



SIDA|AIDS Moncton Inc.
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The Views of Women and Their Experiences Concerning HIV/AIDS

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INTRODUCTION

Studies show that HIV/AIDS is by no means a minor issue. In late 1999, from 45,000 to 53,000 Canadians were living with HIV.¹ In the mid 1980s, studies showed that approximately 95 percent of persons with the virus were men who had sex with other men. Moreover, the virus is now spreading more and more among heterosexuals and IV drug users who share syringes, to the point where in recent years the number of women in Canada with AIDS has been constantly rising. Across the world, women comprise 47% of persons living with HIV (UNAIDS, 2000).

"The proportion of all AIDS cases that were diagnosed in women before 1990 was 6.2%; between 1990 and 1995, it was 6.9%, and in 1996, 10.6%."² The mortality rate associated with HIV/AIDS in women between 24 and 44 years of age increased from 0.4 / 100,000 in 1987 to 1.0 / 100,000 in 1994 (Hogg et. al., 1997). Until the year 2000, 1,330 cases of AIDS and 5,419 cases of HIV had been diagnosed in Canadian women. Among the reported cases of AIDS in women, 66.9% were attributed to heterosexual sex and 22.8% to IV drug use (Health Canada, 2000).

To prevent HIV infection among women, it is vital to understand the structural, community and individual factors that make women vulnerable to the risk of HIV (Gillis, 1999). Research on HIV has primarily focused on men, and we know little about HIV prevention for women (Bury, 1994; Gillis, 1999). Moreover, since 1999, research on HIV and women has been growing.

In order to develop effective strategies to help women with AIDS and prevent the virus, SIDA/AIDS Moncton and a researcher from the Université de Moncton developed a two-part research action project. The first phase, funded by Health Canada, is entitled *Empowering Ourselves to Address Women and HIV/AIDS Issues*. It ran from November 2001 to March 2002. The purpose of this phase of the research was to offer a series of training workshops on action research to community stakeholders (Elizabeth Fry Society, Carrefour pour femmes; Hepatitis C Society, Salvation Army, New Life Mission; Nazareth House; and Harvest House) whose clientele was likely to include women at risk of a sexually-transmitted disease, to allow them to actively participate in the second phase of the research program. These workshops are offered in collaboration with Dr. William Morrison & Associates.

This report presents the findings of the second phase of the research. The general objective of this second phase is to identify the needs of women at risk of HIV.

¹ Health Canada, [http : //www.service vie. Com/02Sante/Dossier/Dossier291201200/dossier29012001j.html](http://www.service.vie.Com/02Sante/Dossier/Dossier291201200/dossier29012001j.html).

² http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/1997/1997_66bk3_e.html.

The more specific objectives were to:

- ❖ Evaluate the level of knowledge among women with HIV/AIDS
- ❖ Identify unsafe practices among women
- ❖ Determine whether women perceive themselves as persons at risk
- ❖ Explore the sexual health practices of women
- ❖ Explore the experiences of women in terms of how they use sexual health and HIV/AIDS prevention services
- ❖ Identify the services required to prevent HIV among women

The research team consisted of a university researcher and SIDA/AIDS Moncton workers, namely, the Director, a worker, a volunteer and a trainee. These team members collaborated throughout the research process.

The first chapter contains a compendium of writings on women and HIV / AIDS. The historical events that shaped the HIV/AIDS epidemic are described in this first section, along with a profile of women at greater risk of HIV. This first section also addresses the connection between sex and the spread of HIV/AIDS. The second chapter describes the research methodology used. We briefly describe the population under review, the sample, the data gathering strategy and tools and the research questionnaire. This second part also describes the data analysis process and the respondent profile. It also touches on ethical aspects of the research. The third chapter focuses on the research findings. In particular, we address what participants in the study said or thought about unsafe practices and characteristics, their basic knowledge of HIV/AIDS, their perceptions of the risk, their sexual health practices and their knowledge of and access to HIV/AIDS prevention services. Lastly, the final chapter launches a discussion based on this research, and presents a few possible courses of action.

LITTERATURE REVIEW

This literature review has been written at the request of SIDA/AIDS Moncton as part of a project entitled *Empowering ourselves to address women and HIV/AIDS issues*. Partners in this project include the University of Moncton, the Elizabeth Fry Society, the Salvation Army, Crossroads for Women, New Life Mission, Harvest House, Family Services, Addiction Services, Victim Services, and the House of Nazareth. The objective of this project is to enhance the capacity of women at greater risk of acquiring HIV as well as organizations which serve women to engage in community-based research. It is anticipated this community-based research will do the following: assess women's knowledge of risk factors, determine if targeted populations view themselves as being at risk for acquiring an HIV infection and identify the services or programs which may be helpful to women at high risk of acquiring an HIV infection.

