

Life Experiences of Aboriginal Women Living With HIV/AIDS

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ABSTRACT

HIV/AIDS is rapidly becoming an epidemic in Aboriginal communities. There is currently a lack of research investigating the factors influencing the spread of this illness among Aboriginal individuals. Particularly, research is lacking in the area of Aboriginal women and HIV/AIDS. The goal of this study is to contribute qualitative data to our understanding of how Aboriginal women have experienced the impact of HIV/AIDS. Eight Aboriginal women who are *infected with HIV* (n=4) or *affected by* (n=4) HIV participated in qualitative open-ended interviews to generate a propositional theory which described the women's journey on *the path to healing*. Grounded theory methods were used to discover the broad themes. The participants described their journey on the path to healing as a process of integrating acceptance, risk factors and everyday challenges, support, and developing new identities as Aboriginal women living with HIV/AIDS or as individuals affected by HIV. The participants' journeys ("*walking on the path of healing*") are depicted on the medicine wheel – a traditional model of health and healing which represents the stages one must pass through in a cyclical manner. The participants of this study drew strength and personal understanding from the medicine wheel – they could understand their own experience as it was reflected in the model. Even though the women were at a variety of healing stages, the model held meaning for each woman. Through the gift of understanding provided by the medicine wheel, the participants found the strength to begin and continue walking on their path of healing.

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INTRODUCTION

Aboriginal² women have been identified as having one of the highest rates of HIV infection in Canada. Aboriginal women are significantly impacted as they represent nearly half (45.1%) of all positive HIV test reports among Aboriginal Peoples, compared with non-Aboriginal women who represent 19.5% of reports among non-Aboriginal Peoples (Health Canada, 2004). Today, Aboriginal women face a number of health obstacles and challenges which relate to a number of determinants of health. Poverty, addictions, sexually transmitted infections, and limited access to or use of health care services all contribute to their health experience (Health Canada).

Cruikshank (1990) discusses the value of expressive forms like storytelling to generate information and initiate social, cultural, and economic change. In this article Aboriginal women share their stories and life experiences of HIV/AIDS, and are candid about the challenges and obstacles they experience as they walk on their journey of healing while living with or being affected by HIV/AIDS. This research is meant to assist the Aboriginal women who participated to share their life experiences in their own words, to give voice to their experiences, and to contribute to the sparse literature about Aboriginal women and living with HIV/AIDS.

HIV/AIDS AND ABORIGINAL WOMEN IN CANADA

Aboriginal women in Canada are over represented in HIV/AIDS statistics (Prentice, 2004). The rate of new HIV infections among Aboriginal women in Canada is on the rise and has been steadily increasing to epidemic proportions for Aboriginal women over the past two decades (Canadian Aboriginal AIDS Network, 2003; 2005; Mill, 2000). Available statistics on the disease do not indicate the actual number of infected Aboriginal women as many cases go unreported (Mill, 2000). Aboriginal HIV cases are underestimated because of under-reporting for ethnicity, variations in reporting ethnicity within and between provinces, delays in reporting, and misclassifications in ethnic status (Health Canada, 1999).

Aboriginal women in Canada are affected by HIV/AIDS at a higher rate than women of other ethnic groups. These higher rates are explained in the literature as being linked to marginalization, gender, poverty, identity and colonization (Bourassa, McKay-McNabb, & Hampton, 2004). Previous researchers have found that race, culture, gender, and ethnicity are important determinants of health, which are often interrelated (Armaratunga, 2002). As well, Tanenberg (2003) states that the traditional role that Aboriginal women played in their communities has been altered since contact with Europeans. One of the contemporary results of this impact is that Aboriginal women are at greater risk for HIV, and are becoming infected with and affected by HIV/AIDS at alarming rates.

Bourassa, McKay-McNabb, and Hampton (2004) described how sexism, racism, and colonialism have joined to create levels of systematic oppression that differentially affected specific Aboriginal groups, and men and women within these groups. Bourassa et al. discuss how Euro-Canadian legislation, which attempts to define Aboriginal identity, does not take into account the diversity within Aboriginal communities. The *Indian Act* which was officially passed in Canada in 1876 defined what Indian identity and 'Indianness' would mean from that point forward in history. The injustice and ramifications of the sexist specification inherent in this legislation of the *Indian Act* were more severe for Aboriginal women than men. This injustice continues to have implications to this day, and impacts how Aboriginal women are able to live their lives and the choices they have available – limited choices may contribute to the increased numbers of Aboriginal women being infected or affected by HIV/AIDS.

