



ABORIGINAL WOMEN LIVING WITH HIV/AIDS:

CARE, TREATMENT AND SUPPORT ISSUES



Overview of the Canadian Aboriginal AIDS Network (CAAN)

- Established in 1997.
- National and not-for-profit organization.
- Represents over 200 member organizations and individuals.
- Provides a National forum for members to express needs and concerns.
- Provides relevant, accurate and up-to-date information on issues facing Aboriginal people living with and affected by HIV/AIDS in Canada.
- Is governed by a twelve member National Board of Directors and operated by a four member Executive.

Mission Statement

The mission of the Canadian Aboriginal AIDS Network is to provide leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS regardless of where they reside.

Acknowledgement

Funding was provided under the Canadian Strategy on HIV/AIDS. The views and opinions expressed herein do not necessarily reflect the official position of Health Canada.

ISBN: 1-894624-07-6

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April 4, 2005

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Introduction

Aboriginal women with HIV/AIDS (AWHAs) represent 25% of AIDS cases and 45% of HIV cases among Aboriginal Peoples in Canada (Health Canada 2004:51). CAAN noted in its position statement on *HIV/AIDS and Aboriginal Women, Children and Families*, that “there is a startling lack of gender-specific, Aboriginal-specific HIV/AIDS resources, programs and services” to support AWHAs (CAAN 2004a:3).

In this position paper, CAAN draws particular attention to the care, treatment and support issues faced by Aboriginal women living with HIV/AIDS. New information is presented here regarding key services required by AWHAs and the barriers faced by women in accessing HIV/AIDS-related services. Further, this position paper recommends a course of action for further research and projects to address this “startling lack” of AWhA-specific care, treatment and support.

AWHAs in the Care, Treatment and Support Survey

During the summer of 2004 CAAN conducted a national survey among Canadian Aboriginal persons living with HIV/AIDS (APHAs) (CAAN 2005). The survey examined the extent to which APHAs need or use various services, whether these services are meeting APHAs needs, and if not, why needs are not being met. For study purposes, 38 specific services were grouped into the following eight categories:

- *Traditional Aboriginal Health and Wellness Services*: Elders, traditional medicine, ceremonies, sharing/healing circles, traditional camps/retreats.
- *Primary Medical Services*: doctor, hospital emergency, local health clinic, pharmacy, drug plans.
- *Secondary Health Services*: dentist, optician, chiropractor, physiotherapy, dietician, home nurse, professional home care.
- *Alternative/Complementary Therapies*: massage, homeopathic therapy, medical marijuana.
- *Social and Family Services*: social worker, child care, family planning, parenting skills programs
- *Substance Use Services*: addiction treatment centres, harm reduction programs, needle exchanges.
- *Community-based and AIDS Service Organization (ASO) Services*: AIDS treatment information, health education, hospice care, buddy programs, drop-ins, crisis help-lines.
- *Mental Health and Counselling Services*: mental health care, church/spiritual care, grief counselling, financial counselling, legal support.

There were 195 study participants, of whom 74 (38%) were women. The information presented in this position paper is extracted from the results of the 74 surveys completed by 3 Inuit, 10 Métis, and 61 First Nation AWHAs representing all age groups and from all regions of Canada. 75% of the AWhA

participants live in the western provinces; the remaining 25% live in the north or eastern provinces. Most (88%) AWHAs in the study group live in urban areas; 12% live in rural and isolated settlements or on a Reserve. Approximately half (47%) of the AWHAs in the survey are above the age of 40; 34% are in their thirties and 19% are between 15-29 years of age.

Sixty (85%) of these women report they are HIV positive, and ten (15%) indicate they have AIDS.¹ The most commonly reported mode of transmission is sexual contact (47%), followed by IDU (27%) and blood product contamination (4%). Another 16% indicate a combination of these modes of transmission. Based on self-reported CD4 T-cell counts and viral loads, 30% of AWHAs' health status was not serious, and 26% was serious to very serious (CD4 T-cell count under 200 and/or viral load over 10,000). Almost half (45%) of women surveyed did not know (or did not want to know) their CD4 T-cell counts and viral loads. At the time of the survey, 44% of AWHAs were on anti-retrovirals, while an almost equal number were receiving no drugs or treatment (42%).

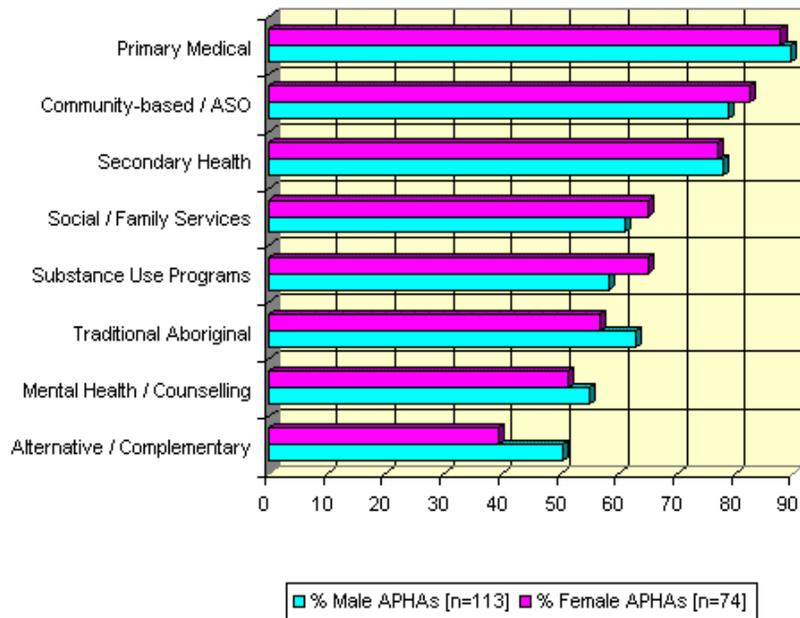
Women-Specific HIV/AIDS Service Needs

A comparison of female and male APHA use rates of care, treatment and support service categories shows that generally, women tend to use all eight types of services at the same rate as male APHAs

| SERVICES | Male Use/Need Rate (%) | Female Use/Need Rate (%) |
|-----------------------------|------------------------|--------------------------|
| Alternative / Complementary | 50.4 | 39.2 |
| Mental Health / Counselling | 54.8 | 51.4 |
| Traditional Aboriginal | 62.8 | 56.8 |
| Substance Use Programs | 58.4 | 64.9 |
| Social / Family Services | 61.1 | 64.9 |
| Secondary Health | 77.9 | 77.0 |
| Community-based / ASO | 78.8 | 82.4 |
| Primary Medical | 89.4 | 87.8 |

1 Data from the 2004 *HIV/AIDS Epi Update* shows 75% HIV cases and 25% AIDS cases among Aboriginal Women with HIV/AIDS (Health Canada 2004:51).