Understanding the structural, community, and individual factors which leave women vulnerable to HIV infection is crucial in preventing HIV infection in Canadian women (Gillis, 1999). To date HIV prevention research has focused primarily on men and research which concentrates mainly on women has lagged behind (Bury, 1994; Gillis, 1999). This is despite the fact that women make up 47% of those adults living with HIV worldwide (UNAIDS, 2000). Nicholas (1996) notes that until recently women have not been visible within the epidemic. This situation is slowly improving and since 1999 research related to women and HIV has increased (Sherr, Hankins, and, Bennett 1998). Roth and Hogan (1998, p.xv) term this an "explosion" and note that Cindy Patton indicates in the past five years a new visibility of "woman" has occurred in discussions about HIV infection. As one important strategy in prevention we must ensure this continues and that women remain visible within the epidemic. Treichler and Warren (1998) caution that in democratic, wealthy, and technologically sophisticated countries for women to still be able to contract a deadly virus when knowledge exists to prevent this from happening suggests that "many sites of silence are implicated" and "many points of intervention have failed" (p. 110).

Fennegan, Davenny, and Hartel (1993) note that gender differences have been ignored in most research related to women and HIV. Mulvihill (1998) concurs with this and following a community consultation in Ontario noted that a lack of gender analysis is apparent in much of the research that does exist on women and HIV/AIDS.

The first section of this report focuses on the method used to carry out this literature review. The review itself contains the following sections: a description of the historical events which have shaped the HIV/AIDS epidemic, an overview of the current AIDS epidemic, a profile of women at higher risk of acquiring an HIV infection, and a discussion about how gender-related issues influence the HIV/AIDS epidemic. In the profile section information is included about best practices as well as recommendations for future community-based research. In addition a specific section of this literature review is devoted to harm reduction approaches as it is understood that injection drug use is playing a major role within the HIV/AIDS epidemic.

Method:

This selective literature review was carried out in order to develop increased understanding of women at greater risk of acquiring an HIV infection. Although the focus of the literature review was initially on the greater Moncton area of New Brunswick it was also necessary to review both national and international literature in order to develop a realistic picture of women at risk. The databases used in this literature review include the Cochrane Database of Systemic Reviews (3rd quarter 2001), Medline (1995 to present), ERIC (1995-2001), and the Mental Health Collection (1995-2001). I also searched through PsychoInfo, Sociological Abstracts, Dissertation Abstracts International and ASSIA. For pragmatic reasons not all of the literature acquired during the search are cited in this review. I have been selective in choosing articles that I believe will be most beneficial to those working in the HIV/AIDS movement in Atlantic Canada.

In addition, I have checked the web sites of the following organizations in order to ensure current literature is included: Health Canada, the Canadian AIDS Society, the Canadian HIV/AIDS Legal Network, the Canadian Centre on Substance Abuse, the Canadian Association of Elizabeth Fry Societies, the Canadian Aboriginal AIDS Network, the Canadian Treatment Information Exchange and New Brunswick Health.

Through my association with AIDS organizations within Atlantic Canada I have also accessed some of the "grey literature." Where appropriate I have included this information within the literature review. In addition the abstracts of the AIDS Impact Conference (2001) have been reviewed.

Historical events which have helped to shape the HIV/AIDS epidemic

In discussing the history of the AIDS epidemic it is important to remember there are not one but many epidemics both worldwide and within the Canadian context. In Canada, as in other developed countries the epidemiology of HIV can be described as "overlapping epidemics moving in waves through a series of different risk groups" (Blower et al, 1990, cited in Albert & Williams, 1998, p. 9). In this section of the paper I will focus not only on key events within Atlantic Canada but also on national and international events.

Significant Events

- 1978: A resident of Halifax becomes the first reported North American AIDS case (Lorway, "n.d").
- 1980: The first cases of unusual immune deficiency are identified among gay men in the United States. It is referred to as the "gay plague" and/or GRID (Lorway "n.d")
- 1982: Acquired Immune Deficiency Syndrome (AIDS) is defined for the first time. The following three modes of transmission are identified: blood transfusions, mother to child, and sexual intercourse (UNAIDS, 2001a).