² The term Aboriginal has been defined by Indian and Northern Affairs Canada as: descendants of the original inhabitants of North America (INAC, 1999). In 1982, the *Canadian Constitution* Section 35(2) defined Aboriginal peoples as being three groups: Indian, Inuit and Métis (Department of Justice Canada, 1982). In this study Aboriginal is defined as individuals who self-describe as First Nations (status/non-status), Inuit and Métis.

DEFINITIONS

Terminology to describe Aboriginal women living with HIV is relatively new to the HIV community and to researchers. It was challenging to find a term that would represent the Aboriginal women who participated in this study. This challenge reflects the changing landscape in the literature that contains varying definitions of groups living with HIV/AIDS, and also reflects the importance for any people with a history of oppression to define their own reality. With some guidance from the Canadian Aboriginal AIDS Network (CAAN), I decided to use a term recently introduced in Jackson's (2005) document, *Aboriginal Women with HIV/AIDS: Care, Treatment and Support Issues*. The term "Aboriginal Person Living with HIV/AIDS" (APHA) has been used for about nine years by Aboriginal groups to identify and reinforce the fact that the experience of APHAs is unique and requires particular attention. The history of Aboriginal women and their relationship to the health system suggests that a term describing this population should be generated from within the Aboriginal community -- a way of claiming their own reality. To address this, Jackson expanded on the APHA term to include Aboriginal women living with HIV/AIDS (AWHAs), suggesting that the experience of Aboriginal women is unique in its own right. The term AWAHA appears to be an appropriate term that incorporates the uniqueness of "Aboriginal" and "women" and has been adopted for use in this research to describe the Aboriginal women who have participated in this study.

There are few definitions in the literature describing Aboriginal women *affected* by HIV. Again, it was a challenge to find a definition that would describe Aboriginal women who are affected by HIV through a family member living with HIV, a community member having HIV, or working in a front-line capacity with an Aboriginal AIDS Service Organization (AASO)/AIDS service Organization (ASO). One study specifically addressed this issue and defined Aboriginal women who are caring for AWHAs as *caregivers* (Ship & Norton, 2001); however, the participants in my study were not always the caregiver, so this definition would not work for my purposes. The term *affected* has been used in this study to refer to any Aboriginal woman who is close to an Aboriginal person living with HIV/AIDS.

METHODOLOGY

Grounded theory methodology (Strauss & Corbin, 1998) was used to explore how AWHAs and women affected by HIV/AIDS experience the illness. This method is well-suited for research with Aboriginal people as oral stories are part of the history and traditions of Aboriginal communities, where storytelling was a means of sharing and transferring information (Mill, 1997). Furthermore, qualitative methods have been shown to be useful when exploring areas about which little is known, such as Aboriginal women's experiences with HIV/AIDS (Strauss & Corbin, 1998). This was also an appropriate choice of methodology as it facilitates open-ended questioning about lived experiences.

PARTICIPANTS

Eight Aboriginal women ranging in age from 25 to 50 years participated in this study. Purposive sampling methods were used to recruit participants (Berg 1995). Inclusion criteria for participating in the study were: (1) Aboriginal women living with HIV/AIDS (AWHAs); (2) Aboriginal women affected by HIV/AIDS, which consisted of a family or community member living with HIV/AIDS or an AASO/ASO frontline service provider. Four AWHAs and four Aboriginal women affected by HIV/AIDS participated in this study.

Pseudonyms were chosen for each participant from a baby name generator web site (www.popularbabynames.com) which included a section for Aboriginal names. The names were chosen to represent the Aboriginal women in this study and to protect their identities. Confidentiality for the participants was particularly important because HIV/AIDS is a highly stigmatized illness, especially within the Aboriginal community. The pseudonyms and some demographic information of the participants are presented in Table 1.0 and Table 2.0.

RECRUITMENT PROCESS

Potential participants were recruited through AASOs and ASOs in Regina that provide support services for AWHAs and those affected by HIV/AIDS. All Nations Hope AIDS Network, AIDS Program South Saskatchewan, and community-based centres in Regina assisted in the recruiting process in a number of ways: agencies posted notices describing the study within their offices, front-line service providers hand-delivered information posters to potential participants, and introduced me to potential participants at various HIV/AIDS functions in our community.

