Experiences of sexual violence and relocation in the lives of HIV infected Canadian women

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ABSTRACT

Objectives. To investigate the role, if any, that violence and physical relocation may play in the acquisition of HIV infection in Canadian women. Study Design. The present study is qualitative. Methods. Using in-depth open-ended interviews conducted among HIV-positive women volunteers as a method. Results. Twenty women were interviewed. Eighteen of the 20 were of aboriginal (First Nations) ethnicity. All participants reported experiences of isolation and violence in childhood (sexual abuse, domestic violence, emotional abuse). Half of those who experienced childhood sexual abuse reported being afraid to disclose the events to adults at the time due to fear of reprisal and/or shame. The majority reported running away from home to escape violence, with subsequent involvement in the sex trade and drug abuse as economic and emotional survival/coping strategies. Half reported previous incarceration in jail. The majority reported that they currently looked to community social programs for guidance and support. Conclusion. Early intervention programs must be implemented in partnership with communities to reduce family violence and create support networks for children, youth and adults at risk.

Keywords: HIV, women’s health, aboriginal health, sexual abuse, child abuse

INTRODUCTION

In 1999 an estimated 49,800 people in Canada were living with HIV infection (0.16% prevalence); women accounted for 6,800 (14%) of those infected (1). These numbers represent a 24% increase of all prevalent infections since 1996, and a 48% increase in prevalent female infections. An estimated 4,190 new cases of HIV infection occurred in 1999 (annual incidence 0.01%), of which 917 (22%) were in women. Fifty-four percent of incident HIV infections in women were attributed to intravenous drug use (IVDU), and 46% to heterosexual exposure.

Although self-identified aboriginal (First Nations, Inuit and Metis) persons comprise 3.3% of the Canadian population, they accounted for an estimated 5.5% of all prevalent HIV infections in 1999 (an increase of 91% since 1996), and 8.8% of all incident infections(2). Compared to non-aboriginals, new cases of HIV infection in aboriginals are more likely to occur in females (45.3%), younger individuals, and be associated with IVDU as a risk factor.

While research has begun to focus on HIV infection in Canadian aboriginal populations(3), few studies directly address the risk factors for infection among aboriginal women. Previous studies in non-aboriginal female populations have explored the relationship between experiences of violence and engagement in HIV risk behaviours(4). It has been postulated that the frequent migration (relocation) of individuals between communities and between rural and urban centres may facilitate the acquisition and spread of HIV infection(5).

In 2000, the authors attended a meeting in which representatives of 17 community organizations that provide HIV/AIDS services to women
in Winnipeg, Manitoba voiced the need for participatory research on the determinants of HIV infection in women of all ethnic backgrounds. Subsequently a focus group of HIV positive women suggested an investigation of the roles that violence and relocation play, if any, in the acquisition of infection. One woman from this group volunteered to assist in the study. With these suggestions in mind, this qualitative study was undertaken to elucidate the social risk factors’ association with HIV acquisition among infected women receiving care and/or support in Winnipeg.

MATERIAL AND METHODS
With the aid of our HIV positive volunteer (who was aboriginal), recruitment occurred through poster advertisement and verbal information provided by workers in six clinics, hospitals and social aid organizations located in the south central Canadian city of Winnipeg. Approximately 120 HIV positive women (approximately 50% of whom are aboriginal) were either intermittently or consistently receiving care or support through these organizations at the time of the study; over 90% lived in Winnipeg. The only inclusion and exclusion criteria were the ability or inability, respectively, to give informed consent.

No required study size was defined. The identified goal was to recruit as many participants as possible within the defined enrolment period of December 2000 to August 2001. In-depth open-ended tape recorded interviews were conducted with women who agreed to participate. Questions were open-ended (e.g. "Tell me about your childhood" and "Can you tell me how you think you became HIV infected?") in order to avoid bias in the elicitation and interpretation of responses. Participants were told the purpose of the study was to explore past and present issues in the lives of HIV positive women. Specific references to the study’s interest in violence and relocation were not made. The interviewer only asked for clarification of these issues if the participant initially introduced them.

