will, and the spirit of Aboriginal communities. Therefore, improving the health and well-being of Aboriginal people (including those with HIV/AIDS) means addressing the causes of cultural dislocation, ruptures within families, violence within families, substance use, chronic poverty, unemployment, poor housing and utilities, environmental destruction, lack of information and services, and lack of control over resources and programming.

HIV and Hepatitis C infection have increasingly become a problem for Aboriginal women in Saskatchewan, who are members of a “minority” population in its inner cities. The Aboriginal women profiled in this research are primary examples of how HIV and Hepatitis C infection are concentrated among the poor and dispossessed.

The literature available on risk factors associated with HIV/AIDS and/or Hepatitis C in the Aboriginal community is extremely inadequate. In the past, this literature has only focused upon individual risk behaviours, knowledge, and attitudes and rarely addressed the broader social

issues of colonization, discrimination, marginalization, oppression, and poverty. Nowhere in this literature is the link between the movements of Aboriginal women from reserve to urban communities in Saskatchewan, changing employment opportunities, and their involvement in high-risk activities, acknowledged or addressed. In addition, research data that have been accumulated reveal an overwhelming lack of acceptance of Aboriginal women with HIV/AIDS and Hepatitis C in their own communities. It was admittedly challenging for many of the respondents to confront their feelings of shame and guilt with regards to having contracted HIV/AIDS and/or Hepatitis C. As well, more than seventy-five percent of the women were had a debilitating fear of being ostracized by their friends and family, if their HIV/AIDS or Hepatitis C status were revealed on the street or in their home community both on and off reserve.

Women constitute the greater part of the urban Aboriginal population in Saskatchewan, as well as the majority of migrants from reserve to urban neighborhoods (RCAP, 1996). Forty-six percent of the respondents migrated from urban to reserve communities. For all of them, the urban center was where they spent the majority of their time. Aboriginal women also play a crucial role and assume much of the responsibility for the welfare of Aboriginal people in urban communities. Their initiatives have been essential in ensuring the day-to-day survival of Aboriginal communities in Saskatchewan's cities. Aboriginal women's position within society must be recognized and their needs met.

It is fundamental that Aboriginal women engage in determining the developing relationship between Aboriginal people and urban institutions. Overwhelming evidence shows that urban service delivery groups are not meeting the specific needs of urban Aboriginal women, and endeavors to resolve this situation are key to advancing Aboriginal women's health and well-being (RCAP, 1996). The risks that HIV/AIDS and Hepatitis C pose in the Aboriginal community have not decreased in the period following the report of the Royal Commission on Aboriginal Peoples in Canada, released in 1996. In fact, the general perception is that the risk level has actually intensified. Discoveries concerning the nature of HIV and Hepatitis C infection

- the increase in the heterosexual population and among Aboriginal women - have intensified concern regarding its potentially rapid spread in the Aboriginal community in Saskatchewan.

The bleak reality is that the sexual and economic subordination of Aboriginal women fuels the HIV/AIDS and Hepatitis C crisis in Saskatchewan. In order to break the cycle of neglect produced by colonization, that has affected Aboriginal women during their lifetimes and across generations, it is vital that measures be taken that will allow Aboriginal women to make informed choices and enable them to improve the quality of their own lives, with certainty and in a positive direction. Aboriginal women need to empower themselves by exchanging ideas, forming alliances, and promoting change in improving their own health and living conditions in Saskatchewan communities. Effective HIV/AIDS and Hepatitis C prevention and treatment efforts, along with sound policies and programs targeting Aboriginal women affected by HIV/AIDS and Hepatitis C, need to be developed and integrated into existing governmental organizations. These efforts must be executed at both the community and the family level. Since social vulnerability cannot be effectively challenged by Aboriginal women as individuals alone or even in groups, building efficient and empathetic affiliations between Aboriginal women and Aboriginal men based on mutual respect remains the greatest challenge. It is also the most promising option for Aboriginal women in Saskatchewan in the future.

HIV/AIDS and Hepatitis C have affected Aboriginal women in Saskatchewan first and foremost. A decade ago Aboriginal women seemed to be on the periphery of the HIV/AIDS and Hepatitis C crisis; today they are at the forefront of concern. Half of newly infected Aboriginal adults are women. Over half of the respondents in this research were in the 20-30 year age group; in addition, the symptoms of HIV/AIDS and Hepatitis C do not necessarily surface for approximately 7-10 years following infection. However, the peak age of infection is lower in girls than boys with a female to male ratio of two to one. An analysis of reported HIV/AIDS and Hepatitis C data from several areas suggests that young Aboriginal women under 25 years of age account for nearly a third of female AIDS and/or Hepatitis C cases. As contagions among

Aboriginal women rise so do infections in the infants born to them. Overall, about one-third of Aboriginal babies born to HIV and Hepatitis C- infected mothers become infected as well (Health Canada, 1998d).

