

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

A Final Report for the Bridges and Foundations Project on Urban Aboriginal Housing

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Introduction

There is strong evidence that lower income and socioeconomic status are associated with poorer health in general, including lower standards of reproductive and sexual health (de Bruyn, 1998). Economic inequities often contribute to the continuing marginalization of certain groups, including women and Aboriginal communities. **Marginalization is a deleterious effect of the colonization of Aboriginal people in Saskatchewan. It is often manifested in reduced access to education and housing, low self-esteem, a diminished degree of control over one's life and environment, unequal power in relationships and a lower capacity to make positive choices about health, including strategies aimed at reducing the risk of HIV/AIDS transmission (de Bruyn, 1998).**

It is not difficult to see from the viewpoint of a colonized group such as Aboriginal women in Saskatchewan, just how the HIV/AIDS crisis has once again brought the divisions of society to the forefront. These are divisions based on race, ethnicity, gender, and class. Berer (1993:39) holds that the conviction that HIV/AIDS is only confined to specific marginalized groups has succeeded in perpetuating “stereotypical views and prejudices about sexual identity and immoral sex, rather than accentuate the commonalities in sexual behavior.” Discoveries about the nature of HIV/AIDS - the increase in the heterosexual population and among women - have raised concerns of its potential for rapid spread in the Aboriginal community (Aboriginal Nurse's Association, 1996).

Women in general and Aboriginal women in Saskatchewan in particular, who have contracted HIV/AIDS, have to face numerous obstacles. The fear and stigma attached to HIV/AIDS keeps many women from disclosing their status and as a result, this has led to a lack of adequate treatment as well as support. **Family members, who would normally support a person dealing with grief and loss, stay away from the person touched by AIDS. As remaining aspects of colonization racism, sexism, and homophobia can also lead to further isolation.** Societal discrimination has many implications, and being from a group that is discriminated against, marginalized, or stigmatized reduces a person's capacity to learn and respond. **Discrimination creates an environment of increased risk for anyone who experiences it.** Saraswati and Sahas (1996:7) contend that “only to the extent that we as a society can reduce discrimination and promote respect for rights and dignity, will we be successful in preventing HIV transmission, be

able to care for those who are infected and ill and advance the health of all people.” **The quality of life of Aboriginal women in Saskatoon with HIV/AIDS and/or Hepatitis C can be enhanced by belonging to a community that accepts them and their families for who they are; a community that does not reject them in response to the disease they have contracted.**

The stigma linked with HIV/AIDS makes it difficult for not only the person who has contracted the disease, but those associated with that person as well. The result for people with HIV/AIDS and/or Hepatitis C is that they are treated differently based on the attitudes and ignorance of others. Pipiciw (2000:16-17) offered her thoughts about HIV/AIDS and Hepatitis C and Aboriginal women: “When I get talked to on the street by the street nurses and stuff I just go yeah okay and I walk away. It’s not enough to make me just sit up and listen. **There’s nothing being done that really just makes you want to do something about it and to be more careful, like make tricks wear condoms. There is no reason that I have that I should change.**” The majority of the Aboriginal women in this research were not very optimistic about the future for themselves and their families.

HIV infection rates are interrelated with the general health conditions of Aboriginal communities in Saskatchewan. Many of the factors that contribute to a higher risk of HIV infection are associated with economic and social disadvantage, such as unemployment, poor housing, low income and poor sanitation. The high incidence of physical, emotional, and sexual violence experienced by Aboriginal women is an additional indicator of the general social conditions in Aboriginal communities in Saskatchewan.

Through the process of assimilation, many Aboriginal people in Saskatchewan were separated from their communities and thus, separated from their culture and identity. With the implementation of residential schools, children were removed from their homes, parents were left without purpose, and the Elder system was severely disrupted. In most cases, Aboriginal people were pressured to abandon their traditional ways of caring for themselves, in place of government assistance programs. **The loss of roles, values, beliefs, traditions, language, spirituality, and identity were imposed upon Aboriginal people, and were not replaced with anything tangible.** When you lose your whole identity and have nothing to replace it with, how can a culture and/or traditions survive?