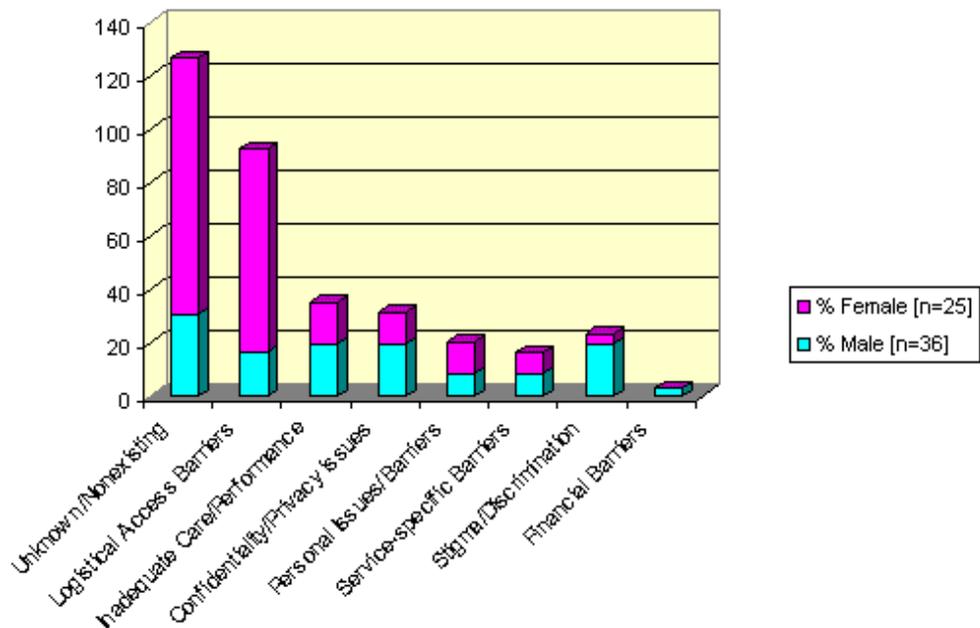
Figure 1.
Female vs. Male APHA Service Needs



However, the extent to which some services meet women’s needs, and the barriers faced by women in accessing these services, are unique when compared with male APHAs in the study group. This is particularly the case with traditional Aboriginal wellness services. Although only a slighter higher percentage of women (40.6%) compared to men (34.6%) feel that their needs are not being met by traditional service providers, the reasons for APHAs dissatisfaction varies along gender lines (Figure 2). AWHAs are mainly responsible for identifying the two main barriers to traditional Aboriginal wellness services: 1) they do not know if these services exist or where to find them in their area, and; 2) they lack logistical support such as transportation to centres where such services are offered, or to home communities where familiar traditional wellness resources (eg., Elders) exist.

| Barrier: Traditional Aboriginal | % Male [n=36] | % Female [n=25] |
|---------------------------------|---------------|-----------------|
| Unknown/Nonexisting | 30.6 | 96 |
| Logistical Access Barriers | 16.7 | 76 |
| Inadequate Care/Performance | 19.4 | 16 |
| Confidentiality/Privacy issues | 19.4 | 12 |
| Personal Issues/Barriers | 8.3 | 12 |
| Service-specific Barriers | 8.3 | 8 |
| Stigma/Discrimination | 19.4 | 4 |
| Financial Barriers | 2.8 | 0 |

Figure 2.
Barriers to Traditional Aboriginal Wellness Services:
Female & Male APHAs

