
The Intersecting Risks of Violence and HIV for Rural Aboriginal Women in a Neo-Colonial Canadian Context

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ABSTRACT

An ethnographic study looking at the intersecting risks of violence and human immunodeficiency virus (HIV) for rural women shows that the neo-colonial and racist context of Canadian society creates particular challenges for Aboriginal women. This article focuses on the experiences of the Aboriginal women who took part in the study. These women's experiences of violence occurred within a rural context of poverty and declining economic resources, and within a historical context of colonial abuses and cultural disruptions. Consequently, the women's lives were often characterized by disconnection from family and community, making them vulnerable to further violence and exploitation. Social support programs in this rural setting were limited and access was sometimes problematic. Understanding how the intersecting dynamics of gender, rural living, poverty, racism, and colonialism create risk for Aboriginal women provides a basis for developing policies that aim to strengthen the well-being of women, particularly their economic well being. It also highlights the need for an anti-racist agenda within the social service and health care sectors and at all levels of government.

KEYWORDS

Violence against women, HIV, rural health, colonialism, gender, rural living, poverty, racism, Aboriginal women

INTRODUCTION

Because Aboriginal women face more structural inequities, they are at greater risk of both experiencing violence (Amnesty International Canada, 2004; Brownridge, 2003; Statistics Canada, 2005) and contracting human immunodeficiency virus (HIV) (Craib et al., 2003; Public Health Agency of Canada, 2006) than the general Canadian population. For instance, Aboriginal women aged 25–44 are five times more likely to die of violence than other Canadian women (Amnesty International Canada, 2004) and account for about 50 per cent of all HIV-positive tests among Aboriginal people,

as compared to 16 per cent for non-Aboriginal women (Desmeules et al., 2003). Rural women face particular challenges related to poverty (Ross, Scott & Smith, 2000; Sutherns, McPhedran & Haworth-Brockman, 2004) and intimate partner violence (Biesenthal, Sproule & Plocica, 1997; Levett & Johnson, 1997) due to their isolation and because of limited economic opportunities and services in rural locales. Thus, Aboriginal women living in rural areas face multiple and intersecting forms of oppression. However, these well-known intersections rarely inform health policy and practice related to violence or HIV, or policies related



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



limited safety and survival options due to specific economic and social conditions that were part of the ongoing legacy of colonialism and systemic racism. Thus, while both Aboriginal and non-Aboriginal women shared some common experiences, the study illustrates how certain risk factors—namely gender, rural living, poverty, racism, and colonialism—intersected differently for the various women.

Aboriginal women's lives shaped by colonialism

Gender, rural living and poverty shaped the intersecting risks of violence and exposure to HIV for all of the participants. However, for the Aboriginal participants, these features were shaped by systemic racism within the neo-colonial context of Canadian society. All of the Aboriginal women, for instance, were affected by the consequences of generations of their families having been confined to reserves and residential schools (a number of the women in the study had attended residential school themselves). As documented elsewhere (e.g. Browne & Fiske, 2001; Browne & Smye, 2002; Furniss, 1995 & 1999), the consequences of this systemic racism have included poverty, disconnection from family and community, and feelings of despair. Red described her experience as a small child in residential school in the late 1960s:

When we were little and we were at the residential school . . . I ran away three times. I ran away, like, I didn't know what to do. I didn't have a clue. Just went through the bushes and came out at a small community. We were sleeping [outside and I] got all wet, and I ended up being really sick. We went down to this house and asked if they could give us an apple or something, because we were so hungry, and they phoned the [residential] school and they picked us up, and strapped us. That time I got really sick. And the nun was telling me that she should send me to school, but my temperature was really high . . . They still strapped me. The last time, they said if I ran away again, they would shave my head. (interview, April 2003)

Red's mother, also a residential school survivor, repeatedly rejected her. Not surprisingly, Red did not do well in school, started drinking at a young age, and had difficulty developing connections with others. She was released from residential school at age 17 and, with no employable skills or access to further education, and unable to live with her mother, she "ended up" living with a series of men, most of whom were abusive:

I ended up pregnant. I told him, and he told me "Pack your stuff, you're going back to town." He dumped me off and said, "Go have an abortion." And he left me there. And I don't know how I got back, but I went back there, and he said, "As soon as that baby is born, you're giving it up for adoption." (interview, April 2003)

Red had several children, all of whom were either given up for adoption or apprehended by the state and placed in foster care, thus continuing the emotional and familial disruption that she experienced as a child.