In order to prevent the spread of HIV/AIDS effectively, one must look at why Aboriginal people are over-represented in high-risk groups for HIV transmission. Why are there more Aboriginal people in Saskatchewan using drugs? Why are Aboriginal women in Saskatchewan more prone to becoming involved in prostitution and drug use? Why are more Aboriginal people in Saskatchewan involved in substance abuse and violence (Health Canada, 1996:3)? It is critical

to accept that only communities can heal themselves. One would think that the number of AIDS cases would be in proportion to the number represented in the general population. In fact the overall infection rates for HIV/AIDS cases, among Aboriginal women in Saskatchewan, are on the rise while in non-Aboriginal populations the numbers have started to level off.

What this information emphasizes is the importance of each person protecting him/herself by making healthier choices, to reduce their risk of infection. Social and economic factors increase the chance of becoming infected. Of special importance are low levels of education and high levels of unstable housing and poverty, which must be addressed along with other risk factors, to stem the spread of disease. In order for Aboriginal women in Saskatoon to protect themselves from both the health and the social ills of society, they must be provided the opportunity to enhance their own quality of life including a stable home with which to raise their children.

HIV/AIDS is still a very new challenge in Aboriginal communities in Saskatchewan. Comparatively low levels of known HIV infection, in the community at the onset of the AIDS crisis, allowed some to assume that the disease had “passed them by.” Saskatchewan Aboriginal communities have also faced other major social and health concerns, such as youth suicide, solvent abuse, and violence, on a scale far higher than the broader Canadian population.¹ In such a context, it is not difficult to see how other issues can overshadow HIV/AIDS. Confronting HIV/AIDS in the Aboriginal community in Saskatchewan requires significant effort. Great advances have been made in awareness about the disease in Canadian society and a broad range of services has developed in the past decade. However, too few of these initiatives have focused on the specific needs of the Aboriginal community and the distinct ways in which effective care, education, and support must be approached. **As a result of many factors, including poverty, racism, and attempted assimilation, significant numbers of Aboriginal people in Saskatchewan are in remote areas. These can and do include places such as correctional facilities, temporary accommodation such as rooming houses, or living on the street (RCAP, 1996 III: 12).**

Female poverty brings with it an increased risk of HIV infection through restricted access not only to health information but also to health services. **Poverty affects attitudes to conscious risk-taking in complex ways. When too much energy is expended upon basic survival, people tend to ignore a disease that may or may not materialize for seven to ten years. The contending issues of poverty can crowd out the seriousness of HIV/AIDS (Easton, 1992:16). This, according to Mariasy and Thomas (1990:36), can result in “a lack of economic, social, cultural, sexual and technological options to lead vulnerable women to**

concentrate on addressing the more immediate risks in their lives: poverty, homelessness and the frequent disruption of socioeconomic support systems.”

As the heterosexual spread of HIV/AIDS increases in Saskatchewan, the relationship between social and economic advantage and risk behaviour becomes clearer. Many of the factors that contribute to a higher risk of HIV infection are associated with economic and social disadvantage. Saraswati and Sahas (1996:10) claim that: “HIV infection rates are interrelated with the general health conditions of communities.” The general health of Aboriginal people in Saskatchewan indicates that there is a very high risk of HIV/AIDS transmission. De Bruyn (1998:11) points out: **“The cumulative effect of HIV/AIDS-related stigma and discrimination is to objectify, marginalize and exclude people with HIV/AIDS. Those who were already objectified, marginalized and excluded are pushed even further from recognition of shared humanity and from the support of human society.”**

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

Groups in which the rate of HIV/AIDS is already high, such as street youth, prostitutes, and the prison population include a significant number of Aboriginal women. **Even more troubling is the fact that many Aboriginal people in Saskatchewan apparently do not think of AIDS as a disease that affects them.** Some think of it as a gay disease, imagining that homosexuality is rare among Aboriginal people; as a city disease, imagining that it will not follow them into small or isolated communities; or as a white man’s disease, imagining that it can somehow be restricted to non-Aboriginal people. These are false hopes (RCAP, 1996 III: 12). The results of this research illustrate Health Canada’s contention that HIV/AIDS and Hepatitis C do exist in Aboriginal communities in Saskatchewan, due primarily to low condom use, high rates of STDs, low self-esteem, and increasing intravenous drug use, violence, sexual abuse, and prostitution (Health Canada, 1998).