Working within the agencies as a volunteer, attending numerous HIV/AIDS conferences and gatherings, as well as work on previous research projects facilitated trust building with potential participants, which helped facilitate the recruitment process. In addition, being an Aboriginal woman who has personally experienced the affects of HIV/AIDS with an older sister who lived with HIV/AIDS for a number of years assisted in the recruitment process – participants knew I understood personally and culturally.

Each participant filled out a background information form. Interviews were approximately sixty to ninety minutes in length and were conducted at All Nations Hope AIDS Network, AIDS Program South Saskatchewan, or a participant’s place of residence. Six out of the eight participants requested interviews in their homes because they wanted to ensure their identities were kept confidential.

The AWHAs and the Aboriginal women affected by HIV/AIDS in this study are from First Nations in Saskatchewan, Manitoba, and British Columbia. However, many of the women reside in urban centers. Many are mothers and grandmothers. Some have strong connections to their families and communities. Others do not have this support. A number of the women have a connection to their culture and traditional ways, while others do not. Each of the women has an individual experience with HIV/AIDS, which demonstrates the diversity and individuality of the Aboriginal women’s’ experiences.

TABLE 1.0
ABORIGINAL WOMEN LIVING WITH HIV/AIDS (AWHAs)

<i>Pseudonym:</i> Meaning	Aiyana : Eternal bloom	Honovi : Strong Deer	Gaho: Mother	Mahala: Woman - Powerful
Age	25	42	45	26
Marital Status	Common-Law	Common-Law	Single	Divorced
Children	4	5	1	3
Experienced a pregnancy while living with HIV	Yes. Four pregnancies & all children have tested negative for HIV	No	No	Yes. One pregnancy and child has tested negative for HIV.
Ages of Children	4, 2-2, 1	25,23,19,17, &13	22	16 months 4, 9
Years Infected by Illness	6 years	11 years	4 years	1 ½ years

TABLE 2.0
ABORIGINAL WOMEN AFFECTED BY HIV/AIDS

<i>Pseudonym:</i> Meaning	Chloe: (Intelligent, wise, serious)	Ituha : (strong, sturdy)	Zonta : (trustworthy)	Natane : (sister)
Age	47	58	40	36
Marital Status	divorced	single	common-law	divorced
Children	3	2 : one daughter one son (son deceased) 5 grandchildren	2 daughters one son	4 daughters
Ages of Children		Daughter 28 grandchildren range in age from 12 - 3	20, 17 & 12	18,17,9 and five months
Years Affected by Illness	Over 20 years with her brother	8 years with her son	9 years as a support worker	Five years with her sister

INTERVIEWS

Qualitative, semi-structured interviews were used, which are considered a useful tool for discovering information about under-researched issues (Rubin & Rubin, 1995). Interview questions were designed to allow participants the freedom to share their life experiences with HIV/AIDS. Open-ended questions were asked in order to encourage participants to describe their unique experiences of HIV/AIDS. The questions were adapted and changed as the research progressed to accommodate differences in the participant's stories and to create an open environment in which they could express their individual life experiences.

Consistent with grounded theory, joint data collection and analysis was employed (Strauss & Corbin, 1998). Interview data were individually transcribed and the transcripts were entered into the qualitative software package NVivo version 6.0 (Richards, 1999). Strauss and Corbin (1998) recommend three levels of coding: open, axial, and selective coding and this process guided the data analysis. Throughout data analysis, the constant comparative method described by Strauss and Corbin was used to analyze the data and occurred until theoretical saturation was achieved. Using NVivo computer software enhanced the ability to objectively compare stories at this stage of coding. Quotes that best illustrate the emerging theory were chosen and provide the "grounding" for the themes. Through this process the data is transformed into various themes and a propositional theory emerges to describe the life experiences of AWHAs and Aboriginal women affected by HIV/AIDS.

