HIV, Sexual Violence and Aboriginal Women[1]

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A variety of factors contribute to HIV risk in Aboriginal women. One of these factors is the sexual violence they experience in their lives. Sexual violence is prevalent among all women, including Aboriginal women. While HIV is not nearly as prevalent, rates are increasing rapidly among Aboriginal women. Chances are great that all health care workers, even those not aware of it, are working with Aboriginal women who have experienced sexual violence and are at risk for HIV or currently living with HIV/AIDS. It is important that health care workers who work with Aboriginal women become aware of the connections between HIV and sexual violence. This includes health care workers who work at Aboriginal-specific services such as Native Women's resource centres, First Nations health centres and Aboriginal friendship centres, and at other services such as sexual assault centres, women's shelters, AIDS service organizations, hospitals, drug treatment programs and correctional centres.

This article will address the connections between HIV and sexual violence among Aboriginal women and offer some suggestions as to how health care workers and organizations can connect these issues in their work with Aboriginal women. It is beyond the scope of this article to address the full range of issues related to HIV and sexual violence. For a more thorough exploration of these issues, the reader is encouraged to seek out the suggested readings at the end of this article. Attempts have been made to cite existing research and literature on Aboriginal women. Lack of information in this area has made it necessary to cite some research and literature which is not necessarily specific to Aboriginal women.

Beliefs related to the social conditions affecting Aboriginal women have informed the writing of this article. The first belief is that sexual violence and HIV are major social and health problems which can potentially affect the lives of all Aboriginal women. The second belief is that multiple societal barriers such as sexism[2], racism[3], and colonialism[4]

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1 The authors acknowledge the following document as the primary resource for this article: Neron, C. (1998). *HIV and Sexual Violence Against Women. A guide for counsellors working with women who are survivors of sexual violence.* Ottawa: Health Canada.

2 Sexism refers to discrimination against women based on their sex.

3 Racism refers to discrimination against people based on their race or skin colour.

affect the conditions of Aboriginal women's lives and may increase their risk of sexual violence and HIV[5] by:

- decreasing access to education and employment and increasing poverty among Aboriginal women;
- increasing Aboriginal women's social and economic dependency on men;
- reducing Aboriginal women's power and choice in their relationships and in other aspects of their lives;
- contributing to low self-esteem and poor health among Aboriginal women;
- reducing the availability of and access to gender- and culturally-specific information and services for Aboriginal women, including information and services developed and delivered by Aboriginal communities.

Definition of Sexual Violence

Sexual violence refers to any unwanted or non-consensual sexual touching, act or exploitation achieved through physical force, threat, intimidation and/or coercion. The continuum of sexual violence includes acts from sexual harassment through to childhood sexual abuse, sexual assault and murder.[6]

For the purposes of this article, the term "sexual violence" will be limited to acts that increase women's risk of HIV, specifically:

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4 Colonialism refers to the policy and practice of establishing and maintaining colonies and settlements. The process of colonization by Europeans resulted in the physical, social, spiritual and cultural oppression of Aboriginal peoples in Canada.

5 For further discussion on how racism, sexism and colonialism have affected the lives of Aboriginal women and increased their risk of violence and HIV, see: LaRocque, E.D. (1994). *Violence in Aboriginal Communities.* Ottawa: Health Canada; Ship, S.J. & Norton, L. (1998). *Triple Jeopardy: The Dynamics of Gender, Race and Class Discrimination, Aboriginal Women and HIV/AIDS* (unpublished paper). Kahnawake, Quebec: The National Indian and Inuit Community Health Representatives Organization.

6 The definition of sexual violence was partially adapted from the following sources: Phelps, C. (1992). *Sexually Transmitted Diseases and HIV/AIDS in Adult Victim/Survivors of Sexual Assault in Colorado.* Denver: Colorado Coalition Against Sexual Assault; Rondina, M. (1994). *Vocabulary of Family Violence.* Ottawa: Minister of Supply and Services Canada.

- sexual assault;
- historical sexual assault (childhood sexual abuse and repeated sexual assault);
- woman abuse (sexual assault, sexual coercion and other acts of sexual violence against women in their relationships).

