

to the social determinants of health, such as poverty and housing.

In 2002, organizations from communities in a rural area of Canada initiated a study to research the intersecting risks of violence and HIV infection for rural women as a basis for developing a local HIV prevention strategy. Although women of all ethnicities were invited to participate, half of the 30 participants in the study identified as Aboriginal. Analysis of the interviews and contextual data offers insight into the specific ways that neo-colonial relations and racism shape Aboriginal women's experiences and risks.

LITERATURE

Women represent an increasing proportion of reported HIV and Acquired Immune Deficiency Syndrome (AIDS) cases in Canada (Public Health Agency of Canada, 2003; Health Canada Centre for Infectious Disease Prevention and Control, 2001; Public Health Agency of Canada, 2006). Women in Canada also experience violence at epidemic levels (Biesenthal et al., 1997; Brownridge, 2003; Johnson, 1996; Rodgers, 1994; Statistics Canada, 2002). Histories of exposure to violence are common among women who are HIV positive (Gielen et al., 2000) because violence is a central factor in women's risk of contracting HIV (Canadian AIDS Society, 2000; Kirkham & Lobb, 1998; Summers, 1997; Zierler & Krieger, 1997). First, a person with a history of childhood sexual abuse is more likely to experience recurrent sexual assault and to engage in risky behaviours—such as high-risk sex, prostitution and injection drug use—which can lead to incarceration or homelessness (Harlow et al., 1998; Johnsen & Harlow, 1996; Mullings, Marquart & Brewer, 2000; Zierler & Krieger, 1997), all of which are associated with a higher probability of exposure to HIV. Second, women in abusive relationships often have difficulty negotiating safe sex practices (Canadian AIDS Society, 2000; Davila & Brackley, 1999; Zierler, 1997) and have trouble accessing HIV diagnosis and treatment services (Stevens & Richards, 1998; Zierler & Krieger, 1997). Typical prevention strategies—such as condom use and knowing your partner's sexual history—are consequently irrelevant to many women. Although the links between violence and exposure to HIV have been recognized, studies of this relationship are limited, particularly within rural contexts, and programs and policies addressing these two problems are rarely integrated.

Aboriginal women and rural women face disproportionate socio-economic burdens—such as poverty and isolation—that magnify the difficulties they face in

dealing with violence (Adler, 1996; Biesenthal et al., 1997; Dion Stout, 1998; Levett & Johnson, 1997; MacMillan, MacMillan, Offord & Dingle, 1996; Sawicki, 2001). These inequities can create barriers to their accessing meaningful health care services (Browne, 2005; Browne & Fiske, 2001; Browne & Smye, 2002), which, in turn, can increase their risk of contracting HIV. Mill (1997) argues that because of these inequities some Aboriginal women engage in risky behaviours—such as “hitting the streets” and using drugs and alcohol—as survival strategies. In addition to increasing their exposure to more forms and incidents of violence, these behaviours increase the women's risk of HIV infection through drug use. Because Aboriginal and rural women face multiple barriers to their health and safety, and because their rates of HIV infection are rising more quickly than for other women, development of appropriate prevention strategies that take into consideration unequal power dynamics and issues of violence is urgent.

BACKGROUND

The study was conducted in a rural area that has a population density of about one person per square kilometre. Overall, the population has a similar income profile to the rest of the province, but has lower health and education levels (BC Stats, 2001). Aboriginal people comprise 12.3 per cent of the area's population, as compared to 3.8 per cent of the provincial population (BC Stats, 2001). Most people live in three towns that range in population from about 2,000–12,000. Others live in small, rural settings, including over a dozen Aboriginal communities. The area is home to three First Nations, with distinct but related languages. One of the most infamous residential schools in Canada was located in the area (Furniss, 1995 & 1999). From 1891 to 1981, Aboriginal children were confined to the school, allowed little or no contact with their families, and “subjected to a strict regime of discipline in which public humiliation, beatings and physical punishments were used to maintain their submission” (Furniss, 1999, p. 43).