There is a desperate need for more knowledge regarding the social determinants and risk factors associated with the transmission of HIV and Hepatitis C infection in Aboriginal women in Saskatchewan. More pertinent studies, addressing groups at risk and unsafe behaviours and attitudes, have just begun to appear in contemporary literature, but a much broader perspective is overdue. Of particular concern are studies that address the issues of self-esteem and the development of personal identity or the lack thereof, among Aboriginal youth who continue to be over-represented in high-risk groups for HIV and Hepatitis C infection. Studies that underestimate the extent of the HIV/AIDS and Hepatitis C crisis run the risk of reinforcing the predominant attitude in most Aboriginal communities in Saskatchewan, that HIV/AIDS and Hepatitis C are not an Aboriginal problem.

Unmistakably, research to date in this area is deficient in the task of preventing the further spread of HIV/AIDS and/or Hepatitis C and in providing valuable and culturally appropriate treatment to Aboriginal women in Saskatchewan living with HIV/AIDS and Hepatitis C. Much of the current knowledge is especially relevant to urban Aboriginal women, with few studies pertaining to the on reserve population. Reserve and urban communities are inextricably linked through the migration and mobility of Aboriginal women and research should determine these links more readily (Aboriginal Nurses' Association, 1996).

HIV/AIDS and Hepatitis C have become a serious public health concern in Saskatchewan's Aboriginal communities. Studies that underestimate the magnitude of this crisis run the risk of reinforcing prevailing attitudes in many of these communities. These are attitudes that suggest that HIV/AIDS and Hepatitis C in the Aboriginal community will likely exacerbate negative stereotypes and discrimination against Aboriginal women and their families, who have already contracted HIV/AIDS and/or Hepatitis C.

The question of ethics and research methodologies must be given careful consideration at all levels of HIV/AIDS and Hepatitis C research affecting Aboriginal women in Saskatchewan. This is a "triple-jeopardy" focus for research sensitivity, involving the reality that these women are Aboriginal, that they are members of a sub-population in Saskatchewan cities, and that they are infected with HIV/AIDS and/or Hepatitis C. The issues of confidentiality, collaboration with other affected groups, organizations, and communities and the ownership and control of the research data produced, are extremely important to Aboriginal women. Partnerships, shared administrative structures, and participatory methodologies are essential to efficacy. Research in Aboriginal communities must accommodate capacity building, in terms of effective training for Aboriginal researchers about preventative and educational strategies against HIV/AIDS and Hepatitis C.

Proficient studies should have a community-team approach that is more effective in involving Aboriginal women who reside in urban centers, in actually participating in proffered social programs. In addition, this type of program proposal recognizes the importance of Aboriginal community dynamics and the need for more sharing of information. It will instill Aboriginal women with a sense of competency, in dealing with HIV/AIDS and Hepatitis C infection and an understanding that their traditional methods of dealing with life and crisis situations can be modified and integrated. This competency will in turn give Aboriginal women in Saskatchewan the confidence to handle the issues that surround HIV/AIDS and Hepatitis C and the credibility that they will require in their respective communities to garner support for their efforts.

Many of the respondents in this study were aware of the existence of both the HIV and Hepatitis C virus and how it was transmitted however, some still thought that a cure was imminent. When Anikwacas (2000:4) who confirmed that she had just been diagnosed with Hepatitis C for only a month, was asked if her children were tested she replied, "Yeah they are fine. When I 'had' Hep. C they (her children) had to get shots and everything, but that was about it. I never had them tested for the Hep. C." She was not aware that once you have contracted

Hepatitis C it can be treated but it cannot be cured. For these women obtaining knowledge about HIV/AIDS and Hepatitis C was done through necessity, while working as prostitutes on Saskatchewan streets. Information was also accessed via various STD Clinics in the province, yet the bulk of the respondents were diagnosed with HIV/AIDS and/or Hepatitis C while they were incarcerated. Attitudes and behaviours toward condom use, the age of sexual debut, STD control, sex work, sexual orientation, and sexual abuse must all be addressed, in order to reduce the incidence of HIV and/or Hepatitis C infection among Aboriginal women in Saskatchewan.

The effects of two centuries of colonization, racism, oppression, and displacement are evident in the current health status of Aboriginal women in Saskatchewan. As the Royal Commission on Aboriginal Peoples (1996) notes, the life expectancy at birth is approximately seven to eight years less for Aboriginal people in Canada than for Canadians in general; infant mortality is twice as high as the national average; many infectious diseases are more common in the Aboriginal community than others; overall rates of injury, violence, and self-destructive behaviours are alarmingly high; and rates of overcrowding, educational failure, unemployment, welfare dependency, conflict with the law, and incarceration all point to imbalances in the social conditions that shape the welfare of Aboriginal women in Saskatchewan. Many of the factors that have contributed to a higher risk of HIV/AIDS and Hepatitis C in Aboriginal women in Saskatchewan relate directly or indirectly to discrimination. These factors include high rates of sexually transmitted disease and teenage pregnancy, which indicate a lack of safer-sex practices and a higher risk to Aboriginal youth, low self-esteem and high rates of sexual and physical violence, drug and alcohol abuse, a lack of access to health information and facilities, and extensive overall poor health.