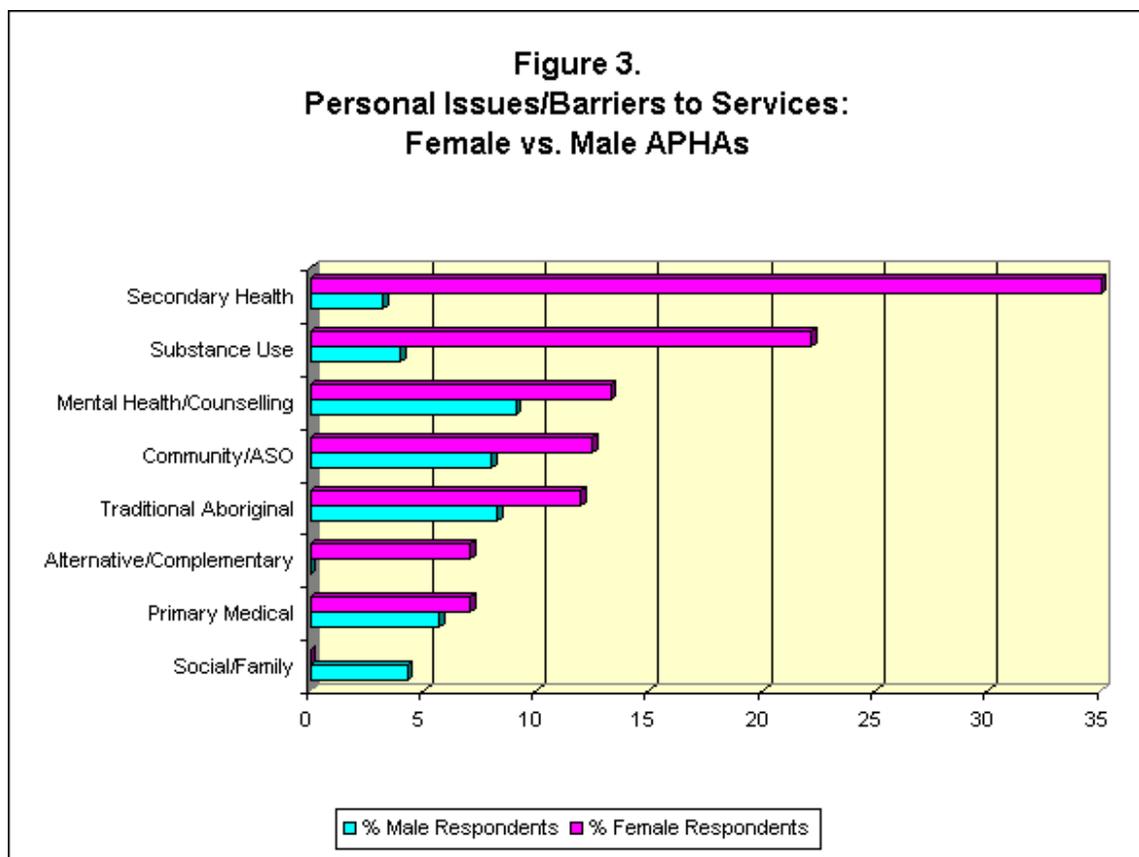


There are significant differences for specific services as well. For example, women tend to use traditional medicines at a significantly lower rate than do male APHAs. 35.4% of male APHAs said they need or use traditional medicines, compared with only 21.6% of female APHAs (Table 1). Women also indicate a significantly higher dissatisfaction rate (62.5%), stating that traditional medicines only sometimes or never meet their needs. In contrast, the majority (67.5%) of male APHAs are satisfied (Table 2). As is the case with all traditional Aboriginal wellness services, AWHAs say the greatest barrier to using traditional medicines is that they do not know where to access these medicines in their present place of residence, nor can they find the information they require about if and how to use certain traditional medicines in combination with antiretroviral drugs.

In the context of primary medical services, women with HIV/AIDS tend to visit hospital emergency centres at a significantly higher rate (67.6%) than do male APHAs (54.9%) (Table 3). 40% of AWHAs state that hospital emergency services do not meet their needs, mainly because of the long wait times. AWHAs also utilize the services of their local health clinic significantly more often (51.4%) than do men (38.1%) (Table 4). Again, almost 40% of women stated their needs were not fully met at local health clinics, for two reasons: women felt that confidentiality and privacy was compromised, and they did not receive knowledgeable care with respect to specific HIV/AIDS health matters.

In every instance except social and family services, women cited personal issues as barriers more often than male APHAs (Figure 3).

| "APHA Personal Issues/Barriers" | % Male Respondents | % Female Respondents |
|---------------------------------|--------------------|----------------------|
| Social/Family | 4.3 | 0 |
| Primary Medical | 5.7 | 7.1 |
| Alternative/Complementary | 0 | 7.1 |
| Traditional Aboriginal | 8.3 | 12 |
| Community/ASO | 8 | 12.5 |
| Mental Health/Counselling | 9.1 | 13.3 |
| Substance Use | 4 | 22.2 |
| Secondary Health | 3.2 | 35 |

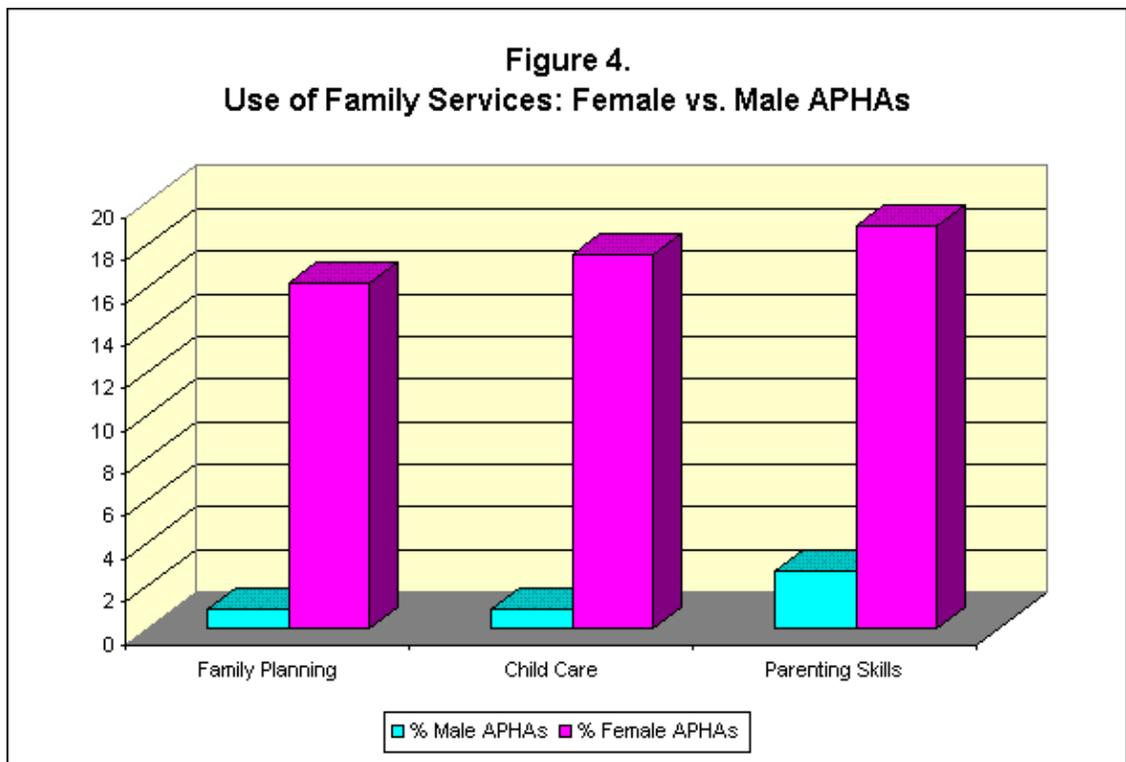


For example, although AWHAs' use and satisfaction rates for secondary health services such as dentists, chiropractors and home nursing is similar to that of the general APHA population, the reasons given by AWHAs differ as to why such services do not meet their needs. Most commonly, AWHAs indicate that the service itself is not at fault, but rather personal circumstances such as fear of dental examinations, a tendency to miss appointments, or a preference for self-help techniques prevent them from taking advantage of these services.