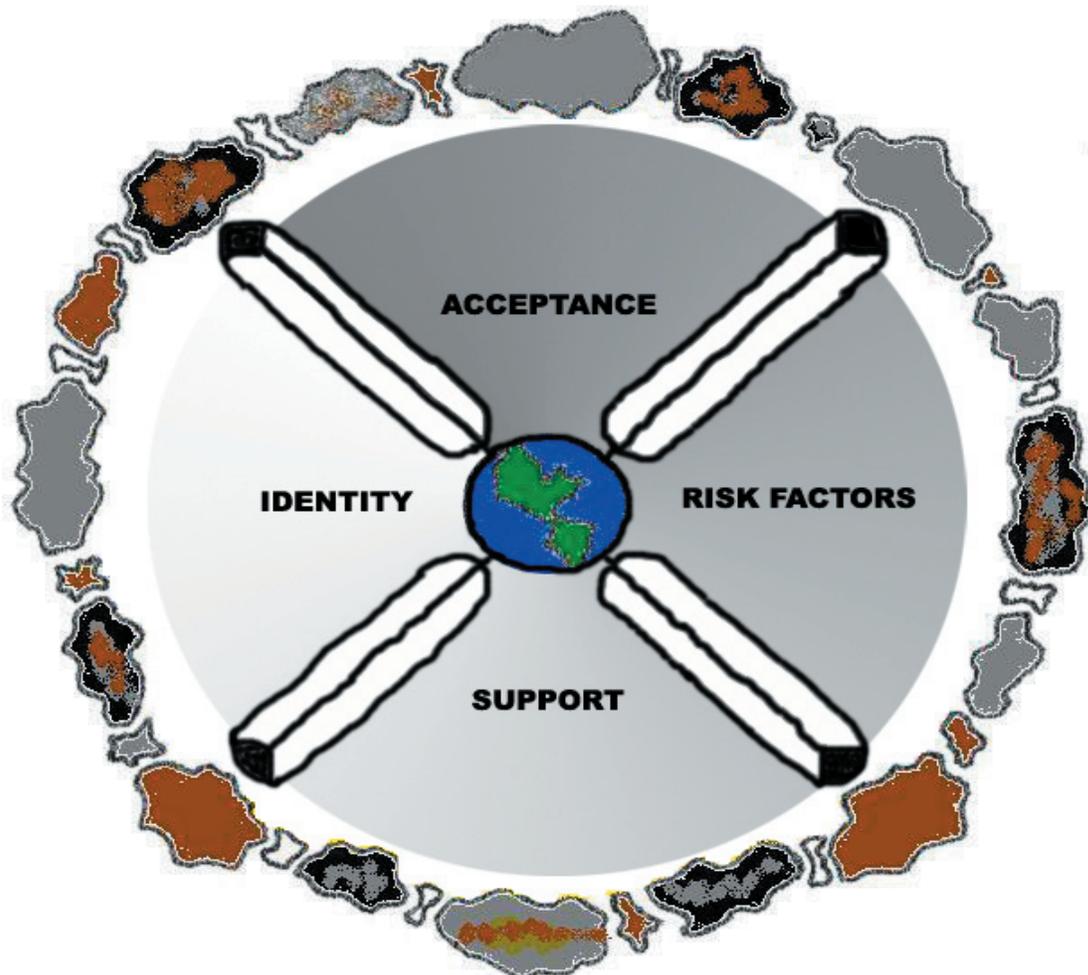
CULTURAL APPROACH

There were a number of traditional and cultural aspects that were introduced to the Aboriginal women by the researcher to assist with the interview process. Participants were given the option of smudging before and after

the interview if they chose to, as well, if the participant requested a particular traditional ceremony or approach to the interview, it was carried through respectfully. For example, Mahala requested that she have her feather present and that she burn her own sweet grass. Also, the participants were presented with a selection of rocks at the beginning of each interview and were encouraged to choose a rock or two to handhold for support through the interview process, if they were interested. They were advised that they could share their stories while holding the rocks; afterwards they could choose to keep the rocks with them or the researcher would take the rocks to an upcoming sweat where the rocks would be cleansed in the sweat and the womens' stories would be released back to the Creator. Many participants chose two rocks and returned one to be cleaned through the sweat. Many of the women kept the other rock with them and took it home once the interview was completed. This process was truly an important aspect to the research methodology as it represented their connection to mother earth and traditional aspects of First Nations Culture. Some women commented that it was an important aspect to them and it added meaning to the interview process.

RESULTS: THE HEALING JOURNEY

The propositional theory generated from the data analysis suggests that Aboriginal women “walk on a path to healing”; the steps in the journey include acceptance, risk factors, support, and identity (see Model 1.0). As the participants walk on this path to healing they have different experiences and, therefore, are at different steps in this journey. The path that they are walking is analogous to the medicine wheel model in that each woman’s journey takes them through steps that integrate their personal experiences into a holistic sense of identity.