Aboriginal leaders in Saskatchewan and in Canada have been slow to recognize and respond to the presence of HIV/AIDS and Hepatitis C amid their communities. There are a number of unresolved reasons for this. HIV/AIDS and Hepatitis C have in the past been understood as “a disease of white gay men in the cities” in Saskatchewan. The majority of Aboriginal women with

HIV/AIDS and Hepatitis C are not living on reserve and are, therefore, not within the jurisdiction of Aboriginal leaders. Jurisdictional issues have seriously impeded the progress of effectual prevention and educational services and programs. As a result, the concern at present is that if the authority for health services is transferred to Aboriginal people funding for programs and services, for those with HIV/AIDS and Hepatitis C, will be inadequate. In some Aboriginal communities people have been reluctant to address HIV/AIDS and Hepatitis C, because of the shame and stigma associated with the issues of sexuality and/or homosexuality. These attitudes compound the problems of striving to reduce the risks of HIV and Hepatitis C infection among Aboriginal women in Saskatchewan. As Matiation (1998:23) argues:

HIV/AIDS workers cannot simply go into communities and talk about HIV/AIDS. All the issues around HIV and public health in Aboriginal communities must be addressed, including the impact of a foreign culture on community practices and traditions, residential schools, assimilation policies, health problems, sexual and physical abuse, and alcohol. All these topics make it difficult to talk about sexuality issues.

Ninety-five percent of the respondents were sexually abused, most of them at a very young age. Ninety-five percent of the women were also physically and emotionally abused as well as victims of violence, most while working as prostitutes. The many stories of sexual abuse that the respondents revealed made it clear that they were more often than not attacked or taken advantage of as teenagers. All of the respondents had been affected by sexual abuse and violence when they were teenagers and rape can devastate young Aboriginal girls who already face a severe lack of self-esteem and self-identity. There is growing documentation that following sexual assault Aboriginal teenagers turn to substance abuse, prostitution, and suicide, not to mention that they can get pregnant, and contract sexually transmitted diseases including HIV/AIDS and Hepatitis C.

The suicide rate for Aboriginal youth is five times the national average in the 15-24 year old age group. If violence takes place there must be emotional, psychological, medical, and legal support systems put in place. All Aboriginal youth should have immediate access to counselling services both on and off reserve. They also require safe houses for those times when their homes

or communities no longer feel safe. There should also be attention given to young Aboriginal people's spiritual needs. If young Aboriginal people enjoy their daily existence and if they can perceive their dreams, as within their reach, they will hopefully respond to a motivating environment and move away from destructive attitudes, influences, and behaviours. To eliminate violence, it must be replaced with constructive, creative, and meaningful alternatives that Aboriginal youth in Saskatchewan can relate to (La Rocque, 1996).

As a result of the shame and stigma associated with HIV/AIDS and Hepatitis C in Aboriginal communities, confidentiality of status is irrefutably crucial. However, it is often difficult to ensure anonymity in Aboriginal communities. A number of the respondents spoke of improper disclosure by health-care providers, as well as the unwelcome talk of friends in both urban and reserve communities. The reaction of the surrounding community upon finding out that the respondents were HIV and/or Hepatitis C-positive included ostracism, avoidance, and in some instances a denial of services. In the face of these kinds of responses, one of the three priorities cited most often (after the issues of funding and poverty) by the respondents, was uninhibited access to their home communities with adequate services and without the fear of discrimination (de Bruyn, 1998).

The greater number of respondents in this research with HIV/AIDS and Hepatitis C live in Saskatchewan cities, not in remote reserve communities. The exact number of Aboriginal women in urban centres in Saskatchewan is not known. Although more services associated with HIV/AIDS and Hepatitis C or substance abuse are available in Saskatchewan cities, they are sometimes provided in ways that are discriminatory, particularly to those who are at greater risk of HIV and Hepatitis C infection, such as Aboriginal women that are intravenous drug users and prostitutes. A positive approach to treating Aboriginal women, including those with HIV/AIDS and Hepatitis C, with dignity is clearly to provide them with services of the same value as those provided to others in Saskatchewan, with the same needs. As well, it means affirming the insights and practices of Aboriginal cultures in Saskatchewan in developing and delivering programs and

services, plus incorporating traditional Aboriginal healers and healing practices into those programs and services (de Bruyn, 1998).

Aboriginal women involved in street prostitution are stigmatized by society, because they cannot depend on the basic rights of humanity such as confidentiality, health care, protection by the police, or access to other services. In relation to HIV/AIDS and Hepatitis C, Aboriginal prostitutes are usually viewed as “vectors of transmission” rather than people in need of education, treatment or support. In her book titled, *Race, Space, and the Law: Unmapping a White Settler Society*, Razack (2002: 136-7) describes the context within which Aboriginal women are viewed in prostitution:

I have argued elsewhere that the spatial boundaries and transgressions that enable the middle-class white male to gain mastery and self-possession are generally evident in his use of a woman in prostitution. When they purchase the right of access to the body of a prostitute, men, whether white and middle-class or not, have an opportunity to assert mastery and control, achieving in the process a subjectivity that is intrinsically colonial as well as patriarchal. Naturalized as necessary for men with excess sexual energy, prostitution is seldom considered to be a practice of domination that enables men to experience themselves as colonizers and patriarchs, that is, as men with the unquestioned right to go anywhere and do anything to the bodies of women and subject populations they have conquered (or purchased). Instead, the liberal idea that we are autonomous individuals who contract with each other is used to annul the idea that prostitution is non-reciprocal sex and thus a violation of the personhood of the prostitute. The contract cancels the violence, although we readily recognize the violence of other financial transactions. The space of prostitution,...is the space of license to do as one pleases, regardless of how it affects the personhood of the others.