It is uncertain whether the higher rate of personal issues is because women are more willing than men to share personal information, or if in fact women experience greater personal barriers to accessing services. Comments such as: “[The lack of] child-care and respite for my children is a barrier to accessing services for me,” and; “[My needs were not met] because I was the only woman in detox at the time,” may indicate that as women, AWHAs face personal barriers not experienced by male APHAs.²

Significant gender differences are also apparent in the use of family services. AWHAs’ need/use rates of parenting skills programs, child care services and family planning services are significantly higher than that of male APHAs (Figure 4; see also Tables 5, 6, 7). Although 25-40% of women who use these family services indicate their needs are not being met, few reasons were given for their dissatisfaction and no clear picture can be drawn regarding barriers to family services.

| “Family Services” | % Male APHAs | % Female APHAs |
|-------------------|--------------|----------------|
| Family Planning | 0.9 | 16.2 |
| Child Care | 0.9 | 17.6 |
| Parenting Skills | 2.7 | 18.9 |



² The reverse is true with regard to stigma and discrimination as a barrier to services. Male APHAs consistently identified these as barriers more frequently than did women, and it is possible that male and female APHAs recognize situations of stigma and discrimination differently. For instance, women may define these types of issues in more personal terms, than do men.

The use of marijuana for medical purposes also differs significantly by gender. Male APHAs indicate a need/use rate of 41.6% compared to AWHAs who indicate a rate of 27% (Table 8). Interestingly, AWHAs appear to be more satisfied that their marijuana needs are being met than are male APHAs (88.2% and 61% satisfaction rates, respectively) (Table 9). Several women offered positive comments about marijuana as an aid in promoting appetite, sleep, mental and spiritual calm, and pain relief. The main barrier faced by women in using marijuana for medical purposes is the issue of illegal access, and related limitations in current legislation regarding growing marijuana for medical use.

The Literature: AWAH Issues

Many of the AWHAs in the study group commented specifically on the need for women-centred support services. The HIV/AIDS literature has also focused some specific attention on women's issues, stating for example, that empowerment means ensuring that women are involved in providing health care and counselling (Melchior et al 2001:32).

AWHAs from across Canada voice their need for support services specifically aimed at Aboriginal women living with HIV/AIDS:

As an Aboriginal women, I need to get in touch with other HIV/AIDS women. There isn't much for women in [the Atlantic region] who are First Nations. I do know a lot of men. [We] need more representation for APHA women. I don't know what's out there for me.

I think there needs to be more for women specifically. Not enough in place right now [in Alberta]. I would like to see treatment services that target me as an Aboriginal woman.

The context of women's lives, and subsequently their health needs, result in issues that are not normally seen in health for men (Worth 1990:128; de Guzman 2001:666; Huba et al 2001:55; Melchior et al 2001:31; Ship and Norton 2001:26; Vernon 2001:50-51; Kenagy et al 2003:235; Métis National Council 2003:32). For example, there is a lack of knowledge and understanding of women's concerns with regard to HIV/AIDS and how it affects not only them, but also the infants they carry and breast-feed (Vernon 2001:58, 63). A female APHA in the study required information on exactly these issues:

I would like to know more about how HIV/AIDS can affect an unborn child and what is the survival rate of the infant. I would like to know where to obtain this information and I would like for it to remain confidential.

Women who are single-mothers bear an additional burden of concern for the psychological and social effects of discrimination against their own children should their HIV status become known (Ship and Norton 2001:28; Vernon 2001:58). Studies have also shown that women cross-culturally are more likely to shoulder the burden of home-based care giving for HIV-positive family and friends, even if they themselves are affected with HIV/AIDS (de Guzman 2001:670; Ship and Norton 2001:27, 29). What money women have tends to be allocated to the family before their own needs (Vernon 2001:49). Anecdotal data from within the CAAN membership suggests that AWHAs are more likely to find themselves in health crisis because women tend to take care of the needs of others (eg., their children) before themselves. This tendency may help explain the survey results showing that AWHAs use hospital emergency rooms more frequently than male APHAs.

Studies indicate that increasing numbers of Aboriginal women are moving into urban centres or simply moving away from Reserves or remote communities in order to escape family violence (Ship and Norton 2001:27). CAAN's care, treatment and support survey results show that 46% of women have already moved or will need to move to be closer to services; another 14% are unsure if they will need to move.

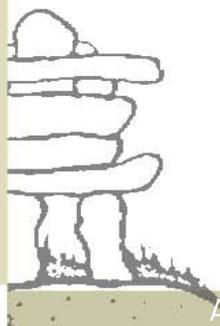
The survey results also show that it is mainly AWHAs who require access to child care services (Table 5). Other studies indicate that single-mothers face greater risks for earlier death from AIDS because they are too busy to seek help early (Kenagy et al 2003:236). An additional concern that may keep women from seeking an HIV/AIDS diagnosis and/or treatment is the fear of losing custody of their children (Huba et al 2001:62). In addition to this, isolation in rural areas becomes a significant barrier for women who have no day care access on days when they must travel for medical appointments (Vernon 2001:50; cf. Huba et al 2001:67; Kenagy et al 2003:236). AWAH mothers, therefore, are not as able to access health care because of lack of transportation and the absence of child care. One AWAH in the survey group explained her difficulties as follows:

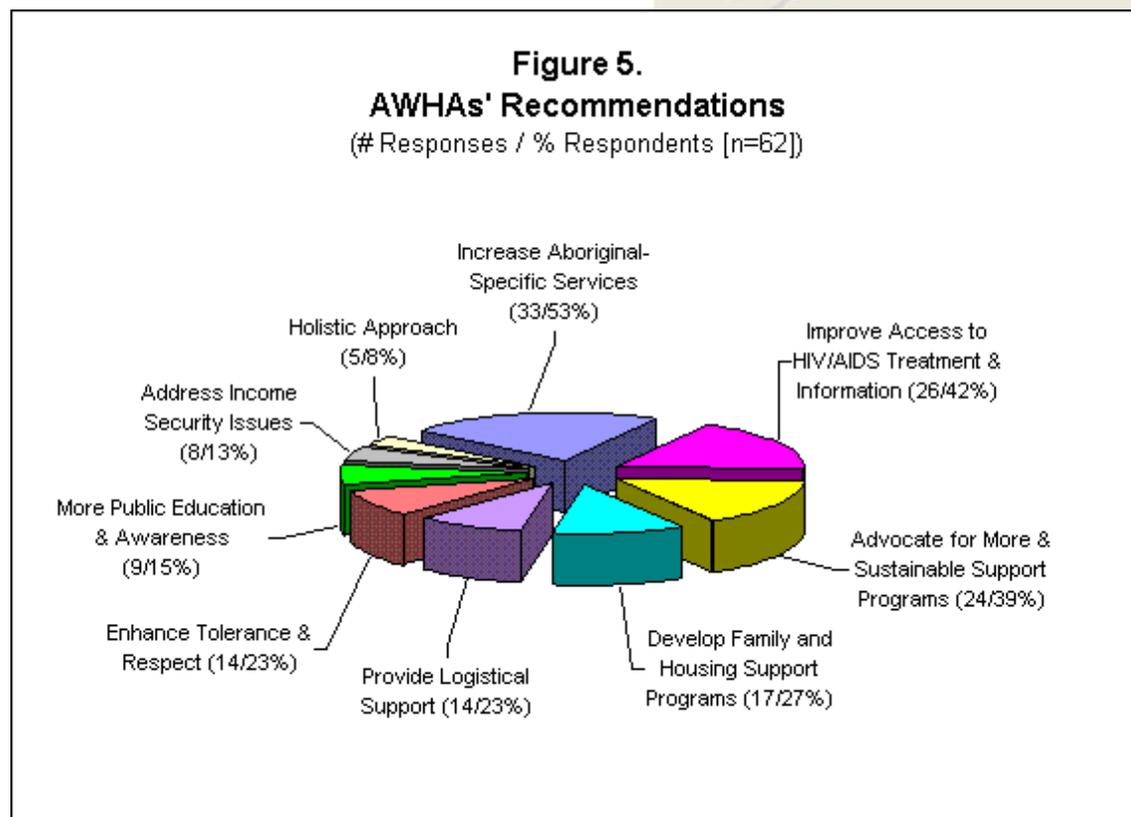
I would like to have help with childcare for appointments. Sometimes people do not qualify for daycare yet they do not have the supports in place. HIV programs should coordinate appointments better for children and parents, especially for out of town patients. [We need] relevant information for rural HIV+ people who are needing information on ASO's treatment and support.

AWHA Voices: “Best Ways to Improve Services”

Sixty-two (84%) of the women in CAAN's care, treatment and support survey provided recommendations, in their own words, on how best to improve HIV/AIDS related services (Figure 5).

| AWHAs' Recommendations | Count |
|--|-------|
| Increase Aboriginal-Specific Services | 33 |
| Improve Access to HIV/AIDS Treatment & Information | 26 |
| Advocate for More & Sustainable Support Programs | 24 |
| Develop Family and Housing Support Programs | 17 |
| Provide Logistical Support | 14 |
| Enhance Tolerance & Respect | 14 |
| More Public Education & Awareness | 9 |
| Address Income Security Issues | 8 |
| Holistic Approach | 5 |





In general, the three most frequent types of recommendations made by AWHAs are consistent with those made by the APHA study group as a whole:

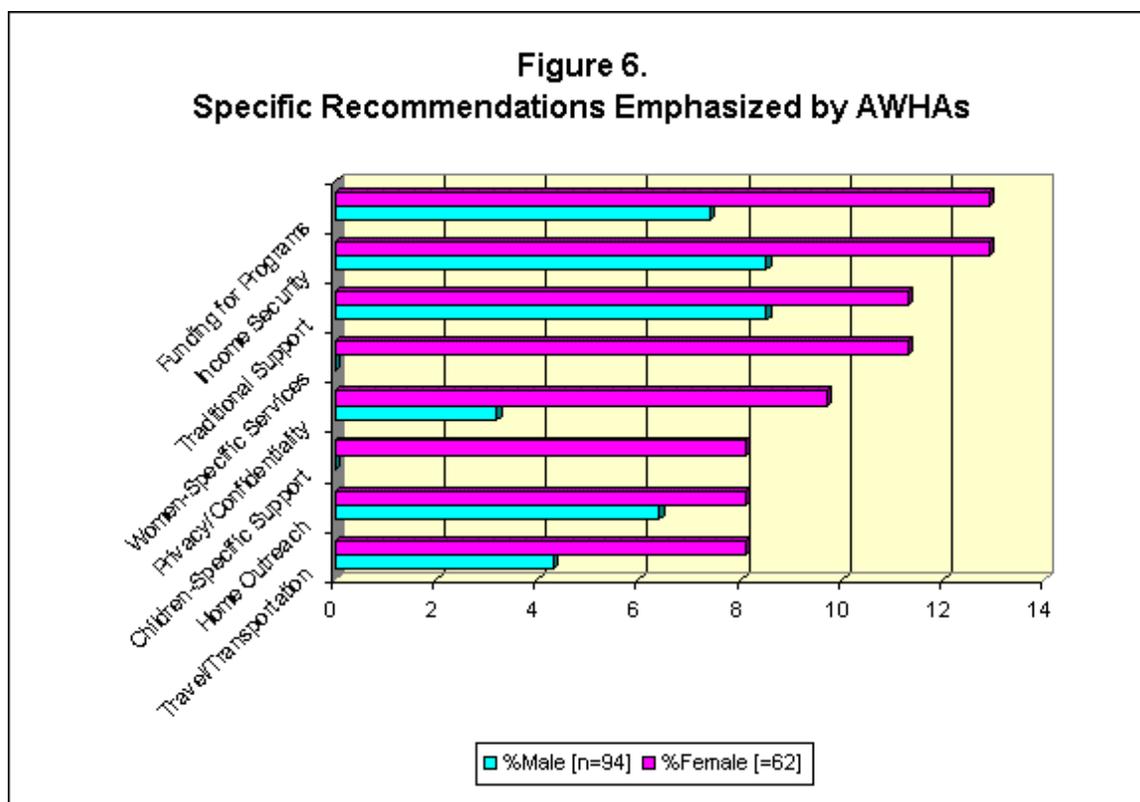
Aboriginal-Specific Services: Although APHAs generally call for more Aboriginal services, especially front-line workers at ASOs, clinics, and drop-ins, including first-language services, it is women who lead the demand for a traditional support system, including resident Elders at Health Centres and ASOs, healing and talking circles, and country food (11.3% Female vs. 8.5% Male APHAs; see Figure 6). Support services are needed on Reserves, in rural/isolated communities, and in towns/suburbs distant from large urban centres, and support services should generally become more HIV+ client-based.