The interviews lasted approximately 2 hours and were conducted by one author (IM), and a research associate. Identities were coded to protect confidentiality. Audiotapes were transcribed and then destroyed. Themes from the interviews were coded by the three authors, and were then shared with the research participants in a group meeting, in order to clarify meaning.

The study was approved by the Research Ethics Board of the University of Manitoba.

RESULTS
Despite vigorous attempts to recruit subjects, only 20 women agreed to participate. Eighteen (90%) of the 20 self-identified as aboriginal (specifically First Nations). The mean age of the participants was 37 years (range 22-48). All resided in core area of Winnipeg. Eighteen of the 20 were born in rural communities. Ten were currently single, while the other 10 were living with a partner. The mean level of education was the ninth grade.

All participants were currently receiving government financial ("social") assistance with a mean monthly income of $1,079. One woman reported ongoing involvement in the sex trade (prostitution) in order to supplement her income. Participants reported previous involvement in casual legal employment (n = 12), theft (n = 16), sex trade (n = 13) and illegal drug dealing (n = 2).

The majority of subjects perceived that they had acquired HIV infection through intravenous drug use (IVDU); a minority felt that they had become infected through unprotected sex. A majority of the participants indicated they had no understanding of HIV before diagnosis, although some acknowledged having heard the word "AIDS". Most participants reported IVDU on a regular basis in the past, with one reporting current use of IV drugs. The main drugs of choice were heroin and cocaine. More than half reported that they had shared needles and used dirty needles in the past.

Themes which emerged from all the interviews included violence and loss occurring in childhood and adulthood, associated with physical relocation/dislocation.
Childhood Experiences

All the women indicated feelings of isolation and of being unsafe as children, associated with experiences of sexual abuse, domestic violence, neglect and emotional abuse. A majority of the women experienced sexual violence as children, mainly from male family members. Two reported being assaulted at residential school by members of the clergy. The reported age at which the abuse began ranged from five to twelve years.

"I remember I was so little that I couldn’t even reach the sink to wash the dishes."

In describing abuse experienced at a residential school, one woman explained:

"I used to hear things at night, like the children being bothered…makes me scared it would be me…eventually it was me too."

Of those who experienced sexual abuse as children, half of the participants indicated they did not talk about these events when they were occurring. The women cited a number of reasons, including fear of reprisal from the perpetrator, feelings of shame, guilt and lack of recognition that talking about the events was a course of action open to them. Many remembered the feeling that they would not be believed if they were to disclose the abuse.

One participant described a sexual assault perpetrated by her mother’s boyfriend, and explained the reaction of her mother to the disclosure:

"Well at first I thought she believed me but then we had the school principal there. She seemed understanding about it. I thought she was going to help me, but after everyone was gone she called me a tramp and started hitting me and all that."

Many of the participants reported physical violence inflicted on them in childhood by family members. These acts included hitting, slapping, kicking and punching, usually perpetrated by the adult female caregiver.

As children, 19 participants were apprehended by the Child and Family Services government agency in order to be placed in foster care. Reasons included neglect, abandonment, alcohol abuse of parent(s) and physical/sexual abuse.

In discussing her experience of living in a foster home one woman explained:

"I cried for years wondering when my mom and dad were going to come and pick me up. They never did."

Fourteen participants ran away from either their families of origin or from foster care. Many said they ‘ran’ to escape their home situation, citing sexual abuse as the main reason. Participants described the experience of "growing up quickly", as exemplified in an interview with a woman who as a child obtained (“hitting up”) amphetamines from doctors and administered it intravenously to her parents:

"…my mum met a guy, my stepfather…and he was using drugs so she wanted to try it and she got hooked on it. I kinda grew up hitting up doctors for Ritalin…I knew how to shoot them up with needles, like their veins. That’s how the circle starts. I started running away from home."