Demographic Information

The majority of the respondents in this research supported themselves and their children through prostitution. Many had never completed Grade 12, had been incarcerated more than once, had no permanent address, abused alcohol and/or intravenous drugs, had contracted one or more sexually transmitted disease, had contracted HIV/AIDS and/or Hepatitis C, and had been sexually, physically, emotionally, and/or spiritually abused.

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

A number of the respondents had never been married but had lived common-law. Eighty-six percent of the women maintained that their priority was their children, even if it meant raising them as a single parent. For ninety-five percent of the respondents, the father of the children moved on without committing any psychological or financial support, not long after the children were born. **In large part it can be argued that these issues were reflected in the lifestyles of these women, who felt that their only recourse was prostitution.**

Pipiciw has had HIV and Hepatitis C for roughly six years, and had kept her illness a secret except for a few people. She had two children, a seven and an eight-year old, who were taken care of by her mother-in-law. She had been married for nine years but never divorced and lived with her present common-law. Pipiciw (2000:11-12) contended:

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

Amisk was married and had six children, who ranged in age from 8 years to 19 years and she has had Hepatitis C for nearly eighteen years. Amisk's life had been one of sexual abuse, rape, and incarceration. She had contracted Hepatitis C from a man who was eighteen years her senior and she was determined to make the lives of her children more "normal" than what her childhood had been.

Where Respondents Resided in Saskatchewan

Table 4.3.5 Where the Respondents Resided in Saskatchewan:		
Place of Residence in Saskatchewan	Number in Sample	Percentage of Sample
La Ronge	1	(5.0)
Meadow Lake	1	(5.0)
Duck Lake	1	(5.0)
Prince Albert	8	(36)
Saskatoon	4	(18)
Regina	5	(23)
Moose Jaw	1	(5.0)
Maple Creek	1	(5.0)
Total	22	(100)

More and more Aboriginal women have relocated to large urban centers that are not far from their home reserve; yet close enough to earn money prostituting and to obtain intravenous drugs. **Most of the Aboriginal women profiled lived in urban populations however, urban and reserve women are inextricably linked through migration and mobility. Eighty-two percent of the women lived in large urban centers, while 18% of them migrated to and from the city to their home reserve. Most of them had lived on the street and many had no other option than to live with extended family.**

Mahkesis (2000:13) grew up on the Crooked River Reserve located about 27 kilometers north of La Ronge and described how life on reserve had not changed:

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

Anikwacas was a prostitute who worked the streets of Regina since she was just fifteen years old. Anikwacas (2000:6-7) described how she felt it would be for young women with HIV/AIDS and/or Hepatitis C on reserve:

I think there would be a lot of shame and guilt and I don't know if I would be able to go home with that. I don't know. I don't think anybody in the community would ever understand. A lot of these

girls that hit the streets never come back home just because of the fact that they've been out there and a lot of people make it hard for them to come back.

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

Most of the urban Aboriginal women in this research took part in prostitution and alcohol and/or intravenous drug use, due in part to the reality that these vices were more common in the larger urban areas than on reserve. The women profiled included those women who were and who had been incarcerated in the Prince Albert Correctional System, but had lived in the southern and central areas of Saskatchewan as well as the north.

Occupation of Respondents

Sixteen of the women were or had been prostitutes, which they stated was due in most part to the fact that it required a short period of time to perform and the monetary value was the most profitable. The rationale for choosing a life of prostitution was more than economic.

Table 4.2.6 Occupation of Respondents:		
Occupation	Number in Sample	Percentage of Sample
Prostitute	16	(73)
Housewife	2	(9.0)
Laborer	1	(5.0)
Elder	1	(5.0)
Corrections Officer	1	(5.0)
Unemployed	1	(5.0)
Total	22	(100)