Sexual Violence and Aboriginal Women

There is debate in the literature as to whether or not violence against women existed in Aboriginal cultures prior to colonial intrusion by the Europeans. However, many authors do agree that the role of women in Aboriginal cultures shifted with colonialism (Chester, Robin, Koss, Lopez and Goldman, 1994; LaRocque, 1994; Maracle, 1993; RCAP, 1996; Van Kirk, 1985). As LaRocque (1994) states, "We can trace the diminishing status of Aboriginal women with the progression of colonialism. Many, if not the majority, of Aboriginal cultures were originally matriarchal or semi-matriarchal" (p.73). It also appears that all forms of violence against Aboriginal women increased with colonialism (Chester et al., 1994; LaRocque, 1994; Maracle, 1993). LaRocque continues, "There is little question that European invasion exacerbated whatever the extent, nature or potential violence there was in original cultures. Neither is there much question that Aboriginal men have internalized white male devaluation of women" (p.75). Today, colonialism works in tandem with sexism and racism to perpetuate sexual violence and other forms of violence against Aboriginal women, within and outside of Aboriginal cultures and communities.

There has been little research on the rates of sexual violence among Aboriginal women in Canada. A large-scale Canadian survey on violence against women was conducted in 1993 (Statistics Canada, 1993). However, it is not possible to determine how many Aboriginal women were included in the survey, as information related to race and cultural background was not included. It is likely that Aboriginal women were underrepresented because it was a telephone survey and therefore did not access women who live on the streets, in institutions and in households and remote areas without access to telephones. Many of these women may be Aboriginal women. Nonetheless, it is useful to highlight the major findings of this survey because there is no reason to assume that Aboriginal women would not experience sexual violence at least to the same extent as other Canadian women. Considering the multiple challenges and disadvantages many Aboriginal women experience as a result of sexism, racism and the effects of colonialism, it could be hypothesized that Aboriginal women may be at increased risk of sexual violence compared to white women.The results of a few small-scale studies of American Aboriginal women indicate

that this may be the case (Norton & Manson, 1995; Walters & Simoni, 1993).

According to the 1993 Canadian survey, four of every ten women in Canada have experienced at least one incident of sexual violence since the age of sixteen, and more than half of these women have experienced repeated sexual violence (Statistics Canada, 1993). While all women are at risk of experiencing sexual violence, regardless of race, culture, sexual orientation, socio-economic status, age or ability, the risk is increased for young women and women with disabilities.

Street-involved women and women involved in the sex trade may also be at increased risk of sexual violence. While Canadian data related to the rates of sexual violence these women is limited, in one study involving 85 sex trade workers from the Downtown Eastside area of Vancouver, 62% had been sexually assaulted while they were working in the six months prior to the time they were interviewed (Currie, Laliberté, Bird, Rosa, Noelle &Sprung, 1995).

Women are more likely to be sexually assaulted by someone known to them, such as an acquaintance, a date, a boyfriend or their husband. In the 1993 Canadian survey, one in three women currently or previously in a marital or common-law relationship had experienced at least one incident of physical or sexual violence (Statistics Canada, 1993).

As a result of sexual violence, women can experience a range of physical, psychological and emotional symptoms although the presence, magnitude and duration of these symptoms vary. Headaches, general muscle tension and soreness, nausea and/or gynecological complications may occur after an incident of sexual assault. Many women experience fear and anxiety related to pregnancy and the transmission of sexually transmitted diseases (STDs) including HIV, any of which can occur as a result of sexual assault (Baker, Brickman, Davis, et al., 1990; Gostin, Lazzarini, Alexander, Brandt, Mayer & Silverman, 1994; Resnick, Kilpatrick & Seals, 1996). Emotions such as confusion, fear, shame, self-blame, guilt, humiliation and anger may surface.

Over time, other symptoms may develop as a result of post-traumatic stress, such as sleep disruptions and insomnia, nightmares and night terrors, sexual dysfunctions, chronic anxiety, panic attacks, amnesia and memory flashbacks. Disassociative conditions may also develop, including altered and detached states of consciousness, detachment from body feelings and fragmenting of personality. This fragmenting, also called "splitting," is more likely to occur in cases of early, prolonged childhood abuse (Herman, 1992).