- 1983: HIV is identified as the cause of AIDS (UNAIDS, 2001a). The first Canadian AIDS case is reported to the federal government (Lorway, "n.d.").
- 1983: American and French scientists discover the virus associated with AIDS. It is later called HIV (Human Immunodeficiency Virus) (Lorway, "n.d.").
- 1985: In the United States the Food and Drug Administration approve the first HIV antibody test (UNAIDS, 2001a) and HIV screening of blood begins. The Canadian Red Cross begins screening blood (Lorway, "n.d.").
- 1986: The Canadian AIDS Society has its first general meeting (Lorway, "n.d."). An international commission re-named HTLV-III/LAV and called it HIV (Grmek, 1990).
- 1987: The World Health Organization launches the Special Program on AIDS (UNAIDS, 1999a) The first therapy for AIDS, azidothymidine (AZT), is tried in the United States (UNAIDS 2001a). Africa's first community-based response to AIDS is formed in Uganda and becomes a role model for similar activities around the world (UNAIDS, 2001a)
- 1989. Phase one of the National AIDS Strategy is announced (Lorway, "n.d").
- 1990: The first Atlantic AIDS Network meeting is held (Lorway, "n.d.").
- 1992: Nova Scotia becomes the first place in the world to compensate persons secondarily infected through the blood system (Lorway, "n.d.").
- 1992: The first New Brunswick province wide needs assessment for HIV positive people is published. It is called *Meeting the challenge: A needs assessment of persons affected by HIV/AIDS in New Brunswick* (Olivier & Stanciu, 1999).
- 1993: Phase II of the National AIDS Strategy is announced (Lorway, "n.d.")
- 1994: An HIV breakout in Eastern Europe is detected among injection drug users (UNAIDS, 1999).
- 1995: 3TC a drug developed in Canada is approved for AIDS treatment (Lorway, "n.d.").UNAIDS is created (UNAIDS, 2001a). Protease Inhibitors were introduced.
- 1996: Brazil becomes the first developing country to provide antiretroviral therapy through it's public health system (UNAIDS, 2001a).
- 1996: The Atlantic Regional Treatment Information Project begins (Lorway, "n.d.").
- 1996: Evidence of the efficiency of Highly Active Antiretroviral Therapy (HAART) is produced for the first time (UNAIDS, 2001a).

- 1998: The Canadian Strategy on HIV/AIDS is announced. Funding for community-based AIDS Organizations becomes "A" based (Lorway, "n.d.").
- 1998: The first efficacy trial of an HIV vaccine begins in a developing country- Thailand (UNAIDS, 2001a).
- 1999: The UN Security Council discusses HIV/AIDS for the first time. (UNAIDS, 2001a)
- 2001: The UNGASS Declaration was unanimously adopted by the United Nations General Assembly (Elliot, 2001).

Box 1

Women Specific Events Influencing the HIV/AIDS Epidemic
<ul style="list-style-type: none"> • 1980: The first women with what would later be called AIDS is reported in the United States (Corea, 1992; Haddah, 1994) • 1982: AIDS gets its current name. No gynecological conditions are associated with this condition therefore women are often excluded from being diagnosed with AIDS due to the different symptoms they exhibit (Haddah, 1994). • 1981-1986: The total number of deaths for women in cities with a heavy concentration of AIDS continues at a staggering rates (Corea, 1992). • 1988: Young women continue to die of a variety of symptoms associated with an impaired immune system, however, only 86 women in Canada have met the formal criteria for a diagnosis of AIDS. • 1991: Announcement of the Women and AIDS project by Canadian government (Lorway, "n.d.") • 1993: A new definition of AIDS is conceptualized in the United States. The reworking of this definition made it possible for more women to qualify for insurance benefits (Corea, 1992). • 1997: A seroprevalence study among pregnant women in New Brunswick that was carried out between 1994-1996 is published. It indicates the HIV prevalence rate is 4.1 per 10,000 pregnant women during the study period (Getty, Leighton, Mureika, et al. 1997). • 1997: ACAP funds the third phase of the Women and AIDS project • 1997: A report <i>Sustainability in Atlantic Canada</i> is written and the difficulty accessing rural women for HIV/AIDS prevention/education is noted. • 2000: The first "Women and AIDS Conference" is held in Canada. • 2001: In New Brunswick the first retreat for HIV positive women is held.