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

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

After listening to the personal histories of the respondents it was not difficult to understand why they had no self-worth, self-confidence, self-respect or any hope that they were just as deserving as the rest of humanity to live a decent and happy life. These women had aunts, sisters, and mothers who were already working on the street as prostitutes or drug dealers and who were addicted to alcohol and/or intravenous drugs. They were not preferred role models for ten and eleven-year-old girls, who ran away looking for the love that they did not receive at home. The amount of money many that most of these women made through prostitution was in most instances not totally theirs to keep. **Seventy-five percent of the women profiled had to share their earnings with a pimp. They were put out each day by their pimp, to make a set amount of money and had stay on the street until they did so. In some cases the women were given the amount of money that they made over and above what their pimp wanted, but many of them received only a small stipend.** Makwa (1999:6-7) disclosed her experiences with her pimp, who happened to be a bill collector for the Grim Reapers (an outlaw motorcycle gang that was absorbed by the Hells Angels motorcycle gang in 1997. They take part in money laundering, intimidation, assault, attempted murder, fraud, loan-sharking, extortion, prostitution, the trafficking of illegal weapons and drugs, including cocaine, marijuana, and ecstasy, in both Canada and the United States):

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

followed me. Then I moved to Regina. He followed me there as well. So now I am living in Moose Jaw.

Aboriginal street prostitutes are the most marginalized of sex trade workers and are more likely to be arrested for soliciting and incarcerated. The HIV and Hepatitis C crisis has heightened and exposed the vulnerability of Aboriginal prostitutes to discriminatory attitudes, attention, and regulations. **The twenty-two Aboriginal women profiled in this research, illustrate how HIV/AIDS and Hepatitis C has affected their quality of life as well as the lives of their families.** Seventy-three percent of the women profiled in this research, ‘were’ and continued to be street prostitutes, even after being diagnosed with HIV and/or Hepatitis C.

Respondents’ Level of Education

Only one-third of the women profiled completed Grade 12 (See Table 4.3.7). For many of the women, having children at a very young age and being responsible for those children did not make education an option.

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

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

My alcoholic father, from 3-16 years of age sexually abused me. It was a family secret that nobody wanted to talk about. My mother ignored all the signs because she was in denial pretty much all the time. My dad worked 9-5 and he was home most of the time when I got home from school, which wasn’t a very good situation and that’s just the way it happened. When I told my mother she believed me and she was the one who decided that she should press charges, because she was already divorced from him by then. The day before we were to go to court was

when my dad died and sometimes I think he committed suicide, but no one would ever tell me.

Approximately one-third of the respondents had attended residential school. **Many Aboriginal families were torn apart as a result of the residential school system in Saskatchewan.**

Maskwa (2000:5-6) an Elder who works with inmates at the Pine Grove Institute for Women in Prince Albert, disclosed how years at residential school, continued to influence all aspects of her life:

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

Maskwa (2000:18) talked about why so many young Aboriginal women were turning to prostitution, alcohol, and drugs:

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

Victimization of Respondents

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

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

Family members, including their fathers, grandfathers, uncles, foster-fathers, ex-boyfriends, and common laws, as well as johns violated the respondents (See Table 4.2.15). These women suffered a whole range of abuse, including rape, beatings with a weapon, hospitalization for broken bones, and intimidation, resulting in a cycle of violence for most of them. Nicole (2000:4-5) had been in Saskatchewan's social system since the age of fourteen and described her turmoil:

I had a boyfriend then and I was in a foster home and he introduced me to the street, because he was a pimp. He introduced me to the big city and to doing tricks and stuff like that. I am trying to break the cycle, because I am twenty-three now and I can't keep living like this. I haven't been in a relationship lately because I'm so fucked up in the head. **It's just like I don't know where I belong and that's why I always get high because it heals the pain. It also helps me forget that no one cares about me. It seems like the only time anyone cares about me is when I'm in jail.** I have been thinking about suicide lately, because I am sick of this life of being homeless and everybody just using me for my drugs and my money and my body.

Conclusions

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

It is fundamental that Aboriginal women engage in determining the developing relationship between Aboriginal people and urban institutions. Overwhelming evidence shows that urban service delivery groups are not meeting the specific needs of urban Aboriginal women, and endeavors to resolve this situation are key to advancing Aboriginal women's health and well-being (RCAP, 1996).

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

in Saskatchewan the confidence to handle the issues that surround HIV/AIDS and Hepatitis C and the credibility that they will require in their respective communities to garner support for their efforts.