Sustainable Support Services: AWHAs join in the call for more sustainable support services and programs, for example, drop-ins, counselling, group and peer sessions. However, women most frequently commented on the need for increased, sustainable, and accountable funding for support services (12.9% Female vs. 7.4% Male APHAs; see Figure 6).

HIV/AIDS Treatment and Information: Female and male APHAs equally request and recommend more information about HIV/AIDS generally, and about medications and treatment specifically, that is written and presented for audiences at various literacy-levels. AWHAs point to the need for more doctors; faster/easier access to both existing and new treatments and medications (including medical marijuana); coverage for medications, and; informed options of treatment. Like most if not all APHAs, women express their hope for a cure for AIDS.

In the areas of family and housing support, logistical access support and income security, women lead the call for improvements to services (Figure 6).

| APHAs' Key Recommendations | %Male [n=94] | %Female [=62] |
|----------------------------|--------------|---------------|
| Travel/Transportation | 4.3 | 8.1 |
| Home Outreach | 6.4 | 8.1 |
| Children-Specific Support | 0 | 8.1 |
| Privacy/Confidentiality | 3.2 | 9.7 |
| Women-Specific Services | 0 | 11.3 |
| Traditional Support | 8.5 | 11.3 |
| Income Security | 8.5 | 12.9 |
| Funding for Programs | 7.4 | 12.9 |



In addition to women's emphasis on the need for a traditional support system and program funding mentioned above, AWHAs specifically highlight the following "best ways to improve services":

Income security (12.9% Female vs. 8.5% Male APHAs): AWHAs more frequently express concerns about personal financial matters such as expenses associated with living with HIV/AIDS.

Women-specific services (11.3% Female vs. 0.0% Male APHAs): AWHAs solely made recommendations for services aimed specifically at women living with HIV/AIDS.

Enhance privacy and confidentiality (9.7% Female vs. 3.2% Male APHAs): The majority of comments about an ongoing need for services that can ensure confidentiality were made by AWHAs. Women remarked on the need for services that provide trustworthy, private and/or anonymous counselling.

Children-specific services (8.1% Female vs. 0.0% Male APHAs): Only AWHAs specifically called for services aimed at children who belong to families living with HIV/AIDS, suggesting, for example, that day-care services be provided at ASOs and local health clinics.

Travel/transport assistance (8.1% Female vs. 4.3% Male APHAs): It appears that more women than men have problems with travel and transportation, either to visit distant home communities or to get to medical appointments and treatment or support services in their local area.

Home outreach services (8.1% Female vs. 6.4% Male APHAs): On average, AWHAs more frequently recommended that outreach programs be developed that would allow them to receive care at home and/or to be contacted at home on a regular basis (eg., health check).

Addressing the Service Needs of AWHAs

CAAN joins the call of Aboriginal women with HIV/AIDS who have become vocal advocates for improved services, by recommending the following action plan:

- Develop a “good practices approach” aimed at the specific program needs of Aboriginal women living with HIV/AIDS.
- Conduct follow-up research to the national APHA survey, focussing on women’s issues.

“Good practices approach” to AWA programs: There is a need to document the “good practices” currently being implemented for Aboriginal women with HIV/AIDS across Canada, and to compile a list of possible solutions to AWA service needs such as: travel and transportation assistance; child-care services at ASOs and clinics; HIV/AIDS information and family planning counselling for women of child-bearing age, and; networking with other AWHAs.

A first step toward developing a set of “good practices” for AWA programs is to conduct an ASO/Social Agency environmental scan and/or focus group project. Key participants should include Aboriginal women currently involved in community-based AIDS Service Organizations across Canada. As well, because AWHAs have specific concerns related to family services, housing and income security, participation should also be solicited from among social workers and related agencies where AWHAs are clients. Such an ASO/Social Agency project would frame AWA issues from a service provision perspective, and provide valuable administrative and logistical information needed to frame practical recommendations for the development of AWA-specific programming.

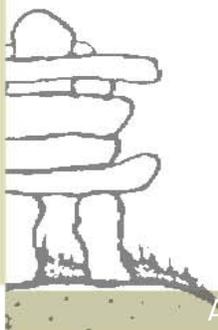
Consistent with CAAN’s “good practices approach,” AWA program recommendations must be “open, inclusive and flexible” in order to meet a variety of cultural and community contexts (CAAN 2004b:5).

Research focus on AWA-specific issues: A survey that targets Aboriginal women with HIV/AIDS from all regions and representing all Aboriginal culture groups in Canada, should focus on gender differences revealed through CAAN's national APHA survey. The objective of this survey should be to elicit a fuller understanding of the nature and scope of the women-specific issues identified in this position paper.

Based on the results of the AWA survey, a purely qualitative study should focus on the lived experiences of Aboriginal women as they seek out and access care, treatment and support related to HIV/AIDS. In-depth interviews should focus particularly on narratives of everyday life and circumstances which prevent full access to needed services, and which women perceive as "personal barriers" to those services. These narratives may in fact reveal commonalities among AWAs that can be addressed at a systemic, service provision level.

Position Statement

Our findings indicate the need to reduce barriers to care, treatment and support specific to Aboriginal women living with HIV/AIDS. Policy and practice must attend not only to cultural competency, but also to gender differences as these relate to HIV/AIDS service provision. The position of the Canadian Aboriginal AIDS Network on this point is to mount a strong and forceful advocacy campaign for appropriate allocation of funding to account for Aboriginal women's concerns under the newly announced Federal Initiative on HIV/AIDS in Canada.