The welfare of Aboriginal women involved in street prostitution depends as much on their access to adequate legal and social counselling and educational resources as it does on decreasing the practice of perilous behaviours and careless attitudes. The majority of the respondents continued to take part in prostitution, even after they had been diagnosed with HIV and/or Hepatitis C infection. Aboriginal prostitutes in Saskatchewan live and work in an environment that stigmatizes and marginalizes them in numerous ways. Personal and public disapproval of prostitution is expressed in the attitudes of both Aboriginal and non-Aboriginal communities,

politicians and service providers, in local by-laws and police surveillance, and in the criminal prosecution of prostitution. Many Aboriginal prostitutes are further marginalized by involvement with the street, poverty, race, alcohol and intravenous drug abuse, and individual sexual identity.

Aboriginal street prostitutes are repeatedly the most marginalized of sex workers.¹ Street prostitution is illegal where escort services are not, which has had an adverse effect on poorer Aboriginal prostitutes. Aboriginal street prostitutes are more vulnerable to harassment and they are more likely than other sex trade workers to be arrested for soliciting and incarcerated in the provincial and federal corrections institutes of Saskatchewan. The HIV/AIDS and Hepatitis C crisis has heightened and exposed the vulnerability of Aboriginal prostitutes to discriminatory attitudes, attention, and regulations. As stated earlier, Aboriginal prostitutes in Saskatchewan have in the past been characterized as “vectors of transmission,” a phrase that ignores the fact that many of them are more consistent in their use of condoms than other populations in Saskatchewan; that they frequently exercise more responsibility than their clients; and that they are generally at a higher risk of HIV or Hepatitis C infection from their clients, than vice versa. Research on Aboriginal prostitutes in Saskatchewan has focused more on their working lives than their private lives, even though many of them are at more risk in the latter than the former. The confidentiality of HIV/AIDS and Hepatitis C status for Aboriginal women is often breached, particularly for street prostitutes, but also by public health officials, under the guise of protecting other members of mainstream Canada.

Young Aboriginal girls in Saskatchewan with little or no sex education and in an environment conducive to alcohol and drug abuse and violence, are particularly vulnerable to adult male sexual abuse. Sexual violence is global and universal. Men of all backgrounds, cultures, classes, and economic status assault women. Indeed, history is replete with examples of rich, powerful, and privileged men who abused women and children. This implies that the origin of sexual violence is considerably more disturbing than any known society would like to avow. Most adults who violate others do so from a position of perceived power, awareness, and out of personal

choice. Humanity may never know for certain what causes sexual violence, but it should never be used as an explanation, be it psychological, personal, or political as absolution for the act itself, sexual violence must never be tolerated or justifiable. The criminal justice system in Saskatchewan is obligated to serve justice. That is essential to every sexual abuse victim's healing and the objective must be that sexual violence under any circumstances is unacceptable.

In order to make significant changes in the delivery of services to Aboriginal women in Saskatchewan, with HIV/AIDS and/or Hepatitis C and to slow the potentially rapid spread in Aboriginal communities both on and off reserve, fundamental changes need to be reputable. These changes must include an increased awareness and understanding of healthy sexuality, honest relationships and alternative lifestyles, provisions for opportunities to increase the perception and understanding of Aboriginal traditional teachings in Aboriginal communities, a stipulation to augment the comprehension and sensitivity in non-Aboriginal communities in Saskatchewan regarding the culture, beliefs, and values of Aboriginal women, confirming efforts to develop a holistic, culturally appropriate plan for Aboriginal women to deal with HIV/AIDS and Hepatitis C, and an arrangement of alliances with Aboriginal communities both on and off reserve.

Aboriginal women need to assist in developing their own HIV/AIDS and Hepatitis C education and prevention efforts. They have to contribute to the establishment of suitable approaches for reaching Aboriginal women living both on reserve and in inner cities in Saskatchewan. Aboriginal women must be involved in the development of programs and services that not only meet the requirements of prevention and education, but also the long-term care needs of Aboriginal women living with HIV/AIDS and Hepatitis C. They have to help in implementing strategies to assist in the development, delivery, and evaluation of programs and services for Aboriginal women. In doing so, they can assist in creating and maintaining a coordinated Aboriginal HIV/AIDS and Hepatitis C organization that promotes optimistic relations both within the Aboriginal community and between Aboriginal and sensitive non-

Aboriginal service providers where they exist, and where funding is provided by the Saskatchewan provincial government. Service providers for Aboriginal women with HIV/AIDS and Hepatitis C cannot survive solely on donations like the PLWA (Persons Living With AIDS) and All Nations Hope Networks in Saskatoon, Regina and Prince Albert have been forced to.