The reality of an increasing number of young Aboriginal women in Saskatchewan, living with HIV/AIDS and Hepatitis C, requires a more effective development of education and prevention programs in affected Aboriginal communities. **Effective HIV/AIDS and Hepatitis C strategies must no longer only be about HIV/AIDS and Hepatitis C prevention and education, they must also be about improving and enhancing the quality of life of Aboriginal women and their families, living with HIV/AIDS and Hepatitis C.** The effects of two centuries of colonization, racism, and oppression are evident in the quality of life of urban Aboriginal women in Saskatchewan. **The Royal Commission on Aboriginal People (1996) argues that many infectious diseases are more common in the Aboriginal community; overall rates of violence and self-destructive behaviour are high and rates of welfare dependency, conflict with the law and incarceration all point to imbalances in the social conditions that shape the quality of life of Aboriginal women (Health Canada, 1998). Many factors that contribute to a higher risk of HIV/AIDS and Hepatitis C in Aboriginal women in Saskatchewan, relate directly or indirectly to their quality of life and living conditions.** These factors include: high rates of sexually transmitted disease and teenage pregnancy; indicating a lack of safer-sex practices and a higher risk to Aboriginal youth; low self-esteem and high rates of sexual and physical violence; drug and alcohol abuse; a lack of access to health information and facilities; and an inferior quality of life.

There are major social, political, economic, and cultural changes currently underway in many bringing increasing respect and utilization of the traditional ways and beliefs of Aboriginal people. This resurrection has taken many forms, including the demonstrated recognition of Elders and traditional healers within the Aboriginal community itself. Even now the process of healing has begun for women in Aboriginal communities.ⁱⁱ Many of them have started to confront the long-term problems faced by Aboriginal women in Saskatchewan, which include the psychological impact of colonization, racism, poverty, marginalization, and now HIV/AIDS and Hepatitis C. Taken together these factors have resulted in Aboriginal people in general, and Aboriginal women more specifically, having the poorest overall health and socioeconomic status of any identifiable group in Saskatchewan. **HIV/AIDS and Hepatitis C and the responses to these diseases are not merely a medical issue; instead they are simultaneously economic, social, cultural, political, and more importantly spiritual issues (RCAP, 1996 IV: 4).**ⁱⁱⁱ

HIV/AIDS and Hepatitis C rates for Aboriginal women continue to rise; yet denial and intolerance remain prominent, with respect to those living with these diseases. **This intolerance has taken a variety of forms, including Aboriginal women living with HIV/AIDS and Hepatitis C being forced to stay away from their home communities.** Mobility between urban and reserve communities is recurrent and in most cases Aboriginal reserve communities can make collaborative health education and prevention strategies extremely difficult.

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

Indisputably the most efficient way to fully comprehend how Aboriginal women have been affected by HIV/AIDS and Hepatitis C and what programs and services would improve their chances of not contracting infection, would be to involve Aboriginal women. This research has overwhelmingly revealed that the best person to talk to young Aboriginal women in Saskatchewan, about the risks of HIV and Hepatitis C infection, is an Aboriginal woman who has been there and has lived the experience. It also exposed the fact that most of the infected women felt that they had no choice but to lead a life of prostitution, in order to survive. **Contracting HIV/AIDS and Hepatitis C involves high-risk behavior and the inability to make healthy life choices.**

Further, the tendency of Saskatchewan Aboriginal women to migrate freely between their home communities and urban centers makes it inevitable that transmission of the virus from city to country will occur. As for cultural or group distinctions HIV/AIDS spares no one. In other words,

Aboriginal women are vulnerable, all the more so if they do not think they are and, therefore, take no precautions. In their chapter titled “Gathering Strength”, The Royal Commission on Aboriginal Peoples: Final Report (1996:1) states:

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

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

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

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

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

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

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

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

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

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

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

The experience of urban Aboriginal women in Saskatchewan has been one of isolation and enhanced risk potential for substance abuse and HIV/AIDS.

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

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

people who are living with AIDS are denied the right to live and die with dignity in their own communities.