Several long-term consequences of sexual violence have been reported by women. These can include poor self-esteem, chronic depression, self-mutilation (e.g., slashing), eating disorders, suicidal

thoughts and attempts, chronic bowel disorders and substance abuse. In two American studies involving Aboriginal women, substance abuse was associated with physical and sexual violence (Norton & Manson, 1995; Walters & Simoni, 1993).

Incarceration may be a consequence of sexual violence. While data on the proportion of women in prisons who have experienced sexual violence vary, one study found that more than half of women serving federal sentences in 1989 had experienced sexual abuse. These figures were higher for Aboriginal women, who are over-represented in the prison population: 61% reported sexual abuse, and the abuse was often prolonged and extensive (Shaw, 1994).

Living on the streets and becoming involved in sex trade work may also be consequences of sexual violence for some women. In the earlier cited study of Vancouver sex trade workers, the majority of women had experienced multiple forms of violence throughout their lives, and 73% had experienced childhood sexual abuse (Currie, et al., 1995). Seventy percent of the women in this study were Aboriginal.

Women who have experienced childhood sexual abuse often experience sexual violence as adults. Symptoms of abuse, such as poor self-esteem and feelings of powerlessness, can increase women's vulnerability to repeated violence (Allers, Benjack, White & Rousey, 1993; Herman, 1992; Johnsen & Harlow, 1996).

HIV/AIDS and Aboriginal Women

The human immunodeficiency virus (HIV), the virus that causes the acquired immune deficiency syndrome (AIDS), is spread through the exchange of body fluids, specifically blood, semen, vaginal secretions, pre-ejaculatory fluid and breast milk. The main routes of transmission are: (i) through specific sexual activities, such as unprotected anal and vaginal intercourse; (ii) through injection drug use by sharing used and uncleaned needles or syringes; (iii) from mother to child, in the uterus, during childbirth, or through breastfeeding.

HIV can also be spread through the sharing of equipment that is used when injecting drugs, such as water and spoons, and through unprotected oral sex, if blood, semen or vaginal secretions are exchanged (Edwards & Crane, 1998), such as when there are cuts, sores or burns in the mouth.[7] Although it has been possible to become infected with HIV through

[7] Although the risk of oral transmission of HIV appears to be low, burns on the lips and inside the mouth caused by crack smoking may increase the risk of oral transmission of HIV. See: Faruque, S., Edlin, B., McCoy, C., et al. (1996). Crack cocaine smoking and oral sores in three inner-city neighbourhoods. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 13, 87-92.

contaminated blood, organ transplants or donated sperm, these risks have been greatly reduced as a result of screening procedures introduced in Canada in 1985.

HIV and AIDS have disproportionately affected groups marginalized by society. Initially, the epidemic in Canada was concentrated among men who have sex with men. Over the last ten years, other groups have become increasingly infected with HIV, including injection drug users, people who are incarcerated, women and Aboriginal people.

Information related to the HIV/AIDS epidemic among Aboriginal people in Canada has been limited. Historically, information on race or ethnicity within HIV and AIDS epidemiological data has not been recorded consistently across the provinces and territories. Other factors may contribute to the underreporting of HIV/AIDS data related to Aboriginal women, such as late diagnosis or misdiagnosis of women living with HIV/AIDS, and poor access to health care services and HIV-testing facilities for Aboriginal people, particularly those who live in remote areas.

From the available information, it is clear that Aboriginal women in Canada are at increased risk of HIV infection. AIDS cases and new HIV infections among Aboriginal women have risen steadily over the last decade, and this increase is more rapid than that for Aboriginal men and non-Aboriginal women (Health Canada, 1999b; Nguyen, Laframboise, Archibald, Patrick, Houston, Romanowski, Mill & Sutherland, 1997). Aboriginal women living with HIV/AIDS tend to be young. Recent data indicates that 34-37% of Aboriginal women with reported HIV or AIDS are under 30 years of age (Health Canada, 1999a).