According to the respondents there were numerous avenues to pursue to prevent other Aboriginal women from contracting HIV/AIDS and/or Hepatitis C. As stated previously in this dissertation, half of the respondents believed that education and prevention through the school system and at the street level was essential. Some also claimed that keeping Aboriginal women off the street would be a major hurdle in the prevention of HIV/AIDS and/or Hepatitis C, deemed more outreach services and needle exchange programs as a priority, and viewed parents as positive role models who could emulate the practices of safe sexual activity and abstinence from intravenous drugs and alcohol. As well, some of the respondents viewed Elders as having a very prominent role to play in the education, prevention, and counselling of Aboriginal women with HIV/AIDS and/or Hepatitis C, while others endorsed the medical community.

Most of the respondents contended that Aboriginal women did face violence if they refused to perform sexual acts without the use of a condom. All of the women made it clear that more information on HIV/AIDS and/or Hepatitis C was necessary, to prevent Aboriginal women in future from contracting infection. Aboriginal women who are living with and affected by HIV/AIDS and Hepatitis C, need to be involved in the development and implementation of programs and services at the community level. An Aboriginal woman's choice of programs and services, her right to privacy, as well as her freedom to make decisions concerning her own body, must be acknowledged and respected (Ontario Aboriginal HIV/AIDS Strategy, 1993).

The fundamental objectives of this research were achieved via the profiling of twenty-two Aboriginal women from Saskatchewan. This research has documented the veracity of the premise that the initial male domination of the struggle against HIV/AIDS has made Health Canada's statistics that confirm an increasing number of HIV infections in Aboriginal women in

Saskatchewan, virtually imperceptible. Through the lack of available knowledge about HIV/AIDS, the Aboriginal community in Saskatchewan has not been able to respond as promptly and proficiently to prevention and education programs. Aboriginal women with HIV/AIDS and Hepatitis C were unable to identify with this categorization of risk factors or to interpret their own behaviours and attitudes as dangerous to their welfare. As such, Aboriginal women who are already members of an impoverished marginalized, and oppressed group in Saskatchewan, saw their needs and experiences as entirely separate from those of homosexual and bisexual men. Instead, the respondents maintained that they required access to gender specific prevention, education, and treatment programs and services that would realize their own specific needs.

Following the implementation of Canada's policies of colonization, assimilation, and the residential school system Aboriginal women in Saskatchewan were forced to deal with the loss of a previously prominent role that they had played in their communities for centuries. Maskwa (2000:3-5) described how her life was altered, following her residence at the Lebret Residential School in Saskatchewan:

I didn't have any self-esteem after I left boarding school so that played out a lot in my life in the way I did things and stuff like that. You were never in a family setting so you didn't know how to have a family of your own. So my children were victims also of the time that I spent in boarding school. I never got my self-esteem back until I was around forty and being proud of who I was and what I did and my teachings to my children and stuff like that. I was never a very affectionate person to my children. I didn't know how to tell them that I loved them or give them a hug, so they missed out on all of that. Now I have that kind of relationship with my kids, my adult kids.

A lot of my teaching has to do with women's responsibility to Mother Earth, because if Previous generations of Aboriginal women had performed highly esteemed functions in the political and cultural life of traditional Aboriginal societies. Maskwa (2000:8-11) an Elder, reiterated the past and present role of Aboriginal women:

we didn't have water we couldn't survive. That's one of the gifts that the Creator gave us, water from Mother Earth. That is what I teach my own

granddaughters, that they are responsible for the water and they are responsible for looking after their family. They are responsible for bringing the medicines and being taught about how to use them and stuff like that. You can give them the basics and as you go along in the teachings you will get the knowledge. Another one of the gifts that we have been given from the Creator is to procreate. That's the second gift we were given. Men can't do that, just women can. I used to wonder why a long time ago when they would have circles or whatever, why the women were always away, but I know now. It was because women were stronger than the men and they didn't have to say I'm here, let me have the bird or whatever. It wasn't necessary, because everybody knew that you had more power than the men did. You just get this knowledge over the years of going to ceremonies and stuff like that and listening to other people talking. It doesn't come to you in a book. It is just something that you listen to and you gain knowledge that way. Like the sweat lodge is for women and that's why I ended up spending many years in the different prisons across Canada.

Currently, Aboriginal women in Saskatchewan are reclaiming their essential roles and are offering encouragement and personal knowledge with regard to the prevention, education, and treatment of HIV/AIDS and Hepatitis C in other Aboriginal women. The twenty-two Aboriginal respondents in this research sincerely hoped to prevent other Aboriginal women from making the same unhealthy choices that they had, by sharing their experiences while living on the street. Several of them had already contributed to HIV/AIDS and Hepatitis C prevention and education.

Angel (1999:8) revealed:

When I went up north to speak to the school children I always felt that if I could reach one out of a hundred it would be worth it. I told them about unsafe sex, because you don't know how this person got to be HIV positive and you don't know if the person is HIV positive. They could be feeling healthy up until they start getting sick and that's when they'll know. I thought I was invincible and I didn't think anything would ever happen to me, but it did.

Maskwa (1999:11) pointed out that she had spoken at schools as well, but had taken the sharing of information one step further:

I am educating myself so I am able to go to these schools. That's what I'm trying to do in Moose Jaw, is open up a resource center. There is no information there at all. So I am getting together with community organizations and we're opening up a resource library. I'm putting together meetings, group sessions all that kind of stuff. I'm educating my doctor down there (Moose Jaw) too.