The greater number of respondents in this research with HIV/AIDS and Hepatitis C live in Saskatchewan cities, not in remote reserve communities. The exact number of Aboriginal women in urban centres in Saskatchewan is not known. Although more services associated with HIV/AIDS and Hepatitis C or substance abuse are available in Saskatchewan cities, they are sometimes provided in ways that are discriminatory, particularly to those who are at greater risk of HIV and Hepatitis C infection, such as Aboriginal women that are intravenous drug users and prostitutes. **A positive approach to treating Aboriginal women, including those with HIV/AIDS and Hepatitis C, with dignity is clearly to provide them with services of the same value as those provided to others in Saskatchewan, with the same needs.** As well, it means affirming the insights and practices of Aboriginal cultures in Saskatchewan in developing and delivering programs and services, plus incorporating traditional Aboriginal healers and healing practices into those programs and services (de Bruyn, 1998). Maskwa (2000:17-18) described her thoughts and feelings about the young Aboriginal women that she advised:

A lot of these girls are third generations and they have never had anything. Some of them have lived in the cities all their lives, so they don't know what it is that they are missing. **That is what is happening in our society today especially around Aboriginal people, is that they don't know who they are. They get so mixed up in prostitution, alcoholism, drug addiction and stuff like that. I think a lot has to do with their home lives, but it also has to do with education.** They are not going to be able to get a job if they don't have an education. A lot of these young women drop out, because they are alone in the classroom with no other Aboriginal person there or they have no push to go. Their mothers and fathers are alcoholics or drug addicts or whatnot and they have to learn how to look after themselves when they are really young, at eight or nine years old.

This research offers numerous examples of urban Aboriginal women in Saskatoon and other urban centres in Saskatchewan, that are explicit illustrations of what it is like to live in low-income neighborhoods. The quality of life of Aboriginal women in Saskatchewan is affected by lifestyle, socioeconomic status, gender and physical environment. This research has revealed that for the most part urban Aboriginal women live in a class of poverty. The "Bridges and Foundations Project on Urban Aboriginal Housing" could have a tremendous effect on the quality of life and the living conditions of the Aboriginal women discussed in this research. Aboriginal women and their children form a substantial segment of the low-income families in Saskatoon. However, it is a very small percentage of these families that can afford even low-income

accommodations. This research reveals the extent of the specific needs for urban Aboriginal women and their families and how Bridges and Foundations can best assist these women. I truly believe that the Bridges and Foundations Project in Saskatoon could greatly benefit urban Aboriginal women's living conditions, which would in turn enhance their quality of life.

By completing this research and preparing this report I have given the twenty-two Aboriginal women, who so openly and caringly entrusted their stories to me, an avenue to validate their experiences. I have passed these experiences on to you and underscored the explicit needs and life issues of urban Aboriginal women and their families living with HIV/AIDS and/or Hepatitis C in Saskatoon. The Bridges and Foundations Project on Urban Aboriginal Housing can assist these women in establishing a foundation on which they can build the rest of their lives. A foundation that would include a permanent home for themselves and their families and a community: where they would not be discriminated against because they were Aboriginal and had HIV/AIDS and/or Hepatitis C; where they could obtain some control over their own lives and how they lived; where they could feel secure, safe, and a sense of belonging and not have to worry about violent pimps and johns; where they could raise their children and not have to fear social services removing them and placing them in foster care; where they could get a "real" job and not have to work on the street prostituting themselves; where there was no overcrowding and poor sanitation; where their children could go to the same school on a regular basis; where their spiritual needs could be met by community Elders; and where they could hopefully attain some sense of self-esteem, self-respect and self-worth. These are the same desires and feelings of all of the Aboriginal women who shared their lives and thoughts with this researcher.

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Notes

ⁱ It is stated "Saskatchewan Aboriginal communities have also faced other major social and health concerns, such as youth suicide, solvent abuse, and violence.... In such a context, it is not difficult to see how other issues can be overshadow HIV/AIDS." One of the major tenets of this thesis is that HIV/AIDS (and by implied extension, Hepatitis C) is a product of social marginalization - just like those conditions just mentioned - it could be that HIV/AIDS was not so much overlooked but subsumed by a pre-occupation with these other conditions. It does appear that this thesis is trying to argue two contradictory points. On the one hand, a sound argument is made for the interconnectedness of health conditions that stem from cultural oppression and

colonialism. On the other hand, a recurring argument is that HIV/AIDS should stand alone as a specific, and perhaps competing, health concern. This research would be greatly enhanced by including a clear discussion of how these conditions are inter-related at an experiential level among the Aboriginal women who participated in this research.

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

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

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