One of the primary routes of HIV transmission for Aboriginal women is injection drug use. Transmission can occur through the use of contaminated needles, or through unprotected heterosexual sex with a partner who injects drugs. Among reported AIDS cases, Aboriginal women are more likely than non-Aboriginal women to have injection drug use as their exposure category (56.4% vs 17.7%) (Health Canada, 1999b).

The other main route of HIV transmission for Aboriginal women is heterosexual sex. Biological factors related to women contribute to increased risk of HIV from heterosexual sex. Women have a greater risk of becoming infected during vaginal intercourse than men, because of higher concentration of HIV in semen than in vaginal fluid, the larger surface area

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There are also a few anecdotal reports that indicate that inflammation caused by common throat infections, allergies or sexually transmitted diseases, such as gonorrhea, may increase the risk of oral transmission. See: Chen, W. & Samarosinghe, P. (1992). Allergy, oral sex and HIV. *Lancet*, 339, 627-628; Murray, A., Greenhouse, P., Nelson, W., et al. (1991). Coincident acquisition of Neisseria gonorrhoeae and HIV from fellatio. *Lancet*, 338, 830.

of the vagina and cervix, and the fragility of membranes in this area (Padian, Shiboski & Jewell, 1991).

Social conditions brought on by sexism, racism and colonialism – such as poverty, poor health, high rates of STDs and sexual violence – have contributed to Aboriginal women being disproportionately affected by HIV and AIDS. Poverty and poor health, which can increase vulnerability to HIV infection, are important risk factors for Aboriginal women. They are one of the most poorly educated and economically disadvantaged groups in Canada (Stout & Kipling, 1998). In addition, Aboriginal women have higher rates of suicide and violent death and are more likely to suffer from chronic diseases than non-Aboriginal women (Stout & Kipling, 1998).

High rates of STDs are another risk factor for Aboriginal women. The presence of an STD and/or a history of STDs can greatly increase the risk of HIV transmission. In some regions of Canada populated predominately by Aboriginal people, the rates of some STDs are 2-11 times the national average (Health Canada, 1996c). Lastly, sexual violence, within and outside the context of relationships, is another important factor which increases the risk of HIV infection for Aboriginal women.

Despite the steady increase of HIV and AIDS among Aboriginal women, gender- and culturally-specific information, resources and services for Aboriginal women have been lacking. Many existing HIV prevention and risk reduction strategies, support services and programs have failed to target Aboriginal women or to consider the social conditions they experience. To become meaningful for Aboriginal women, HIV prevention, education and support must acknowledge these conditions, including the violence they experience in their lives.

Connections Between HIV and Sexual Violence Among Aboriginal Women

Sexual violence can be both a cause and a consequence of HIV. When considering the connections between these two issues, it is important to note a few points. First, the connections are complex and reflect the range of experiences with sexual violence and HIV risk that many Aboriginal women face. Second, while these connections can be categorized, women's experiences do not necessarily fit neatly into these categories. Women are often repeatedly subjected to sexual violence, and as a result, they can experience more than one of these connections simultaneously or at different points in their lives.

Sexual Assault

Aboriginal women who have been sexually assaulted, whether by a stranger or by their partner, may have been placed at risk of contracting HIV through direct transmission of the virus from the assaulter. While the rate of transmission of HIV due to sexual assault is unknown, it is known that some factors may be present during sexual assault which can increase the risk of HIV transmission. They include the following:

- If the assaulter is known to be HIV-positive. The stage of HIV infection can increase infectiousness, i.e. times when viral loads[8] are high, such as recent infection or later stages of illness (Royce, Seña, Cates & Cohen, 1997). If HIV status is unknown, it should be assumed that the risk of infection exists.
- Direct contact (without a condom or with a broken condom) of body fluids (blood, semen) with the anus, vagina or mouth (if there are cuts, sores or burns in the mouth) (Gostin et al., 1994).
- The presence of anal and/or genital injuries (cuts, abrasions) which can create a more efficient route for HIV transmission. In various studies, 40% to 87% of women who were sexually assaulted showed signs of genital injury (Lacey, 1990; Lauber & Souma, 1982; Slaughter & Brown, 1992).
- Multiple assaults. The risk of transmission increases with the frequency of assaults and the number of assaulters (Gostin et al., 1994).
- A pre-existing STD. If a women or her assaulter has an STD, she has a three to five times greater risk of acquiring HIV if exposed to the virus (Wasserheit, 1992; Wasserheit, 1996).