Overview of the current AIDS Epidemic

International

Some of the factors which make people especially vulnerable to HIV include the following: under development, economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, sexual exploitation of women, girls, and boys (UNAIDS/WHO, 2001) and gender and sexual inequality (Gupta, 2000).

AIDS has been described as the most "devastating disease humankind has ever faced." (UNAIDS/WHO, 2001, p. 2). Worldwide it is the fourth biggest killer (UNAIDS/WHO, 2001). According to UNAIDS and the World Health Organization there are currently 40 million people world wide who live with the HIV/AIDS virus. Out of this total 17.6 million are women. In 2001, 1.1 million women died of AIDS worldwide and an additional 1.8 million women became newly infected with HIV (UNAIDS/WHO 2001). The Canadian International Development Agency (CIDA) (2000) reports that worldwide 3000 women a day contract the Human Immunodeficiency Virus (HIV) (CIDA, 2000).

National

Up to December 31, 2000, within Canada a total of 1330 AIDS cases and 5419 HIV cases have been reported in women. Currently heterosexual contact and injection drug use are the two major risk factors for HIV infection within women (Health Canada, 2001a). In addition women with high risk sexual partners are increasingly at risk of acquiring this virus (Health Canada, 2001a).

Of the cumulative AIDS cases reported in women 66.9% are attributed to heterosexual contact, 22.8% to injection drug use, and 10.1% to blood and blood products. (Health Canada, 2000). There has been a steady increase in the proportion of adult female AIDS cases attributed to injection drug use from 16.7% prior to 1995 to 34.6 % in 2000 (Health Canada, 2001a). While AIDS data contributes to an understanding of trends in HIV infection, it is only reflective of those infections acquired approximately 10 years in the past (Health Canada, 2001).

HIV test results provide a more current picture of the epidemic within Canada. Where age and gender are reported, women represent a growing proportion of those with positive HIV test results. For example, before 1995, 9.9% of all positive HIV tests were among women. Between 1995 and 2000 this proportion increased from 18.8% to 23.9%. The portion of women presenting with positive HIV tests varies considerably by age. It is highest among adolescents (51.5%) and young adults (40.8%) (Health Canada, 2001a).

It should be noted these statistics are reflective of only those who have come forward for testing. Those who present for testing and those who test positive for HIV are believed to represent only a portion of those who are HIV infected within Canada (Daley, 2001). In addition some underreporting of positive test results occur within Canada (Health Canada, 2001).

The following table provides a summary of positive HIV tests among women in Canada for the years between 1985 and 2000. It also provides a breakdown according to category of exposure.

Table 1: Proportion of Positive HIV Tests Among Adult Females by Exposure Category and Year of Test, Canada

Year	Exposure Category		
	Heterosexual Contact	IDU	Blood & Blood Products
1985-94	49.1	31.9	12.4
1995	35.5	53.6	3.7
1996	43.6	51.0	1.3
1997	45.7	45.0	1.4
1998	52.8	38.5	3.7
1999	48.4	47.5	1.1
2000	55.9	38.5	1.7
TOTAL	47.5	40.2	6.4

Source: Bureau of HIV/AIDS, STD and TB, Centre for Infectious Disease Prevention and Control, Health Canada, May 2001

New Brunswick Health also provides the following information regarding the prevalence of HIV and AIDS within the province of New Brunswick.

Table 2: Distribution of reported cases of HIV and AIDS in New Brunswick, by age group and gender, 1985 to 2000 (Provincial Epidemiology Service: HIV and AIDS in New Brunswick)

Age Group	HIV		AIDS	
	Male	Female	Male	Female
under 15	7	1	2	1
15-19	15	2	5	0
20-29	74	13	19	4
30-39	110	7	48	2
40-49	55	6	43	4
50+	8	3	17	4
Total	269	32	134 Living: 46 Deceased: 88	15 Living: 6 Deceased: 9

The following table identifies risk factors within New Brunswick among those women and men who have already tested positive for HIV.

Table 3:
Distribution of risk factors* by gender among the HIV cases reported in New Brunswick, 1985 to 2000

Risk Factor	Male	Female	Total
Sexual relations with men	168	31	199
Sexual relations with women	115	1	116
Sexual relations with men and women	56	1	57
Use needles for self-injection of drugs	39	6	45
Received blood products	50	2	52
Received transfusion	19	6	25
Work in a health care setting	12	0	12
Maternal-Fetal Transmission	0	1	1
Other Exposure(s)	12	3	15
Provincial Epidemiology Service: HIV and AIDS in New Brunswick			
Note: *All risk factors for any one case are reported; one person may have more than one risk factor identified.			