Amisk (2000:19) was also proactive and helped other Aboriginal women with HIV/AIDS and Hepatitis C in Prince Albert, through the STD Clinic and the All Nations Hope Network. She also worked as a counsellor at an Aboriginal girls' camp near La Ronge. In 2001, Amisk walked from Prince Albert to Saskatoon to raise money to assist young Aboriginal prostitutes in getting off the street and to offer them healthier alternatives. Maskwa (2000:17-18) offered her teachings to the Cree at James Bay in northern Quebec:

I was invited to go and do some teachings there. They thought I knew something, so I went over there. That's where I really found myself, when I was doing those kinds of things. That's where I did lots of ceremonies and stuff way up in northern James Bay, because they wanted to get their teachings back also, but they didn't have anyone who knew about native spirituality. Evangelists, Anglicans, and Catholics had totally brainwashed them so it took a long time for them to be proud of whom they were. That is what I do mostly now. I have been working in women's prisons for almost eighteen years. I go and talk to them and visit with them, do ceremonies and share in talking circles and stuff like that.

Maskwa (2000:17-18) also shared her traditional teachings and how she has used them to help the Aboriginal inmates:

I usually go in and have a circle. What I usually do when I go in is I go to see the girls and we'll have tea or we'll talk about something and sometimes the girls want to talk to me themselves. I've been there so long they are just like my kids. They'll come up to me and say kokum (grandmother) I want to talk to you, will you come and see me before you go? That's what I do. I go from unit to unit and spend some time with the women and listen to what they have to say. Sometimes I can help and sometimes I can't. I am someone that they can talk to or share whatever it is that's bothering them. I school myself into listening and then it is just gone from my mind. I don't remember the person that has told me this or anything like that. I had to do that over the years, otherwise I would go nuts listening to all the pain and the heartache that they go through.

In addition, Maskwa (2000:17-18) described her thoughts and feelings about the young Aboriginal women that she advised:

A lot of these girls are third generations and they have never had anything. Some of them have lived in the cities all their lives, so they don't know what it is that they are missing. That is what is happening in our society today especially around Aboriginal people, is that they don't

know who they are. They get so mixed up in prostitution, alcoholism, drug addiction and stuff like that. I think a lot has to do with their home lives, but it also has to do with education. They are not going to be able to get a job if they don't have an education. A lot of these young women drop out, because they are alone in the classroom with no other Aboriginal person there or they have no push to go. Their mothers and fathers are alcoholics or drug addicts or whatnot and they have to learn how to look after themselves when they are really young, at eight or nine years old.

This research has revealed the extent to which Aboriginal women in Saskatchewan have been affected by both HIV/AIDS and Hepatitis C. Initially, the primary concern for this research was the effect of HIV/AIDS on the lives of Aboriginal women in Saskatchewan, but once the profiling began it was revealed just how extensively Hepatitis C had affected them as well. The incidence of both of these infectious diseases has continued to escalate since the crisis began in 1982. However, conscientious education, prevention, and treatment strategies for Aboriginal women in Saskatchewan have not increased accordingly and will not, until Aboriginal women are given the opportunity to play a prominent role in the process of program development.

Maskwa (2000:20-21) shared her concern for Aboriginal women who had already been affected by HIV/AIDS and Hepatitis C:

For the girls that come out of Pine Grove they don't have any place to go, but they do have lots of sweat lodges and they can prepare themselves for Sundance if that's what they want to do. There is no excuse and I tell them that. There is no excuse I tell them and if they can go look for drugs or go look for alcohol so you can go look for a sweat lodge or you can go look for a teacher. I think that there are some who are never going to be able to get out of what they are into with drugs and alcohol and prostitution. I think the only thing that is going to help is for them to learn about who they are, their self-worth and their self-esteem. If you don't think anything of yourself well, you don't make it. I think the cycle has been broken. I think there are a lot more Elders that are out there now than there was when I first started, that are teaching their grandchildren that are teaching their great-grandchildren and even their own children's children.

Even though many Aboriginal women in Saskatchewan with HIV/AIDS and Hepatitis C continue to be marginalized during this current crisis, they are working together to improve the situation of other Aboriginal women and their families. The twenty-two Aboriginal women

profiled in this research, who had never been given the opportunity to openly share their life experiences, illustrated how HIV/AIDS and Hepatitis C had permanently affected them and the members of their community. The personal histories entrusted by these women have underscored the legitimacy and convincing success of this research.

Notes

^{xxiv}. All of the respondents who took part in this research were exclusively “street” prostitutes. They all exchanged sex for cash as well as for drugs. Eighty percent of the women worked independently while approximately twenty percent of them worked under a manager or “pimp.” All of the respondents saw their identity as a prostitute as a means to an end, to support themselves and their children. Ninety-percent of the women saw their identity as a “prostitute” as acutely affecting how they viewed themselves as well as how others viewed them.