Historical Sexual Assault

Increased risk of HIV can exist for some women who have a history of sexual assault, specifically women who have experienced childhood sexual abuse and/or repeated sexual assault. Women can develop a variety of mechanisms to cope with sexual assault and the associated post-traumatic effects, including risk activities associated with HIV, such as exchanging sex for drugs, money or shelter; having multiple sex partners; having a sexual relationship with someone who is at high risk for HIV; injecting drugs and sharing needles; and using drugs during sexual activity. In numerous studies, including one study with Aboriginal women (Walters & Simoni, 1999), childhood sexual abuse and repeated sexual assault have

[8] Viral load is the amount of HIV in body fluids (e.g. blood) and tissues.

been found to be associated with risk activities which can increase women's vulnerability of exposure to HIV (Allers, et al., 1993; Johnsen & Harlow, 1996; Miller, 1999; Zierler, Witbeck & Mayer, 1996; Whitmire, Harlow, Quina & Marokoff, 1999). While the nature of the association between HIV risk and historical sexual assault is not entirely clear, it appears likely that the relationship is fairly complex, with historical sexual assault leading to short- and long-term post-traumatic effects (such as low self-esteem, depression and substance abuse) which can contribute to risk activities (Miller, 1999; Whitmire, et al., 1999).

Woman Abuse

Women who are in abusive relationships, including Aboriginal women, can experience physical, verbal, emotional, psychological and/or sexual violence, and often live in fear of their male partner. Their partner may control many aspects of their lives, including their finances, contact with others, and their sexual and reproductive choices. These conditions increase women's risk of HIV. Specifically, women who are in abusive relationships may be at increased risk of exposure to HIV due to the following factors:

- The fear and threat of further violence, rejection, abandonment and/or loss of economic support if they attempt to negotiate safer sex or refuse sex. In one Canadian study, 34% of Aboriginal women surveyed indicated that they were afraid of being abused if they refused to have sex with a partner (ANAC, 1996).
- Violent/rough sex or sexual assault by an abusive partner. In an American study of Aboriginal women who had been abused, 50% of the women in the study experienced marital sexual assault or an attempted sexual assault by their partner (Norton & Manson, 1995).
- Being forced to have sex with other persons or to participate in degrading sexual acts (McLeod, 1996).
- Being forced into prostitution by an abusive partner.
- Having unprotected sex with a partner who is having sex outside the relationship (Weissman, 1991; Worth, 1989).

Sexual Violence Against Women Living with HIV

All women living with HIV, including Aboriginal women, face some unique challenges connected to sexual violence. Disclosure of a woman's HIV status to her partner can increase her susceptibility to sexual and physical violence and may give her abuser further control in the

relationship (North & Rothenberg, 1993; Rothenberg, Paskey, Reuland, Zimmerman & North, 1995).

Aboriginal women living with HIV may face the fear and threat of rejection and emotional, physical and/or sexual violence from acquaintances, friends, family members and their community. Aboriginal women living in remote and isolated communities may confront increased risk of stigmatization and even violence as a result of disclosure of their HIV status.

Another issue with which HIV-positive women must contend is the fear of reinfection, and its impact on future health. As a result of sexual violence, women living with HIV could be at risk of reinfection with a different strain of the virus which may be resistant to available treatments. The risk of acquiring another STD is also a concern for HIV-positive women because there is evidence to suggest that HIV may affect the progression and severity of symptoms of some STDs (Wasserheit, 1992).

If sexually assaulted, HIV-positive women must contend with the post-traumatic effects in addition to the numerous physical and emotional challenges they face as a result of their HIV status.