Although not all of the Aboriginal participants attended residential school, their lives were affected by the wider legacy of colonialist policies and practices, such as the reserve system and the Indian Act, and by the residential school system through its effects on others in their communities. For example, Melissa said, "My mother was ripped away from her family. She was lonely and isolated. She turned to alcohol . . . How are we supposed to parent?" (interview, July 2003). Residential school and policies such as those that required people to obtain written permission to leave reserves and those that continue to limit employment and ownership options for Aboriginal people, have created extensive damage.

Most of the Aboriginal women in the study have endured multiple forms of racism and discrimination. The effects of this were reflected in the participants' interviews when they spoke of their challenges related to employment and being able to afford off-reserve housing, the loss of language and parenting skills, and the breakdown of family and community structures. These dynamics shaped the participants' lives and increased their likelihood of getting into, or remaining in, abusive relationships.

Multiple experiences of violence created risk for exposure to HIV

Although we only sought out women who had experienced IPV and who thought they had been at risk for HIV, the participants described multiple experiences of abuse over their lifetimes. All experienced IPV that included sexual coercion and 14 of the women experienced sexual violence or abuse as children or youths, primarily in the context of intimate or family relationships. Most had been forced into unwanted and unprotected sexual acts that directly increased their risk of contracting STIs and HIV infection. None of the participants were HIV positive, but 15 of the 26 women who answered questions about STIs had been treated for infections such as syphilis, gonorrhoea, chlamydia, and genital herpes. All of the women connected these infections



Risks in context

The Aboriginal women's experiences demonstrate how gender, rural living, poverty, racism, and colonialism intersect and increase their risk for health problems, including exposure to STIs and HIV. However, these risks are also shaped by other factors, including a widespread lack of understanding about violence and HIV, larger social service provision issues, and inadequate and varied community resources and leadership.

MISCONCEPTIONS ABOUT VIOLENCE AND HIV: Throughout this study we encountered numerous misconceptions about violence and HIV, including those related to the types and rates of violence against women and children; the rates of HIV infection and who it affects; the ways in which HIV is transmitted; the interrelationship between HIV and violence; and the linkages between HIV, violence, and the social determinants of health (in particular poverty and employment). Focus group participants repeatedly expressed concerns regarding widespread misunderstandings about sexual health, including focusing on pregnancy prevention, with little concern for risk of infections. They said that the dynamics of violence are poorly understood, particularly in relation to sexual coercion. Participants also said that the related risks of STIs and HIV infection were mostly overlooked. Overall, there was a misconception that HIV is a gay man's disease, largely confined to urban settings. One youth said, "There are a lot of kids at my school [who] don't think it's possible that it could happen in our community—that it only happens in big cities and that it doesn't happen here" (focus group interview, February, 2004). There was also a misconception that HIV was confined to Aboriginal communities in the study area.