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8.0 APPENDICES

A1. DEFINITION OF TERMS

1. HIV/AIDS

HIV stands for the human immunodeficiency virus and is a sexually transmitted disease. It is mainly transmitted through unprotected anal and vaginal intercourse, blood and blood products, the sharing of intravenous drug equipment, and during childbirth. AIDS stands for acquired immune deficiency syndrome. Immune deficiency means that a person's immune system is prevented from operating properly and he/she is more prone to opportunistic infections. A syndrome refers to a group of symptoms or illnesses originating from one cause, in this case HIV (Berer, 1993: 5).

2. Sexually Transmitted Diseases (STDs)

An STD is a bacterial or viral venereal infection that may be passed from one individual to another by sexual contact. It is also referred to as VD (venereal disease). These diseases include herpes, syphilis, gonorrhea, chlamydia, genital warts and HIV (Ontario Aboriginal HIV/AIDS Strategy, 1993: 5).

3. Colonization

Colonization, in the context of this dissertation, "refers to that process of encroachment and subsequent subjugation of Aboriginal peoples since the arrival of Europeans. From the Aboriginal perspective, it refers to the loss of lands, resources and self-direction and to the severe disturbance of their cultural ways and values" (La Rocque, 1994:3). The individual and personal impact of colonization, on the lives of the Aboriginal women profiled in this research, is especially evident.

4. Aboriginal

As stated in the 1982 Constitution of Canada, the term "Aboriginal" refers to all people of Indian, Inuit and Metis heritage, including non-status Indians (Waldram, 1995:Preface: xi).

5. Marginalization

As stated by Gordon Marshall (1994:304) marginalization refers to "a process by which a group or individual is denied access to important positions and symbols of economic, religious, or political power within any society...a marginal group may actually constitute a numerical majority...and should perhaps be distinguished from a minority group, which may be small in numbers, but has access to political or economic power".

6. Homophobia

Homophobia refers to the fear by heterosexuals (and by some “gays” i.e. homosexuals) of being in close quarters with homosexuals; among gays themselves, it refers to self-loathing (Feldman, 1990:13).

7. Cultural Oppression

Cultural oppression is derived from the loss of cultural identity, either imposed or denied. Historically, the Aboriginal people of Canada were deprived (“raped” in the words of Lynne (1998:2) of their culture, traditions, language, spirituality, and values.

8. Patriarchy

Patriarchy, “literally means ‘rule of the father’; the term was originally used to describe social systems based on the authority of male heads of household. It has now acquired a more general usage, especially in some feminist theories, where it has come to mean male domination in general” (Marshall, 1994:383).

9. Standpoint Methodology

In the “standpoint” methodology developed by feminist scholars, it is recognized that people in institutionalized positions of power are blinded by their advantaged standpoint and tend to neglect or not fully understand the world-views, issues, and experiences of less empowered or marginalized groups. When describing standpoint methodology stress is placed on research that focuses on marginalized groups, whose participation will generate questions that the institutionalized authorities would not think to ask. In effect, marginalized lives are better places to start asking critical questions about certain issues, practices, and policies. This is particularly true in the area of medical research involving human subjects in which the potential for harm to the study objects cannot be fully appraised by the institutional group conducting the research (Allman, Myers and Cockerill, 1997:25).

10. Ethnography

Hurtig (2000:4) states that ethnography refers to the research, analysis, interpretation, and representation of social and cultural processes. The dialogue has included anthropologists, for whom ethnography is the principal methodology and narrative form for the discipline, as well as sociologists, psychologists, and other feminist researchers who incorporate cultural inquiry into their studies of gender and sexuality. Among the issues raised by feminist critiques are the androcentrism (male-centeredness) of the analytical categories, “master” theories, and modes of representation found in ethnographic research and writing.

11. Participatory Research

Participatory research refers to research in which the researcher and members of the community share in the way research is designed, carried out, and brought to bear on particular life circumstances (Hurtig, 2000:8).

A2. CONSENT FORM

“HIV/AIDS and Aboriginal Women in Saskatchewan: Colonization, Marginalization and Recovery”:

I am Carol Romanow, a graduate student in the Sociology Department at the University of Saskatchewan. I can be reached at (306) 374-1644.

The purpose of this research is to better understand if First Nations women know how they can get HIV/AIDS, how it can be transmitted from one person to another, how they can protect themselves, and if they know what treatment is available and how they can acquire it. This information will be used to conclude whether First Nations women receive adequate education, prevention, and treatment concerning HIV/AIDS.

There is no direct benefit to you from this research, however it will assist in revealing to society the impact that HIV/AIDS has had on First Nations women in Canada.

If you agree to take part, I would like to spend some time with you on an individual basis to discuss how AIDS has affected you and your family. You will be asked to answer questions about your age, education level, general health, and attitudes towards HIV/AIDS, knowledge of HIV/AIDS and sexual behavior. With your permission I will audiotape the interview, as well as make handwritten notes.

The risks of the research are that you may find some of the questions personal. You may also feel reluctant about revealing your HIV/AIDS status. I will take care to minimize these risks.

Your participation in this research is voluntary. You are free to refuse to take part, and you may refuse to answer any questions or may stop taking part at anytime.