Model 1.0: Medicine Wheel: Walk on a Path to Healing

At the first step, an Aboriginal woman is accepting her HIV illness and embracing it as a part of her identity. During the second step, she may be confronted with numerous risk factors and challenges. The third step involves establishing and walking with a network of support from numerous sources: families; front line support workers, urban community, First Nations communities, conferences, and women's retreats and gatherings. The support takes numerous forms which may include traditional support, spiritual support, informational support, and most importantly unconditional support. At the fourth step, the Aboriginal women have passed through their journey of acceptance, have identified with living positive or being affected by HIV, and are now embracing their new identity. As they journey on this path they may spend more time at one part of the path, skip over a step on the path, or return back to a step. The journey is not a linear process of stages where each stage occurs one after the other building on the previous; rather, it is a process that varies for each individual woman. Although the journey is unique to each woman, there are shared experiences along the path.

The participants' journeys ("walking on the path of healing") are depicted on the medicine wheel, which is a holistic approach to understanding that each of us as individuals has our own medicine wheel, no two are the same, and we each walk on our own path (see Model 1.0). The journey includes holistic elements of the medicine wheel which are the spiritual, mental, physical and emotional. Many of the Aboriginal women who participated in this research walk on the path that comes from a place of pain and abuse; they come to a moment of realization; then they arrive at a crossroads where they may decide to follow the medicine wheel in their journey or wait for the time to be right when they are willing to step on to the path of healing.

CORE CATEGORIES

Four core categories emerged from data analysis. The most salient core category for the Aboriginal women participating in this study was *acceptance*, followed by the categories of *risk factors and challenges*, *support*, and *family*. Quotations from AWHAs and participants who are affected by HIV/AIDS are included to highlight and contextualize the core categories. Analysis of interviews suggested that the experience for these two groups were similar in that they could be described within the same core categories.

ACCEPTANCE

All participants stated that they experienced a lack of acceptance of people living with HIV/AIDS. This lack of acceptance comes from broad society, but more painfully may come from their family members, and from members of their Aboriginal communities. Participants agreed that unconditional acceptance from individuals who are important to them is essential to their healing.

All of the Aboriginal women associated a multitude of feelings with coming to terms with their illness, a family member's illness, or being in an AASO/ASO. Their healing journeys are at different steps on the path to healing and they are at different places dealing with the emotions that accompany the path to acceptance, which is a part of their first step on the path to healing. Gaho describes the emotional turmoil she experienced while she was coming to terms with accepting her illness. She describes her initial feelings after being told that she was HIV positive and reflects on where she is now in the following way:

Depression...It was like I was walking in a nightmare for about the first six months. I was numb. Like, I was walking around alive, but yet my mind was dead and numb. All I could just like think of was the virus. It was so hard. That and the battle with the depression part. I was just thought my life was going to totally end right there. And I am ashamed. I was ashamed to know that I was sick with that illness. Alone. I really felt that I was alone. That nobody knew what I was going through. Anger. Anger at my partner. Angry at myself. For living the life that did give me that disease.

That's what it was at the beginning. You know, I thought it was like instant death. I've been there. And as I begin to read books, research it myself that I realized that I could live years and years.

After many years walking her path, Gaho now speaks out at numerous gatherings in Saskatchewan about HIV, informs her family and Aboriginal communities about HIV through learning as much as she can about HIV, and educates others in order to battle this illness. Her acceptance and understanding of her illness has equipped her with the tools she needs to assist her on her path to healing.

Mahala has just begun her journey and she shared what it is like for her to be newly diagnosed. Her journey has included numerous hardships to overcome before she will be prepared to accept what it means for her. Mahala describes the everyday struggles that she endures while facing this illness which includes high risk situations, lack of support, and not being ready to accept her new identity. She also describes that she still relies on her addictions to assist to cope with HIV/AIDS:

Living with it now is a struggle, even though I am in the beginning of the HIV stage. Yes. But it is a struggle for me to go to my doctors every three months just to get blood drawn. Worried about what my next CD 4 and my viral load is going to say. And um, it's scary to me to just watch as the CD 4 drops every time I go in for a visit. And, it's also scary just to see the rise in virals of HIV in your system. Thousands. And um, whether it is starting next. I do know that there are lots of side effects to these meds and they don't make you feel all that great. I just don't like being sick. Usually when I get sick, I cope with it by doing heroin, morphine. It helps me cope with the pain. I also find it hard being HIV positive living on a reserve. So isolated. Um, especially in a province where I have no family and I don't know anybody. The only people I got is my husband and my daughter. And even that doesn't help me all the time.