The study documented here was initiated by members of service organizations concerned about the relationship between rates of violence against women and rising rates of HIV infection in their area. Local information (e.g., internal police and shelter statistics, anecdotal community information) suggested that both were significant issues for women in the area, but resources and information were inadequate to developing local strategies.

Preliminary focus groups were conducted with service providers and Aboriginal and non-Aboriginal community



leaders as a basis for the research proposal. Although we wanted to pay attention to the particular challenges that Aboriginal women faced, the project was purposefully inclusive of women from all ethnic backgrounds. This was because we did not want to feed into racist misconceptions about violence, drug and alcohol use, and HIV as problems of concern only to Aboriginal people.

The overall goal of the study was to identify strategies to minimize the interacting risks of violence and HIV infection among women in rural communities. It also aimed to improve understanding of the relationship between violence against women and their risk of exposure to HIV, as well as the impact of social and economic factors on risk for HIV for women living in rural communities.

METHODOLOGY

An ethnographic design was used for the study. Ethnography is the study of “culture” and thus enables an in-depth understanding of context and is appropriate for a focus on social and economic factors (Clifford & Marcus, 1986; Hammersley & Atkinson, 1995; Quantz, 1992; Spradley, 1979). Data were collected through individual interviews with women who had experienced intimate partner violence (IPV) and thought they had been at risk for HIV. Data were also collected through a group interview with six of the women and through focus groups with community members and service providers. Observational data were collected during field work. Textual data were gathered in the form of media articles, policy documents and meeting minutes. Supplementary textual data came from some women who provided items such as police pictures of injuries, letters from ex-partners and court orders.

Women were recruited primarily by word of mouth. Protocols to promote the safety of both the women and interviewers were followed carefully (Langford, 2000; Paterson, Gregory, & Thorne, 1999). To protect confidentiality and anonymity, we masked the women’s identities and offered them a choice of interviewer (i.e., a researcher they knew personally or a researcher from out of town) and a choice of location (e.g., our office, their homes, or other safe locations such as hotels). Interviews lasted from 1.5 to four hours, and were audio-taped with consent from participants. Interviews were transcribed verbatim and participants were given a copy of their own interviews. All of the women were then invited to participate in a group interview, and the six who did were representative of the larger sample in age, income and ethnicity.

Data were analyzed using principles of ethnographic analysis (Hammersley & Atkinson, 1995; Clifford & Marcus, 1986). The women’s interviews were coded to identify themes. The interviews were compared with one another and with textual data to develop an overall understanding of the women’s experiences and the context of their lives. This analysis formed the basis for discussion in the group interview and six focus groups. We then used this additional data to expand the analysis, which was later presented to the Regional Health Authority, City Council and the community at large.

Sample

Thirty women ranging in age from 16 to 58, with self-identified experiences of violence and risk of exposure to HIV, participated in the individual interviews. Seventeen of the women lived in town, 11 lived in small villages or reserves, and two lived in remote, isolated settings. Most of the women lived in poverty: 13 of them were on income assistance and only three were earning over \$20,000 per year. Eleven of the women identified as being from one of the three indigenous First Nations, another 11 identified as Caucasian, and the remaining eight identified as being of mixed ethnicity—four of whom identified as Aboriginal. Education levels also ranged, from five women having completed Grade 9 or less, to nine women—most of whom were Aboriginal—having university degrees.

Forty-two community representatives—four men and 38 women—read and discussed the analysis of the women’s experiences in the six focus groups. These representatives included community and organizational leaders, counsellors, nurses, support workers, activists and youth, who all came from diverse fields, including the health sector; social and victims’ services; police, drug and alcohol services; women’s organizations; First Nations organizations; and youth services.