CHALLENGES TO SOCIAL SERVICE PROVISION IN RURAL AREAS: In rural areas, social and public services are fewer and access to them is more difficult compared to urban settings. Where they do exist, provision of these services is fraught with safety and ethical issues due to the insular nature of many rural communities. Abusers and victims often live in the same places, meaning that women who seek assistance are often threatened or exposed to further violence by the abuser's family or friends, or the abusers themselves. Some women, particularly Aboriginal women and those living in remote areas, may have no support outside of their home communities. One service provider commented:

[Where I worked, women] were afraid to report because they were afraid of, one, testifying in court, if that was the case, and, second, afraid of that person's family. Even if he goes to jail, that person's family is still out there and . . . the threats to her for sending him to jail were phenomenal. (focus group interview, November 2003)

Both the women and service providers told us that confidentiality was often "a joke" for many reasons: women would often end up with family members or friends as service providers, information was shared outside of professional relationships, and people would observe who went to which offices or clinics. Labelling and stigma—particularly regarding mental health, violence, drug and alcohol use, and HIV—were impossible to escape. Women could not "get away" from abusers. Aboriginal people could not "get away" from discriminatory policies and racist behaviours. Individuals could not "get away" from negative social judgments. For many of the Aboriginal women, part of this inability to "get away" was related to the fact that, as cuts to social assistance deepened, they could not afford to move off their reserves or were forced to return to their reserves, thus risking their personal safety. A community leader said:

You can't buy a house somewhere else or you can't leave or function on the income that you have there or function elsewhere, off the reserve. It's very difficult [especially] if you don't have the skills to be able to budget. I know, I didn't grow up learning that. So having to go off into the larger society without needed skills is very difficult. (focus group interview, February 2004)

In addition, rural policies and programs tend to be influenced or dictated from "outside," often resulting in a mismatch with local needs. This divergence, combined with the limited social service, health care and community resources available in the area, was detrimental to many of the women interviewed. One community leader/service provider commented on how policies that are defined by regional, provincial, or federal agencies—which more often than not focus on fiscal restraint—present challenges to service delivery in rural areas:

A lot of government organizations offer services that you have to come into town for, that only operate from 8 o'clock 'till 4 o'clock and . . . that's not realistic for



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,



leadership structures imposed by colonial policy often do not result in women's issues being prioritized. As one Aboriginal woman noted, "with women's issues, the men still like to have a lot of control" (focus group interview, November 2003).

Despite the challenges, women persevered

At the time of their interviews, each of the women had achieved what they saw as some measure of success: most had quit drinking, some had found employment, many had built their self-worth or made connections with others. Stardust explained, "I've got my grandkids to raise and my whole lifestyle's changed. I don't drink, anymore. So, that's it . . . I'm happy with me for that" (interview, July 2003). Red contemplated connecting with her children:

I thought, you know, I should write [my son] a letter for his birthday. I thought, no, not until I'm . . . really to the point, you know, where more rejection isn't going to hurt me. I'm going to get myself healthy. Yeah. And then I might try and find my . . . daughter. (interview, April 2003)

Some of the Aboriginal women associated their success with cultural and spiritual reawakenings in their communities. Describing the role that powwows and her son's traditional dancing had played in her healing, Strong Native Woman said, "I feel very strong and beautiful. I have a lot of pride now" (interview, October, 2003). Women who had received help through accessing various support services were grateful. Describing the support she received in dealing with a lifetime of abuse, one woman said, "Guess what? I'm on top again!" (group interview, December, 2003). Many of the participants also wanted to contribute to political change. Melissa said, "For as much as the government tried to pull my band apart, that's how strong I have to be to pull it back together again" (interview, July, 2003). These examples show how the potential for healing abounds, even when the conditions do not.

DISCUSSION

Whereas research and services related to HIV risk often focus on injection drug use, this study emphasized the importance of attending to the complex intersections between violence and HIV. The participants were not injection drug users, yet all were concerned that they were

or had been at risk of HIV. All of the women experienced multiple health risks that were worsened by broader inequities related to gender, rural living and poverty, as well as to the downsizing of social services. The Aboriginal women's experiences were further shaped by the ongoing effects of colonization and their position in society as racialized women, which contributed to their feelings of disconnection.