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APPENDIX A: TABLES

Table 1. Use/Need Traditional Medicines * Gender (Cross-tabulation)

| Traditional Medicines | | | Gender (Male/Female)* | | Total |
|-----------------------|-----------------|-----------------|-----------------------|--------|-------|
| | | | Male | Female | |
| Traditional Medicines | No | Count | 73 | 58 | 131 |
| | | % within Gender | 64.6% | 78.4% | 70.1% |
| | Yes | Count | 40 | 16 | 56 |
| | | % within Gender | 35.4% | 21.6% | 29.9% |
| Total | Count | 113 | 74 | 187 | |
| | % within Gender | 100.0% | 100.0% | 100.0% | |

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 2 (28.6%) participants indicate they need/use traditional medicines; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

| | Value | df | Asymp. Sig. | | |
|------------------------------------|--------------------|-----|-------------|------|------|
| (2-sided) Exact Sig. | | | | | |
| (2-sided) Exact Sig. | | | | | |
| (1-sided) | | | | | |
| Pearson Chi-Square | 4.046 ^b | 1 | .044 | | |
| Continuity Correction ^a | 3.415 | 1 | .065 | | |
| Likelihood Ratio | 4.154 | 1 | .042 | | |
| Fisher's Exact Test | | | | .051 | .031 |
| Linear-by-Linear Association | 4.024 | 1 | .045 | | |
| N of Valid Cases | | 187 | | | |

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 22.16.

Table 2. Needs Met by Traditional Medicines * Gender (Cross-tabulation)

| Traditional Medicine | Needs Met | | Gender (Male/Female)* | | Total |
|----------------------|------------------------------|-----------------|-----------------------|--------|-------|
| | | | Male | Female | |
| Traditional Medicine | Did meet needs | Count | 27 | 6 | 33 |
| | | % within Gender | 67.5% | 37.5% | 58.9% |
| | Sometimes/Did not meet needs | Count | 13 | 10 | 23 |
| | | % within Gender | 32.5% | 62.5% | 41.1% |
| Total | Count | 40 | 16 | 56 | |
| | % within Gender | 100.0% | 100.0% | 100.0% | |

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 1 participant indicated their needs were not met by traditional medicines; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

| | Value | df | Asymp. Sig. | |
|------------------------------------|--------------------|----|-------------|------|
| Sig. (2-sided) | Exact Sig. | | | |
| (2-sided) | Exact Sig. | | | |
| (1-sided) | | | | |
| Pearson Chi-Square | 4.250 ^b | 1 | .039 | |
| Continuity Correction ^a | 3.101 | 1 | .078 | |
| Likelihood Ratio | 4.221 | 1 | .040 | |
| Fisher's Exact Test | | | .070 | .040 |
| Linear-by-Linear Association | 4.174 | 1 | .041 | |
| N of Valid Cases | 56 | | | |

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.57.

Table 3. Use/Need of Emergency * Gender (Cross-tabulation)

| Emergency | No | Count | Gender (Male/Female)* | | Total |
|-----------|-----|-----------------|-----------------------|--------|--------|
| | | | Male | Female | |
| | | 51 | 24 | | 75 |
| | | % within Gender | 45.1% | 32.4% | 40.1% |
| | Yes | Count | 62 | 50 | 112 |
| | | % within Gender | 54.9% | 67.6% | 59.9% |
| Total | | Count | 113 | 74 | 187 |
| | | % within Gender | 100.0% | 100.0% | 100.0% |

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 4 (57.1%) participants indicate they need/use emergency services; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

| | Value | df | Asymp. Sig. | |
|------------------------------------|--------------------|----|-------------|------|
| (2-sided) | Exact Sig. | | | |
| (2-sided) | Exact Sig. | | | |
| (1-sided) | | | | |
| Pearson Chi-Square | 3.003 ^b | 1 | .083 | |
| Continuity Correction ^a | 2.497 | 1 | .114 | |
| Likelihood Ratio | 3.036 | 1 | .081 | |
| Fisher's Exact Test | | | .095 | .056 |
| Linear-by-Linear Association | 2.987 | 1 | .084 | |
| N of Valid Cases | 187 | | | |

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 29.68.

Table 4. Use/Need of Local Health Clinic * Gender (Cross-tabulation)

| | | | Gender (Male/Female)* | | Total |
|---------------------|-----|-----------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Local Health Clinic | No | Count | 70 | 36 | 106 |
| | | % within Gender | 61.9% | 48.6% | 56.7% |
| | Yes | Count | 43 | 38 | 81 |
| | | % within Gender | 38.1% | 51.4% | 43.3% |
| Total | | Count | 113 | 74 | 187 |
| | | % within Gender | 100.0% | 100.0% | 100.0% |

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 2 (28.6%) participants indicate they need/use local health clinics; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

| | Value | df | Asymp. Sig. | | |
|------------------------------------|--------------------|----|-------------|------|------|
| (2-sided) Exact Sig. | | | | | |
| (2-sided) Exact Sig. | | | | | |
| (1-sided) | | | | | |
| Pearson Chi-Square | 3.221 ^b | 1 | .073 | | |
| Continuity Correction ^a | 2.702 | 1 | .100 | | |
| Likelihood Ratio | 3.216 | 1 | .073 | | |
| Fisher's Exact Test | | | | .097 | .050 |
| Linear-by-Linear Association | 3.203 | 1 | .073 | | |
| N of Valid Cases | 187 | | | | |

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 32.05.