Mahala is in the beginning steps of her healing journey and accepting her new life; and she is determined to make some healthy choices in her life that will begin her journey on the path to healing. Once she begins to understand that, she needs to step on the path to healing, tackle the addictions, gain support, and find peace with her new identity.

All participants experienced numerous hardships and intense emotional turmoil as they come to accept their HIV status. It is important to note that not all women are on the same path and that each AWhA and woman affected by HIV/AIDS shared where they are in their journey in order to share their story and assist other women to begin their journey.

RISK FACTORS

Aboriginal individuals who live within Aboriginal communities often continue to experience high risk situations when they are trying to survive everyday life. The participants shared their diverse experiences of living in both urban and rural settings, which demonstrates the diversity of our Aboriginal communities. A few of the Aboriginal women describe what it was like within their First Nations communities, which is a subjective, individual experience and does not represent a generalization to all First Nation communities. Poverty, addictions, and prostitution are a part of many communities; these are high risk activities that expose Aboriginal women to HIV/AIDS. Participants describe how they are exposed to high risk activities on a daily basis. Most participants will take the time to educate others and share their experiences about living with HIV/AIDS to try and prevent others from contracting the disease. Gaho describes risk factors that she experienced within the urban Aboriginal community, and that she faces on a daily basis:

Sometimes I know that they don't practice safe sex. And this girl, I have a few nieces and different kids that I know and they are on the street, too. Whether they are using condoms or not. I always stress the fact that they should use condoms. And people that I know that are injecting, I tell them to use clean rigs.

Gaho is on her path to healing; she has experienced street life first hand and would like to prevent others from being exposed to what she has endured and now lives with - HIV/AIDS. She shares what it was like for her in

order to educate and provide awareness to her family and members of Aboriginal communities. She shares her story hoping that she may prevent others in the Aboriginal community from becoming infected.

Participants who are affected by HIV indicated that they witness high risk situations within their Aboriginal communities. It is essential to understand that while high risk situations are a part of our urban and rural Aboriginal communities participants felt individuals can decide to take another path involving less risk. Each participant indicated that there are choices in life about which path to take; each choice is up to the individual. If the path is unhealthy the risk increases, however the path can always be changed to lead to a healthy lifestyle.

SUPPORT

The Aboriginal women shared a need to be supported by their families unconditionally. They look primarily to their families as their first line of support and most important source of support. This support impacts their overall well being. For example, Aiyana indicates how her family supports her unconditionally regardless of her HIV status:

From my immediate family. Um, I guess they have always been there. I got to say for my kids. They love me to death no matter what. And that's the biggest support of them all. Um, and as for my sisters, uh, they tend to forget that I am positive and you know they treat me as if I were never sick and that I am never going to die. And in a way that's good and then again its bad cause you know, I don't want to disappoint them because they are always so proud of me. And you know they listen to me. Yes. And I try and keep... And they understand. They are not all scary about HIV and AIDS and even Hepatitis C. They understand eh. They are really good people.

However, participants indicate that not all Aboriginal families provide this support to their family members once they learn about their HIV positive status. When the support is not there women indicate that they struggle with moving forward with their healing journey. Some First Nations communities are not ready to begin to understand how this epidemic is going to affect their communities. For example, Natane describes how she would like to see her First Nation community begin on their healing path and accept and embrace the Aboriginal women living with HIV/ AIDS:

No, not the reserve because it's so much politics out there. You know, back home on my reserve, like I'm not speaking about everybody's. I know that there are a few people there who are infected. But there is no help out there. That's what I would like to see.

At this point in time she knows that her First Nations community is not close to providing the support and acceptance that Aboriginal women need when living with HIV/AIDS.

IDENTITY

Some of the Aboriginal women have embraced their new identities as Aboriginal women living with HIV/AIDS. Most of them have endured the first few steps with perseverance and today they are proud of who they are. They indicate that their new identities have evolved over time as they began to accept and understand the tremendous journey they would take in their path to healing with HIV/AIDS. Some participants have endured hardships and persevered through high risk lifestyles, sought the support they needed and have begun to develop their new identities as Aboriginal women living with HIV/AIDS. Other participants are still struggling to deal with the risk factors that are a part of their everyday lives. It is important to understand that the Aboriginal women who are affected by HIV/AIDS go through developing new identities as well when they have a family member or loved one living with HIV/AIDS. Each of the Aboriginal women interviewed shared experiences unique to their lives and their individual stages of identity that truly revealed what it was like to walk on the path to healing with HIV/AIDS.