Every precaution will be taken to protect your privacy and confidentiality of the records and data pertaining to you in particular and the research study in general, disclosure of which may contribute to identifying you specifically to persons not related to this research. After this research is completed, I may save the tapes and my notes for use in the future. However, the same confidentiality guarantees given here will apply to future storage and use of the materials. The notes and audiotapes will be stored under lock and key in my home.

If you do not understand any portion of what you are being asked to do or the contents of this form the researchers are available to provide an explanation. Questions relating to this research project are welcome at any time. Please direct any questions to Carol Romanow, the researcher, or Patience Elabor-Idemudia, Ph.D., the Supervisor, at the following addresses:

Carol Romanow
C/O Department of Sociology
University of Saskatchewan
Saskatoon, Saskatchewan
S7N 0W0
Campus Tel: (306) 966-6947

Dr. Patience Elabor-Idemudia
Department of Sociology
University of Saskatchewan
Saskatoon, Saskatchewan
S7N 0W0
Campus Tel: (306) 966-6933

If the purpose of the research or your participation in it changes you will be informed immediately by the researcher. Once the study is completed you will be given a copy of the research as well as an opportunity to discuss its contents with the researcher.
I have read the statements contained herein, have had the opportunity to discuss my concerns and questions, and fully understand the nature of my involvement in this research program as a participant and the attendant risks and consequences. I also acknowledge that I have received a copy of the consent form for my own personal use.

_____ Date: _____

Research Participant

_____ Date: _____

Researcher

A3. TRANSCRIPT RELEASE FORM FOR RESEARCH: “HIV/AIDS and Aboriginal Women in Saskatchewan: Colonization, Marginalization and Recovery”

I, _____, have reviewed the complete transcript of my personal interview in this study, and acknowledge that the transcript accurately reflects what I said in my personal interview with Carol Romanow. I hereby authorize the release of this transcript to Carol Romanow to be used in the manner described in the consent form. I have received a copy of this Data/Transcript Release Form for my own records.

Participant Date

Researcher Date

A4. DEMOGRAPHICS FOR RESEARCH: “HIV/AIDS and Aboriginal Women in Saskatchewan: Colonization, Marginalization, and Recovery”

Interview #: _____

Date: _____

Place: _____

Name: _____

How you wish to be referred to for this research: _____

Age: _____

Marital status: _____

Number of children: _____

Ages: _____

Ethnicity: (Aboriginal, Metis or Inuit) _____

Place of residence: _____

Who you live with: _____

Occupation: _____

Level of education: _____

Attend residential school: _____

Religion/spiritual practices/traditions: _____

Languages spoken at home: _____

Alcohol use: _____ How much _____

Drug use: _____ How much _____

Treatment for alcohol or drug use: _____

Have you ever been a victim of

Sexual abuse: _____ by whom? _____

Physical abuse: _____ by whom? _____

Emotional abuse: _____ by whom? _____

Violence: _____ by whom? _____

Sexually transmitted diseases: _____

Incarcerated: _____ Where? _____

A5. QUESTIONS FOR RESEARCH INTERVIEW

The questions for Research Study: “HIV/AIDS and Aboriginal Women in Saskatchewan: Colonization, Marginalization, and Recovery”, will focus upon relevant demographics as well as the following twelve major questions:

Demographics:

- | | |
|------------------------|--|
| a) Name (code #) | h) Ethnicity |
| b) Number of interview | i) Place of residence (urban/rural) |
| c) Date | j) Occupation/household income |
| d) Place | k) Religion/spiritual practices/traditions |
| e) Marital status | l) Language spoken most at home |
| f) Number of children | |
| g) Age | |

- 1) How long have you been living with HIV/AIDS?
- 2) Can you explain how you became infected with HIV? What was happening in your life at that time? How were you diagnosed?
- 3) As an Aboriginal woman, how would you describe your illness and experience with HIV? What has it been like for you? How has it affected you and your personal relationships? (family, friends, and so on)
- 4) Do you know other people who suffer from HIV/AIDS? What do you know about other ways of becoming infected with HIV?
- 5) How much do you know about HIV and AIDS and how it affects women? How and where were you able to obtain information on HIV/AIDS?
- 6) As an Aboriginal woman, what would you say is the worst part of having AIDS or being infected with HIV, personal or medical?
- 7) Do you have a strong support system in your life to help you through the problems with your illness? How do people like your family members, reserve, friends, priest, elder, AIDS Saskatoon or the PLWA Network help you?
- 8) What do you feel would be an important way of preventing this disease from being passed on to young Aboriginal people?
- 9) Do you think that sex education in schools, condom use and safe sex is important? Do you think Aboriginal kids feel that they are invincible to HIV/AIDS or do they just not care what happens to them? Do you think that they feel that they have nothing to look forward to in the future anyway? Do young Aboriginal women face violence if they insist on the use of a

condom? Why? Finally, do you think that it is important to have HIV testing programs where a person does not have to give his/her name (anonymous)?

10) Who do you feel would be the best person to educate Aboriginal women on how to prevent HIV/AIDS? (doctor, nurse, teacher, and so on)

11) In the future, how do you think Aboriginal women with HIV/AIDS can best be helped?

12) Is there anything else that you would like to talk about that I might have missed?