Making Connections Between HIV and Sexual Violence

It is important for health care workers to acknowledge the connections between HIV and sexual violence when working with Aboriginal women who have experienced sexual violence. However, the responsibility for addressing these connections extends beyond individual health care workers. Organizations providing services to Aboriginal women also have a role to play in this area. Identified below are some suggestions as to how health care workers and organizations can begin to make these connections.

What Can Health Care Workers Do?

- Acknowledge how sexism, racism and colonialism can lead to sexual violence and HIV risk among Aboriginal women.
- Develop an understanding of the connections between HIV and sexual violence and consider how these connections are relevant to their work with Aboriginal women.
- Become familiar with the key issues related to HIV and sexual violence – including HIV risk and transmission issues, risk reduction and HIV testing – and when and how to sensitively and appropriately address

these issues when working with Aboriginal women who have experienced sexual violence.[9]

- Become familiar with existing local and regional Aboriginal-specific referral sources for Aboriginal women who have experienced sexual violence, and may be at risk of HIV or living with HIV/AIDS including Aboriginal women's shelters, Native women's resource centres, First Nations health centres, Aboriginal friendship centres and respected elders and traditional healers. Other referral sources could include sexual assault centres, women's shelters, hospitals, drug treatment programs, AIDS service organizations, HIV testing sites, needle exchange programs, outreach programs for street-involved women and women who work in the sex trade, counselling centres and crisis lines.
- Help Aboriginal women link up with appropriate individuals and services in their community that include a holistic approach to healing, and that are familiar with and sensitive to issues related to sexual violence, HIV/AIDS and social and cultural issues affecting Aboriginal women.
- Develop a clear understanding of legal and ethical obligations related to confidentiality of information concerning sexual violence, HIV testing and HIV status. Consider how confidentiality can be maintained, particularly in small communities.
- Identify personal attitudes and values related to sexual violence, HIV/AIDS, gender, sexuality, race and culture, and how these attitudes and values may impact on their work with Aboriginal women. Identify strategies to overcome biases.
- Identify how personal experiences with sexual violence and/or HIV/AIDS may impact on their work with Aboriginal women. Seek support from co-workers, a peer support group or a healing circle, and/or consider counselling to deal with personal issues and feelings.

What Can Organizations Do?

- Develop a written policy on HIV and sexual violence which includes related issues such as HIV risk and transmission, risk reduction and HIV testing.

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[9] See the following document for an exploration of the issues related to HIV and sexual violence: Neron, C. (1998). *HIV and Sexual Violence Against Women. A guide for counsellors working with women who are survivors of sexual violence.* Ottawa: Health Canada.

- Develop a written policy on confidentiality of information concerning sexual violence, HIV testing and HIV status, which includes direction on the disclosure and documentation of information.
- Integrate questions and information related to HIV and sexual violence into existing assessment tools, questionnaires and educational materials.
- Integrate HIV and sexual violence issues into staff and volunteer training. Include skills building and values clarification.
- Ensure resources and pamphlets related to HIV and sexual violence are accessible to staff and the women with whom they work.
- Support and encourage information sharing related to HIV and sexual violence with other local and regional organizations.
- Support, encourage and advocate for Aboriginal designed and implemented programs for Aboriginal women who have experienced sexual violence and are at risk for HIV or living with HIV/AIDS.

Summary

As previously stated, there are a variety of factors contributing to HIV risk among Aboriginal women, specifically biological factors and social conditions which include sexual violence. The connections between HIV and sexual violence reflect the range of experiences with HIV risk and sexual violence that Aboriginal women face. Individual health care workers and organizations which provide services to Aboriginal women have a responsibility to understand the connections between HIV and sexual violence, to determine how these connections are relevant to their work with Aboriginal women, and to help Aboriginal women get the support they need to heal from their experiences with sexual violence and HIV/AIDS.

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Suggested Readings and Resources on HIV and Sexual Violence

Bruce, B. (June 2000). HIV and Sexual Assault. Are you at risk? A booklet for Aboriginal women. Winnipeg: Native Women's Transition Centre, Inc. (Available from the Canadian HIV/AIDS Clearinghouse, [613] 725-3434).