Zonta experienced a few tragic deaths while working as an Aboriginal AIDS service provider which took a toll on her path to healing. She describes the emotional affects that this had on her, to a point where she decided to take a leave of absence from her job to recover:

I kinda blamed myself after, because after the first woman who I met committed suicide, there was another person after that who committed suicide. And it was just like one after the other. And I had no support. I tried to take it to talk to my boss about it but I couldn't because it was just, it was all me internalizing the trust.

At this point Zonta felt she was alone and did not feel she had the supports needed to continue to provide support to the AWHAs. She needed to take time off and seek the traditional supports through ceremony that assist her today to continue to provide support as a front line service provider:

And having to see others. I said okay, it's not my fault, I can't take on all of this responsibility. And be that I can only pray for them, so uh, that's why I go to sweats as much as I can because it takes all of that away from me. Ceremonial.

As she continues to seek the traditional support to assist her with her work with AWHAs and Aboriginal women affected by HIV, she has developed a new identity that has assisted her to become the woman she is today. Her new identity was developed through years of front-line work with people living with HIV and she has become a stronger person because of the work that she does.

DISCUSSION

Due to the lack of research with AWHAs, it is important to understand that the participants in this research describe the range of risk factors that they encounter in day-to-day living. Poverty accounts for higher all-cause morbidity and mortality among people at the lowest socioeconomic levels (Amaro et al., 1995). In a study by DeMarco and Johnsen (2003) women clients in inner city Boston who were accessing health support services raised concerns to their health care providers that their needs were unique and complex, compared to male clients. The women described their struggles during contact appointments, including isolation, low-self-esteem, family/child concerns, housing, violence, chemical addictions, and different physical side effects from antiviral medications and paralyzing uncertainty. Many of the participants in this study describe similar struggles to those expressed by the women in Boston. In this research, Mahala and Honovi both stated that addictions had an impact on their lives acting as a means to numb the reality of living with HIV/AIDS. Their high risk lifestyles have not allowed them to step any further on the path to healing.

Binder (2004) describes the layers and layers of discrimination that a woman feels because of her sex, being Aboriginal, an intravenous drug user, poor, homeless or under housed and unemployed. Studies that have been conducted in Vancouver's East Side indicate the incidence of HIV among female drug users is 40% higher than male drug users (Craib, K.J.P. et al, 2003). It is important to note that two participants in this research would like to let go of the addiction, yet with the lack of supportive programs to assist them in Saskatchewan, they are still in the addictions phase of their journey. Binder described the range of social problems which First Nations people experience in Canada, all of which contribute to HIV infection, and specifically discusses the social problems that Aboriginal women face, including alcoholism, substance use, high suicide rates, violence against women, and family violence.

To assist Aboriginal women on their path to healing there need to be more support programs designed to meet the needs of the Aboriginal women. Cultural/ traditional supports also need to be more accessible and in place in both urban and rural communities because at this time there are not enough programs and resources for Aboriginal women to access to meet their needs. Many Aboriginal women do not know they are infected with HIV and may go undiagnosed until their partner tests positive or they become pregnant or very sick. Perhaps it would be beneficial in the future to communicate just how important testing can be to assist with the healing process and a healthy well being.

CONCLUSION

Aboriginal women develop a new identity as an AWA or being affected by HIV/AIDS. When the women have persevered through high risk situations, surpassed some everyday challenges, received supports then they reach a place where they have come to terms with their new identity. The identity that each woman develops evolves over time. Some women are still on the path to healing at the first part of their journey with acceptance, while others have achieved coming full circle and developed a new identity. Their new identity came from their journey of acceptance of HIV/AIDS and most of the women described how it changed their lives. Some express that if they did not experience this illness, they may not be here today because of the high risk lifestyles that they had lived. Many of the Aboriginal women who participated in this study have developed a new identity and are now proactive in the fight against HIV/AIDS.

A major theme that emerged from the interviews was the participants' need and desire to be on their path to healing while accepting their illness of HIV. If they were on this path, they were able to embrace their journey and continue with their healing process. The propositional theory which emerged describes the need for ways to address the everyday risk factors, seek support, and develop a new identity. The Aboriginal women's acceptance of HIV is truly an individual journey of healing.

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