Over a decade ago, LaRocque (1993) wrote that in order to address violence in Aboriginal communities "a multi-faceted, comprehensive approach is required. Socio-economic revitalization is a must" (p. 13). Indeed, the experiences of the Aboriginal women involved with this study—many of whom were on social assistance—underscore the importance of developing economic and employment strategies that could help to address issues of economic dependence, violence and their associated health risks. This will require revising gender-biased policies (Fiske, 2006) and promoting policies that foster economic revitalization in Aboriginal communities, including the settlement of treaty and land claims. It will also necessitate supporting women to become economically independent by increasing social assistance, minimum wage and child care availability, by removing work-for-welfare and other such gender-biased eligibility requirements, and by reinstating employment programs.

As McKeown, Reid, Turner & Orr (2002) argue, prevention of HIV for Aboriginal women must address the dislocation that stems from their experiences of violence and substance use. Thus, all policies and services related to HIV prevention must address the risk of exposure to HIV and violence together, while acknowledging the relationships between violence and substance use. Violence and HIV cannot be prevented or treated in isolation or without significant economic and social change at all levels. Cultural revitalization and social services that are culturally appropriate also are required. To counter the disconnection and dislocation experienced by many of the Aboriginal women, comprehensive, locally developed community responses that address cultural identity, healing, safe social support, and meaningful employment are needed.

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REFERENCES

- Adler, C. (1996). Unheard and unseen: Rural women and domestic violence. *Journal of Nurse-Midwifery*, 41(6), 463–466.
- Amnesty International Canada (2004). Canada: Stolen sisters—A human rights response to discrimination and violence against Indigenous women in Canada. Retrieved February 15, 2005, from http://www.amnesty.ca/resource_centre/reports/view.php?load=arcview&article=1895&c=Resource+Centre+Reports
- Biesenthal, L., Sproule, L. D., & Plocica, Z. (1997). Violence against women in rural communities in Canada: Research project backgrounder. Ottawa, ON: Research and Statistics Division, Department of Justice Canada.
- BC Stats. (2001). 1996 Census Profiles of British Columbia's Census Subdivisions (CSD). Victoria, BC: Author.
- Browne, A. J. (2005). Discourses influencing nurses' perceptions of First Nations patients. *Canadian Journal of Nursing Research*, 37(4), 62–87.
- Browne, A. J., & Fiske, J. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23(2), 126–147.
- Browne, A. J., & Smye, V. (2002). A postcolonial analysis of health care discourses addressing Aboriginal women. *Nurse Researcher*, 9(3), 28–41.
- Brownridge, D. (2003). Male partner violence against Aboriginal women in Canada: An empirical analysis. *Journal of Interpersonal Violence*, 18(1), 65–83.
- Canadian AIDS Society (2000). Women and HIV/AIDS. Ottawa, ON: Canadian AIDS Society.
- Clifford, J., & Marcus, G. E. (1986). *Writing culture: The poetics and politics of ethnography*. Berkeley, CA: University of California Press.
- Craib, K. J. P., Spittal, P. M., Wood, E., Laliberte, N., Hogg, R. S., Li, K., et al. (2003). Risk factors for elevated HIV incidence among Aboriginal injection drug users in Vancouver. *Canadian Medical Association Journal*, 168(1), 19.
- Davila, Y. R., & Brackley, M. H. (1999). Mexican and Mexican American women in a battered women's shelter: Barriers to condom negotiation for HIV/AIDS prevention. *Issues in Mental Health Nursing*, 20(4), 333–355.
- DesMeules, M., Stewart, D., Kazanjian, A., Maclean, H., Payne, J., & Vissandjée, B. (Eds.) (2003). *Women's health surveillance report: A multidimensional look at the health of Canadian women*. Ottawa, ON: Canadian Institute for Health Information.
- Dick, S., & Varcoe, C. (2004). Violence against women and substance use in a rural context. *Visions: BC's Mental Health and Addictions Journal*, 2(4), 15–16.
- Dion Stout, M. (1998). Aboriginal Canada: Women and health—A Canadian Perspective. Retrieved April 29, 1998, from http://www.hc-sc.gc.ca/hl-vs/alt_formats/hpb-dgps/pdf/indigen_e.pdf
- Doane, G. H., & Varcoe, C. (2005). *Family nursing as relational inquiry: Developing health promoting practice*. Philadelphia, PA: Lippincott, Williams and Wilkins.
- Fiske, J. A. (2006). Boundary crossings: Power and marginalisation in the formation of Canadian Aboriginal women's identities. *Gender & Development*, 14(2), 247–258.
- Furniss, E. M. (1995). *Victims of benevolence: The dark legacy of the Williams Lake residential school*. Vancouver, BC: Arsenal Pulp Press.
- Furniss, E. M. (1999). *The burden of history: Colonialism and the frontier myth in a rural Canadian community*. Vancouver, BC: University of British Columbia Press.
- Gielen, A. C., Fogarty, L., O'Campo, P., Anderson, J., Keller, J., & Faden, R. (2000). Women living with HIV: Disclosure, violence, and social support. *Journal of Urban Health*, 77(3), 480–491.
- Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in practice*. (2nd ed.). London: Routledge.
- Harlow, L. L., Rose, J. S., Morokoff, P. J., Quina, K., Mayer, K., Mitchell, K., et al. (1998). Women HIV sexual risk takers: Related behaviors, interpersonal issues, and attitudes. *Women's Health*, 4(4), 407–439.