Profile of women at risk of acquiring HIV/AIDS

It is important to note that although this section of the literature review provides a profile of groups of people who may be considered at high risk of acquiring an HIV infection, it is high-risk practices not being a member of a target group which places one at risk of acquiring an HIV infection (Young, 2000). Bury (1994) makes this point succinctly when she comments "we are put at risk by what we do, not by how we define ourselves or who we are (p. 18).

Injection drug users

Statistics exist about the prevalence of HIV seropositivity among drug users but it is difficult to have a real sense of how accurate these figures are due to the illegal nature of most injection drug use and to the extreme heterogeneity of the group (Brown, 1998, UNAIDS 2000). Injection drug users are one of the most difficult groups to access and tend to experience low socio-economic status (Coleman & Ford, 1996). However, despite this, throughout the world and within Canada injection drug use is considered a major risk factor for acquiring HIV.

In Canada around 125,000 people inject drugs (Canadian HIV/AIDS Legal Network, "n.d."). In studies of injection drug users in Canada a third or more of the participants of both sexes indicated they had exchanged sex for drugs on at least one occasion (UNAIDS, 2000). In Canada the proportion of AIDS cases attributed to injection drug use has increased from 8.3% in 1995 to 21.7 % in 2000.

Within Canada marijuana and hashish are the most common illegal drugs used by women. Illegal use of drugs decreases with age and with the exception of marijuana is almost non-existent after the age of forty-five (Currie, 2001; Hewitt, Vinje, & Macneil, 1995). Cocaine, crack, heroin, and LSD are primarily used by street-involved women. In Canada in 1995, 804 people are known to have died due to illegal drug use. Of these people one hundred and eight or 13% were women (Currie, 2001).

Drug injection exposes both those who inject drugs and their partners to HIV. Both American and British studies suggest that the majority of women who have male injection drug users for partners do not use drugs, however, they are still greatly at risk for acquiring HIV (DesJarlais, 1984). In addition, they have less access to prevention education than injection drug users. One reason for this is that they tend not to get involved with either treatment centers or correctional facilities (Campbell, 1990).

Female partners of drug users are at high-risk for both violence and sexual assault (Gillis, 1999) thus making them more vulnerable to HIV. An American study of 2800 women who had male IDU partners reported that:

- More than a third of the women had lived through childhood sexual abuse;
- Almost half reported adult physical violence;
- One-third had experienced forced sex with a primary partner; and
- More than a third had experienced teenage sexual abuse (Weissman and Brown, 1995, cited in Gillis, 1999, p. 50).

It is extremely important to understand how both networks and personal relationships influence women's drug use behaviors. For example, both international literature (Brimlow & Ross, 1998) and Canadian studies (Leonard, Hotz, & Hansen, 1998) suggest that women tend to obtain their injection equipment from steady partners and that they are more likely to share injection equipment with their steady partner than with other individuals. In contrast men are more likely to inject with friends and acquaintances. If sharing in a relationship is valued this may prevent the women from suggesting that she is no longer comfortable with this practice (Gillis, 1999). In addition because many women start to inject earlier in life than men they may never have developed the assertiveness skills required to negotiate safer injection patterns. Refusal to share a needle with someone may be viewed as a breach of trust (Brimlow and Ross 1998).

A women who uses drugs may be dependent upon her partner for both her drugs and her economic survival (Gillis, 1999). Therefore prevention programs which do not consider the importance of maintaining relationships may be quite ineffective.

HIV risk behaviors vary greatly among IDUs. This may be due to how IDUs are grouped into social networks (Hoffman, Su, & Pach, 1997). A greater movement of people into the network is associated with more risky behaviors occurring. This can be explained in that network members who have few resources may have to move around more frequently in order to have access to drug supplies. Because they lack resources they may find it necessary to share needles and other supplies (Hoffman, Su, & Pach, 1997).

Women injection drug users tend to experience varying degrees of stigma depending upon a variety of factors including whether or not they are pregnant and the socioeconomic class to which they belong. According to Goode (1984) there are many ceremonies involved in the labelling process such as being arrested or being admitted to a treatment center or a jail. Interestingly there are no ceremonies which destigmatize the person should they choose to stop the behavior which is perceived to be deviant.