Canadian Council on Social Development. (1996, Spring). Double jeopardy: women, violence and HIV (special issue). *Vis-a-Vis*, 13(3). (Available from the Canadian HIV/AIDS Clearinghouse, [613] 725-3434).

HIV and Sexual Assault (Forthcoming 2000). Are you at risk? A booklet for Inuit women. Ottawa: Health Canada. (Available from the Canadian HIV/AIDS Clearinghouse, [613] 725-3434).

Miller, M. (1999). A model to explain the relationship between sexual abuse and HIV risk among women. *AIDS Care*, 11(1), 3-20.

Neron, C. (1998). *HIV and Sexual Violence Against Women. A guide for counsellors working with women who are survivors of sexual violence.* Ottawa: Health Canada. (Available from the Canadian HIV/AIDS Clearinghouse, [613] 725-3434).

Walters, K.L. & Simoni, J.M. (1999). Trauma, substance abuse and HIV risk among urban American Indian women. *Cultural Diversity and Ethnic Minority Psychology*, 5(3), 236-248.

References

Aboriginal Nurses Association of Canada (ANAC). (1996). *HIV/AIDS and its Impact on Aboriginal Women in Canada.* Ottawa: Health Canada.

Allers, C., Benjack, K., White, J. & Rousey, J.T. (1993). HIV vulnerability and adult survivors of childhood sexual abuse. *Child Abuse and Neglect*, 17(2), 291-298.

Baker, T., Burgess, A., Brickman, E. & Davis, R. (1990). Rape victims' concerns about possible exposure to HIV infection. *Journal of Interpersonal Violence*, 5, 49-60.

Chester, B., Robin, R.N., Koss, M.P., Lopez, J., & Goldman, D. (1994). Grandmother dishonoured: violence against women by male partners in American Aboriginal communities. *Violence and Victims,* 9(3), 249-258.

Currie, S., Laliberté, N., Bird, S., Rosa, Noelle & Sprung, C. (1995). *Assessing the Violence Against Street Involved Women in the Downtown Eastside/ Strathcona Community.* Vancouver: DEYAS.

Edwards, S. & Crane, C. (1998). Oral sex and the transmission of viral STIs. *Sexually Transmitted Infections*, 74, 6-10.

Gostin, L., Lazzarini, Z., Alexander, D., Brandt, A., Mayer, K. & Silverman, D.C. (1994). HIV testing, counselling and prophylaxis after sexual assault. *Journal of American Medical Association*, 271(18), 1456-1443.

Health Canada. (1999a, November). *HIV/AIDS Epi Update. HIV/AIDS and Ethnicity in Canada.* Ottawa: Bureau of HIV/AIDS, STD and TB, Laboratory Centre for Disease Control, Health Canada.

Health Canada. (1999b, May). *HIV/AIDS Epi Update. HIV and AIDS Among Aboriginal People in Canada.* Ottawa: Bureau of HIV/AIDS, STD and TB, Laboratory Centre for Disease Control, Health Canada.

Health Canada. (1999c, April). *Sexually Transmitted Disease in Canada: 1996 Surveillance Report.* Ottawa: Bureau of HIV/AIDS, STD and TB, Laboratory Centre for Disease Control, Health Canada.

Herman, J. (1992). *Trauma and Recovery. The Aftermath of Violence – From Domestic Abuse to Political Terror.* New York: Basic Books.

Johnsen, L. & Harlow, L. (1996). Childhood sexual abuse linked with adult substance use, victimization and AIDS risk. *AIDS Education and Prevention*, 8(1), 44-57.

Lacey, H. (1990). Sexually transmitted diseases and rape: the experience of a sexual assault centre. *International Journal of STD and AIDS*, 1(16), 405-409.

LaRocque, E.D. (1994). *Violence in Aboriginal Communities.* Ottawa: Health Canada.

Lauber, A. & Souma. (1982). Use of toluidine blue for documentation of traumatic intercourse. *Obstetrics and Gynecology*, 60(5), 644-648.