- Public Health Agency of Canada (2003). Looking forward: Focussing the response. Canada's Report on HIV/AIDS 2003. Retrieved December 12, 2003, from <http://www.phac-aspc.gc.ca/aids-sida/publication/reports/report03/index.html>
http://www.hc-sc.gc.ca/hppb/hiv_aids
- Health Canada Centre for Infectious Disease Prevention and Control (2001). HIV/AIDS Epi Updates. Retrieved October 26, 2001, from http://www.hc-sc.gc.ca/hpb/lcdc/bah/epi/epi_e.html#HIV
- Johnsen, L. W., & Harlow, L. L. (1996). Childhood sexual abuse linked with adult substance use, victimization, and AIDS-risk. *AIDS Educational Preview, 8*(1), 44–57.
- Johnson, H. (1996). *Dangerous domains: Violence against women in Canada*. Scarborough, ON: International Thomson Publishing.
- Kirkham, C. M., & Lobb, D. J. T. (1998). The British Columbia positive women's survey: A detailed profile of 110 HIV-infected women. *Canadian Medical Association Journal, 158*(3), 317–323.
- Langford, D. R. (2000). Developing a safety protocol in qualitative research involving battered women. *Qualitative Health Research, 10*(1), 133–142.
- LaRocque, E.D. (1994). *Violence in Aboriginal communities*. Ottawa, ON: Health Canada. (Reprinted from *The path to healing: Report of the National Round Table on Aboriginal Health and Social Issues*). Retrieved October 1, 2007, from http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/fv-abor-communit_e.pdf
- Levett, A., & Johnson, H. (1997). *A statistical comparison of women's experiences of violence in urban and rural areas*. Ottawa, ON: Research and Statistics Division, Department of Justice.
- MacMillan, H. L., MacMillan, A. B., Offord, D. R., & Dingle, J. L. (1996). Aboriginal health. *Canadian Medical Association Journal, 155*(11), 1569–1578.
- McConney, D. (1999). Differences for our daughters: Racialized sexism in art, mass media, and law. *Canadian Woman Studies/Les Cahiers de la Femme, 19*(1/2), 209–214.
- McKeown, I., Reid, S., Turner, S., & Orr, P. (2002). *Sexual violence and dislocation as social risk factors involved in the acquisition of HIV among women in Manitoba*. Winnipeg, MB: Prairie Women's Health Centre of Excellence.
- Mill, J. E. (1997). HIV risk behaviors become survival techniques for Aboriginal women. *Western Journal of Nursing Research, 19*(4), 466–489.
- Morrow, M., Hankivsky, O., & Varcoe, C. (2004). Women and violence: The effects of dismantling the welfare state. *Critical Social Policy, 24*(3), 358–384.
- Mullings, J. L., Marquart, J. W., & Brewer, V. E. (2000). Assessing the relationship between child sexual abuse and marginal living conditions on HIV/AIDS-related risk behavior among women prisoners. *Child Abuse & Neglect, 24*(5), 677–688.
- Paterson, B. L., Gregory, D., & Thorne, S. (1999). A protocol for researcher safety. *Qualitative Health Research, 9*(2), 259–269.
- Public Health Agency of Canada (2006). *HIV/AIDS Epi Update—HIV/AIDS among Aboriginal Peoples in Canada: A continuing concern*. Ottawa, ON: Centre for Infectious Disease Prevention and Control.
- Quantz, R. A. (1992). On critical ethnography (with some postmodern considerations). In M. D. LeCompte, W. L. Millroy & J. Preissle (Eds.), *The handbook of qualitative research in education* (pp. 447–505). San Diego, CA: Academic Press.
- Rodgers, K. (1994). Wife assault: The findings of a national survey. *Juristat: Service Bulletin, 14*(9), 1–21.
- Ross, D. P., Scott, K. J., & Smith, P. J. (2000). *The Canadian fact book on poverty 2000*. Ottawa, ON: Canadian Council on Social Development.
- Sawicki, L. (2001). *Rural women-centred health care and the boundary region*. Vancouver, BC: BC Centre for Excellence in Women's Health.
- Spradley, J. P. (1979). *The ethnographic interview*. Orlando, FL: Harcourt, Brace, Jovanovich.
- Statistics Canada (2002, June 26). *Family violence: Impacts and consequences of spousal violence*. Ottawa, ON: Statistics Canada.