However, a woman who ran away from home at age 12 years indicated that emotional maturity did not always follow:

"I think when I hit the streets I stopped growing emotionally."

Economic hardship as well as physical and emotional vulnerability were described in association with childhood abuse and dislocation. In turn these became risk factors for drug use and involvement in the sex trade. Half of the participants were incarcerated in correctional institutions as children.

After running away at age 12, one woman explained how she first began to work on the streets:

"I was broke all the time, I never had any money for food or cigarettes or anything and it came to a point where I would hitchhike to get drugs and somebody would say I’ll give you so much money if you do this for me, and I did it. I walked away crying the first time...when you’re that
young and you have somebody do that to you it's like they have taken advantage of you. You see that later on in life but you don't realize what's going on at the time...but that doesn't take away the hurt or the pain or the feeling that you've been used, manipulated."

In discussing alcohol use at a young age one participant explained:

"I started because everybody else was and after a while it just became a coping mechanism to cope with the feelings...I was always taught not to show anger or to cry."

When asked how she dealt with her feelings resulting from childhood abuse, one woman stated:

"I didn't. I pushed it all down and never dealt with it and that was part of the reason I guess why I kept turning to drugs and alcohol seeing it take a bit of the pain away."

One woman described her use of solvents as a means of coping with abuse at home:

"At that age, so small, I tried to commit suicide because I knew it wasn't right what he was doing. I started running away after I got older. When I started running away I started sniffing gasoline because that was the only thing I could do because I was small...there was a garbage dump, people were throwing food away and we used to eat from there because they [parents] were always drinking and not buying food...that was the only thing we had to do because all the little kids were together; protecting each other...it was always in the bush where we hung around together like that, 'cause nobody touched us."

Adult Experiences
Sixteen of the participants reported at least one incident of being sexually assaulted as adults. These events involved past partners, clients and unknown men. As adults, a majority of the participants were also involved in violent incidents, either on the streets or from partners. These incidents included kicking, slapping, choking, stabbing and being forcibly confined. Most had witnessed violence in their homes or on the streets including stabbings, shootings and physical assaults.

Almost half of the participants had been in correctional institutions as adults, citing convictions for theft and violent crime, most often assault with a weapon.

Eighteen of the 20 women were born in rural or remote areas. Thirteen participants moved as adults from one geographic area (excluding moves within communities) to another, some to escape the justice system, others in order to escape abusive relationships. The mean number of geographic moves for these participants was 3.

All of the 13 women who were either currently or previously involved in the sex trade reported having the ability and power to insist on the use of a condom. However, only one participant reported always using a condom with clientele; 12 used condoms during sex trade work on an irregular basis.

A majority of the participants had biological children of their own. Eighteen women had contact, as a parent, with the Child and Family Services agency involving apprehension and custody of their own children. At the time of the interviews, many of the women were actively attempting to regain custody of their children.

The majority associated the use of IV drugs during adulthood as a coping mechanism with past and present emotional issues surrounding experiences of abuse. Many reported involvement in social programs to stop using IV drugs, including methadone programs.

One woman discussed her battle to stop using IV drugs:

"I guess it's my only tool of knowing how to cope [using drugs]...they help you forget about your problems, push them away, push them down, push them deeper and that is nothing but creating your own volcano, then it all comes exploding out. Learning the coping skills other than drug use to deal with my problems is important."

Participants identified other "coping" mechanisms to deal with stress as an adult. Nineteen
participants volunteered that they "put out of their mind", or suppressed, memories of abuse. A few of the women recounted past attempts of suicide. A number of women, at the time of the interview, reported a diagnosis of mental illness including depression, multiple personality disorder, panic attacks, post traumatic stress disorder and schizophrenia.