RESULTS

The diversity of the study sample allowed us to examine how violence and HIV risks intersect for all women, while attending to the differences for Aboriginal women. Both the Aboriginal and non-Aboriginal women had endured harsh life experiences, including multiple experiences of abuse. These experiences were compounded by poverty, drug and/or alcohol use and limited access to support services, all of which put them at significant risk for exposure to HIV and other sexually transmitted infections (STIs). The Aboriginal women’s experiences were shaped by their



rural communities . . . If they can get employment or get a job . . . they don't have the ability to get time off to come into town during working hours . . . There needs to be some realization [of] what life is like in a rural community. (focus group interview, December 2003)

Services that were either not based on an understanding of abuse, not gender-sensitive or not culturally appropriate further limited the women's options when seeking assistance or support. For example, a service provider described how a male physician did not think it important that a woman who had been sexually assaulted be examined by a female. Despite a later suicide attempt, another physician prescribed the same woman 40 sleeping pills. Indeed, many of the women described feeling unheard or disrespected when accessing social services, particularly health care services.

Another challenge to service provision in rural communities is related to the continuous "draw" from rural to urban settings. Many of the participants talked about how they had to move to urban centres for education and employment opportunities, better health care, greater anonymity, and safety from various forms of violence. This both disconnected the women from their support networks and depleted human resources in the rural area.

INADEQUATE AND VARIED COMMUNITY RESOURCES AND LEADERSHIP: This research was undertaken during 2002-2004, a time of declining employment and severe cuts to social and health services, which impacted women in particular (Morrow, Hankivsky, & Varcoe, 2004). Legal aid services and social assistance were reduced, which meant that many women either had to leave the community or return to abusive partners. The women's pre-employment program, which many of the participants described as literally "life saving," was eliminated. HIV and violence prevention programs were cut, the Native Court Workers and Street Nurse services were reduced, the women's centre funding was cut, and funding for a First Nations HIV/AIDS support group was not renewed.

At the same time broader, urban-oriented policies were introduced with negative impacts on the provision of local services. For example, policies requiring "partnerships" for funding were unworkable in communities with few organizations. Other key resources were missing or downsized: there were no children's mental health services, limited family level services (e.g. family counselling),

shrinking advocacy services, and reduced assaultive men's treatment programs. One worker noted, "So, if you need a child mental health worker, you might as well wait until they grow up, basically, because that is how long they'll be on the list" (focus group interview, December 2003). Key service providers also lost the ability to offer an open-door policy, a critical feature for women seeking safety or services related to violence.

Services were often narrowly focused on one issue and did not take into account the intersecting risks associated with violence and exposure to HIV. One mental health worker was asked by her supervisor "How does HIV relate to mental health?" (focus group interview, October 2003). Many community members and participants also expressed dismay that they had never previously "made the connection" between HIV risk and violence. Focus group participants described how policies based on narrow mandates and a "cover your ass mentality" increased risk by limiting service access. Thus, community efforts were often disconnected from one another, or limited to what members of one focus group dubbed "pretend prevention"—simplistic educational efforts that did not address the underlying issues.

Service providers were concerned about the limited impact of their programs and described feeling helpless. One said "Where can I refer to? . . . There's so few services available, and so many people requiring the services, that the wait lists are so long that people give up" (focus group interview, February 2004). Others voiced anguish in trying to help so many "very, very wounded" people with too few resources, noting that there were "too few doing the work" and predicting exhaustion as inevitable. "There are five of us who regularly come and sit around the table. That's not going to do it (focus group interview, November 2003).

In addition, each town and First Nations community had different concerns, leadership styles and access to services. Some communities had established initiatives related to education, youth, employment, drug and alcohol use, violence, and HIV prevention. Others had none of these programs. Tensions, therefore, existed between the different communities, partly because some saw others as better resourced. When describing a proposal about Aboriginal health, one community leader said: "[We] had to get approval and support from each and every community, which we didn't have time to do . . . [And] when it comes right down to the actual work, they're divided" (focus group interview, October, 2003). With the ongoing domination of Aboriginal people by wider society, these differences have deep roots and can create challenges for action. Further,



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