Table 5. Child Care * Gender (Cross-tabulation)

| | | | Gender | | | Total |
|------------|-----|-----------------|--------|--------|---------------|--------|
| | | | Male | Female | Trans-gender; | |
| Child Care | No | Count | 112 | 61 | 6 | 179 |
| | | % within Gender | 99.1% | 82.4% | 85.7% | 92.3% |
| | Yes | Count | 1 | 13 | 1 | 15 |
| | | % within Gender | .9% | 17.6% | 14.3% | 7.7% |
| Total | | Count | 113 | 74 | 7 | 194 |
| | | % within Gender | 100.0% | 100.0% | 100.0% | 100.0% |

Chi-Square Tests

| | Value | df | Asymp. Sig. (2-sided) |
|------------------------------|---------------------|----|-----------------------|
| Pearson Chi-Square | 17.882 ^a | 2 | .000 |
| Likelihood Ratio | 19.629 | 2 | .000 |
| Linear-by-Linear Association | 15.088 | 1 | .000 |
| N of Valid Cases | 194 | | |

a 1 cells (16.7%) have expected count less than 5. The minimum expected count is .54.

Table 6. Family Planning Programs * Gender (Cross-tabulation)

| | | Male | Female | Gender Trans-gender; | Total | |
|------------------------------|-----|-----------------|--------|----------------------|--------|--------|
| Trans-sexual; Inter-sexed | | | | | | |
| Family Planning | No | Count | 112 | 62 | 6 | 180 |
| | | % within Gender | 99.1% | 83.8% | 85.7% | 92.8% |
| | Yes | Count | 1 | 12 | 1 | 14 |
| | | % within Gender | .9% | 16.2% | 14.3% | 7.2% |
| Total | | Count | 113 | 74 | 7 | 194 |
| | | % within Gender | 100.0% | 100.0% | 100.0% | 100.0% |

Chi-Square Tests

| | Value | df | Asymp. Sig. (2-sided) |
|------------------------------|---------------------|----|-----------------------|
| Pearson Chi-Square | 16.239 ^a | 2 | .000 |
| Likelihood Ratio | 17.784 | 2 | .000 |
| Linear-by-Linear Association | 14.004 | 1 | .000 |
| N of Valid Cases | 194 | | |

a 1 cells (16.7%) have expected count less than 5. The minimum expected count is .51.

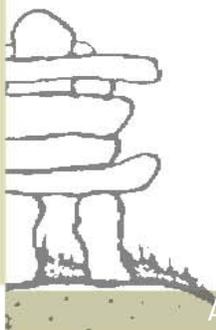


Table 7. Parenting Skills Programs * Gender (Cross-tabulation)

| | | Male | Female | Gender Trans-gender; | Total | |
|------------------------------|-----------------|-----------------|--------|-------------------------|--------|-------|
| Trans-sexual; Inter-sexed | | | | | | |
| Parenting Skills | No | Count | 110 | 60 | 6 | 176 |
| | | % within Gender | 97.3% | 81.1% | 85.7% | 90.7% |
| | Yes | Count | 3 | 14 | 1 | 18 |
| | | % within Gender | 2.7% | 18.9% | 14.3% | 9.3% |
| Total | Count | 113 | 74 | 7 | 194 | |
| | % within Gender | 100.0% | 100.0% | 100.0% | 100.0% | |

Chi-Square Tests

| | Value | df | Asymp. Sig. (2-sided) |
|------------------------------|---------------------|----|-----------------------|
| Pearson Chi-Square | 14.269 ^a | 2 | .001 |
| Likelihood Ratio | 14.645 | 2 | .001 |
| Linear-by-Linear Association | 11.687 | 1 | .001 |
| N of Valid Cases | 194 | | |

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is .65.

Table 8. Use/Need of Marijuana for Medical Purposes * Gender (Cross-tabulation)

| | | Gender (Male/Female)* | | Total | |
|-----------|-----------------|-----------------------|--------|--------|-------|
| | | Male | Female | | |
| Marijuana | No | Count | 66 | 54 | 120 |
| | | % within Gender | 58.4% | 73.0% | 64.2% |
| | Yes | Count | 47 | 20 | 67 |
| | | % within Gender | 41.6% | 27.0% | 35.8% |
| Total | Count | 113 | 74 | 187 | |
| | % within Gender | 100.0% | 100.0% | 100.0% | |

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 3 (42.9%) participants indicate they need/use marijuana for medical purposes; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

| | Value | df | Asymp. Sig. | |
|------------------------------------|--------------------|----|-------------|------|
| (2-sided) Exact | | | | |
| Sig. (2-sided) | Exact | | | |
| Sig. (1-sided) | | | | |
| Pearson Chi-Square | 4.126 ^b | 1 | .042 | |
| Continuity Correction ^a | 3.517 | 1 | .061 | |
| Likelihood Ratio | 4.204 | 1 | .040 | |
| Fisher's Exact Test | | | .044 | .030 |
| Linear-by-Linear Association | 4.104 | 1 | .043 | |
| N of Valid Cases | 187 | | | |

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 26.51.

Table 9. Needs Met by Marijuana for Medical Purposes * Gender (Cross-tabulation)

| | | | Gender (Male/Female)* | | Total |
|------------|--------------------|-----------------|-----------------------|--------|--------|
| | | | Male | Female | |
| Marijuana | | | | | |
| Needs Met | Did meet needs | Count | 25 | 15 | 40 |
| | | % within Gender | 61.0% | 88.2% | 69.0% |
| Sometimes/ | Did not meet needs | Count | 2 | 18 | |
| | | % within Gender | 39.0% | 11.8% | 31.0% |
| Total | | Count | 41 | 17 | 58 |
| | | % within Gender | 100.0% | 100.0% | 100.0% |

* Among trans-gender, trans-sexual and inter-sexed APHAs [n=7], 1 participant indicates their needs were not met by marijuana for medical purposes; however, when factored into Chi-Square analysis, results are not significant.

Chi-Square Tests

| | Value | df | Asymp. Sig. | |
|------------------------------------|--------------------|----|-------------|------|
| (2-sided) Exact | | | | |
| Sig. (2-sided) | Exact | | | |
| Sig. (1-sided) | | | | |
| Pearson Chi-Square | 4.172 ^b | 1 | .041 | |
| Continuity Correction ^a | 2.996 | 1 | .083 | |
| Likelihood Ratio | 4.686 | 1 | .030 | |
| Fisher's Exact Test | | | .061 | .037 |
| Linear-by-Linear Association | 4.100 | 1 | .043 | |
| N of Valid Cases | 58 | | | |

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.28.