Maracle, S. (1993). A historical viewpoint. *Vis-à-Vis* (special issue on Family Violence: Aboriginal Perspectives), 10(4), 1, 4.

McLeod, D. (1996). Asking the right questions. Women at high risk need to know. *Vis-A-Vis*, 13(3), 9.

Miller, M. (1999). A model to explain the relationship between sexual abuse and HIV risk among women. *AIDS Care,* 11(1), 3-20.

Nguyen, M., Laframboise, S., Archibald, C.P., Patrick, D., Houston, S., Romanowski, B., Mill, J.E. & Sutherland, D. (1997, October). HIV/AIDS Among Aboriginal Women in Canada: An Increasing Concern. 10th Annual British Columbia HIV/AIDS Conference, Vancouver.

North, R. & Rothenberg, K. (1993). Partner notification and the threat of domestic violence against women with HIV infection. *New England Journal of Medicine,* 329, 1194-1196.

Norton, I.M. & Manson, S.M. (1995). A silent minority: battered American Indian women. *Journal of Family Violence*, 10(3), 307-318.

Padian, N., Shiboski, S. & Jewell, N. (1991). Female to male transmission of HIV, *Journal of the American Medical Association*, 266, 1664-1667.

Resnick, H., Kilpatrick, D. & Seals, B. (1996). Rape and HIV risk: an epidemiological study. Women's Health Conference, Washington, D.C.

Rothenberg, K., Paskey, S., Reuland, M., Zimmerman, S. & North, R.L. (1995). Domestic violence and partner notification: implications for treatment and counselling of women with HIV. *Journal of the American Medical Women's Association*, 50, 87-93.

Royal Commission on Aboriginal Peoples (RCAP). (1996). *Perspectives and Realities: Voices of Women.* Ottawa: Author.

Royce, R., Seña, A., Cates, W. & Cohen, M. (1997). Sexual transmission of HIV. *New England Journal of Medicine*, 336 (15), 1072-1078.

Shaw, M. (1994). Women in prison: A literature review. *Forum on Corrections Research*, 6(1).

Ship, S.J. & Norton, L. (1998). *Triple Jeopardy: The Dynamics of Gender, Race and Class Discrimination, Aboriginal Women and HIV/AIDS* (unpublished paper). Kahnawake, Quebec: The National Indian and Inuit Community Health Representatives Organization.

Slaughter, L. & Brown, C. (1992). Colposcopy to establish physical findings in rape victims. *American Journal of Obstetrics and Gynecology*, 166, 83-86.

Statistics Canada. (1993). *Violence Against Women Survey.* Ottawa: Author.

Stout, M.D. & Kipling, G. (1998). *Aboriginal women in Canada: Strategic research directions for policy development.* Ottawa: Status of Women Canada.

Van Kirk, S. (1985). *Toward a feminist perspective in Native history.* Toronto: Ontario Institute for Studies in Education (OISE).

Walters, K. & Simoni, J. (1999). Trauma, substance use and HIV risk among urban American Indian women. *Cultural Diversity and Ethnic Minority Psychology,* 5(3), 236-248.

Wasserheit, J. (1996). Heterogeneity of heterosexual transmission: the role of STDs. XIth International Conference on AIDS, Vancouver, British Columbia.

Wasserheit, J. (1992). Epidemiological synergy: interrelationships between HIV infection and other sexually transmitted diseases. *Sexually transmitted diseases,* 9, 61-77.

Weissman, G. (1991). AIDS Prevention for women at risk: experience from a national demonstration research project. *Journal of Primary Prevention,* 12, 49-52.

Whitmire, L.E., Harlow, L.L., Quina, K. & Marokoff, P.J. (1999). *Childhood Trauma and HIV: Women at Risk.* Philadelphia, PA: Brunner Mazel.

Worth, D. (1989). Sexual decision making and AIDS: why condom promotion among vulnerable women is likely to fail. *Studies in Family Planning,* 20(6), 297-307.

Zierler, S., Witbeck, B., Mayer, R. (1996). Sexual violence among women living with or at risk for HIV infection. *American Journal of Preventative Medicine,* 12(5), 304-310.

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