- Statistics Canada (2005, July 14). *Family violence in Canada: A statistical profile*. Ottawa, ON: Statistics Canada.
- Stevens, P. E., & Richards, D. J. (1998). Narrative case analysis of HIV infection in a battered woman. *Health Care for Women International, 19*(1), 9–22.
- Summers, M. (1997). *The intersection of domestic violence and HIV disease in women*. Paper presented at the 10th Annual BC AIDS Conference, Vancouver, British Columbia, Canada.
- Sutherns, R., McPhedran, M., & Haworth-Brockman, M. (2004). *Rural, remote and northern women's health: Policy and research directions—Final summary report*. Ottawa, ON: Centres of Excellence for Women's Health.
- Tjaden, P., & Thoennes, N. (2000). *Extent, nature and consequences of intimate partner violence: Findings from the National Violence Against Women Survey*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.
- Zierler, S. (1997). Hitting hard: HIV and violence against women. In N. Goldstein & J. L. Manlowe (Eds.), *The Gender politics of HIV/AIDS in women: Perspectives on the pandemic in the United States* (pp. 207–221). New York, NY: New York University Press.
- Zierler, S., & Krieger, N. (1997). Reframing women's risk: Social inequalities and HIV infection. *Annual Review of Public Health, 18*, 401–436.

END NOTES

1. Throughout this paper the term “violence” is used to encompass sexual and physical assault by known and unknown assailants, as well as psychological, emotional and financial abuse. Intimate partner violence (IPV) refers more specifically to a pattern of physical, sexual and/or emotional violence by an intimate partner in the context of coercive control (Tjaden & Thoennes, 2000).
2. The term Aboriginal, which encompasses First Nations, Métis and Inuit, is used throughout this paper. There are people from many Aboriginal groups in the study area. However, the three First Nations mentioned are in greatest numbers.
3. The women chose their own pseudonyms, which are used throughout this paper. Aspects of Red's story have been published elsewhere (Doane & Varcoe, 2005).