When asked about perceived sources of emotional support since learning of their HIV status, participants identified friends (n = 12), individuals working in community social programs (n = 12), current partners (n = 5), family (n = 4) and spiritual counsellors (n = 2).

DISCUSSION
The number of HIV positive women who enrolled in this study was low. Given the personal nature of the interview, and the sensitivity of the issues discussed, the authors wish to acknowledge the courage and generosity shown by participants, through the sharing of their stories.

Qualitative methodology allows us to explore the chronological flow of events and themes in these women’s lives. Their words have concrete and vivid meaning that may be more convincing to the reader than tabled numbers (6). The insights that come from this qualitative study are meant to be complementary to those gained from quantitative research.

The results are not to be interpreted as necessarily representative of the experiences of all HIV positive women in our target population. Although we present demographic information, and in some cases indicate the number of responses within the study group, we are not attempting to attach quantitative results to a qualitative study, but rather to provide context to the voices of our participants. In terms of potential recruitment bias, it is difficult to predict whether women with greater or lesser experiences of violence and abuse would agree to participate. Within the interviews themselves, every effort was made to create an atmosphere of trust, and to avoid asking "leading" questions that might bias the response.

It is remarkable that 18 (90%) of the 20 participants were aboriginal, compared to 50% of the population from whom these subjects were enrolled. The involvement of a research volunteer who was aboriginal may have engendered greater trust among women of that ethnic group. Alternatively it is possible that the study provided a valued and needed venue for some women, particularly of aboriginal ethnicity, to be heard.

In these narratives the common theme that runs from childhood to adulthood is one of absence and loss – of love, security, esteem, family, friends, home, education. Relocation, through government apprehension or running away, resulted from the perceived inadequate or abusive parenting that thrived within an environment permeated with absence/loss. Relocation, which may also be viewed as a form of dislocation and isolation, was perceived as solving one problem (e.g. abusive adult) while introducing new dangerous scenarios. Whether living in a garbage dump or on an urban city street, economic imperative combined with emotional and physical vulnerability led to behaviours and situations that put these women at risk for HIV infection.

For those women who were sexually assaulted as children, a process of traumatic sexualization may occur whereby sexual identity and responses develop in an inappropriate and dysfunctional fashion (7). Sexual assault and other forms of abuse may also lead to external or internal stigmatization, erosion of trust, and feelings of powerlessness and betrayal. Resultant behaviours may be harmful to self (IVDU, unprotected sex, remaining in abusive relationships) and others (theft, assault, drug dealing). These behaviours were described by participants as methods to cope with stress and to survive. For many, these behaviours were learned in childhood. Social networks conducive to encourage healthy coping strategies were not described by participants.

The historical context must also be considered in our analysis of the majority of narratives from aboriginal women. References were made to the residential school system, which forcibly separated aboriginal children from their parents, language and culture. In some cases, as one of our
participants explained, sexual and other physical, psychological and emotional abuses occurred. Colonization and racism in Canada have also contributed to environments of loss and absence that fuel HIV risk behaviours among aboriginal groups.

There are several images that stand out among these narratives. The first is that of a child who feels she must run away from home and live in a garbage dump in order to feel safe. The second is the unusual child who dared to tell her mother and teacher of her sexual assault, only to suffer in consequence. How are we to respond? Prevention of HIV risk behaviour in our study group would involve action at several levels. Primary prevention will require tackling socioeconomic, educational, cultural and health-related factors which foster the abuse of children (particularly females) and youth, and alternatively, nurturing the forces that support safe and loving families and communities. Secondary prevention would involve early intervention programs for children, youth, and parents. There is need for better education of caregivers and support workers within communities (including social and health care workers, teachers, police, judges, parents, guardians and family members) in order to recognize and care for children and youth at risk for behaviour that is harmful to self and others. Programs targeting the empowerment of women within sexual relations, knowledge gaps regarding HIV transmission, and access to economic and educational opportunities are required in order to reverse current trends of HIV infection among women who share the experiences recounted in this study.

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