Two ideas which are often associated with women injection drug users are as follows: they are getting what they deserve or they are being punished for past actions. These two notions may be directly related to the Western idea that individuals are master's of their own destiny or that in some way the epidemic is controllable and people can avoid infection by following certain rules (Green and Sobo, 2000).

Both American and British research has shown that drug use is more stigmatizing for women than men (Rosenbaum & Murphy, 1990). Women who use drugs are also more likely to have partners who are involved in the use of illegal drugs than are men who use drugs (Barnard, 1993). The social marginalization and the daily risks which may be associated with injection drug use may make the longer term risks of HIV infection a low priority for many women who inject drugs (Gillis, 1999).

Women substance uses are often doubly stigmatized. There are extremely negative stereotypes associated with being a women and an injection drug user. One of these stereotypes includes the notion that female injection drug users are sexually promiscuous. They may also be perceived to be unfit mothers (Paone & Alperen, 1998) and immoral criminals.

Currie (2001) notes that within Canada key experts who were interviewed indicated that a major barrier to treatment among injection drug users was a "high degree of stigmatization by society, other clients and staff" (p. 18). In addition women who inject drugs are highly stigmatized within the drug culture. They are perceived as the "lowest" (p.18) in the drug-using hierarchy by other drug users because of their lifestyles and other risk-taking behaviors. In this same study women living with HIV also identified stigma as one barrier to seeking treatment.

Sussey (2000) in the document *Regional realities: HIV/AIDS prevention education priority issues in Atlantic Canada* notes that the long-standing myths about "risk groups" and injection drug users is a barrier to carrying out effective HIV/AIDS prevention education in this area.

Because varying substances impact on sexual functioning in different ways (Currie, 2001) the association between acquiring an HIV infection and using substances may differ slightly depending upon what type of drug is being used. For example, Grandy (1995) notes that many crack addicts have psychotic obsessions that may be sexual in nature. In some instances these obsessions involve multiple partners without condoms.

This situation is often exacerbated because addicted young people may become involved in these situations in order to exchange sex for drugs.

Crack users may be more at risk of acquiring HIV than a variety of other drug users. This is at least partially due to the highly addictive nature of crack and the need for frequent fixes (Gillis, 1999). Crack use heightens feelings of invincibility while at the same time heightening sexual pleasure (Nadeau, 1994). Crack use among women has been associated with high-risk sexual behaviors such as multiple partners, exchanging sex for money or drugs and unprotected vaginal or anal sex (Amaro, 1995).

Chronic crack use creates sexual dysfunction thus decreasing the chances that a condom will be used as desensitization is already present (Nadeau, 1994). Crack users may also have more STDs (Fullilove, Fullilove, Boswer, and Gross, 1990) than non-users which also places them at a greater risk of acquiring HIV than women who use other types of drugs (Rofls, Goldberg, & Sharrar, 1990). Cocaine addicts may require as many as twenty injections a day whereas most heroin addicts require only four injections a day (Watershed Writing and Research, "n.d."). This has direct implications for the level of risk people are exposed to while using their drug of choice.

Women who frequently use opiates may experience the cessation of menstruation and as a result eliminate contraceptive methods such as condom use. This may place the woman at increased risk of STDs which may in turn increase her chances of becoming HIV positive (Ralph & Spinger, 1986).

The literature on whether or not the use of recreational drugs causes lasting damage to the immune system is unclear (Alcorn, 1999). Some studies among HIV positive drug users suggest that those who continue to inject heroin develop AIDS faster than those who give up drugs or those who inject other drugs (Ronald, 1994). This study is not specific to women drug users. However other studies claim that little convincing evidence exists that drug injection is harmful to the outcome of HIV infection (Phillips, 1994)

One approach which has proven beneficial in many parts of the world in trying to control the HIV/AIDS epidemic among both female and male IDUs is based upon the principles of harm reduction. This will be discussed in greater detail later, in the section of the paper called information about best practices.

The following box highlights some of the information identified in a recent study by Health Canada. One of the reasons this project was carried out was to develop a baseline profile about injection drug use across the four Atlantic provinces. The information from this study is based on the responses of 77 participants.

Box 2

- A variety of injection drugs are being used by Atlantic Canadians but respondents identified opiates (82%) and cocaine /crack (77%) as the most commonly used drugs in the area.
- Dilaudid is more popular in NB and NS than in PEI and Nfld.
- Alcohol abuse tends to happen in conjunction with injection of prescription drugs.
- Crack house and shooting galleries are common in certain parts of NB and NS including Halifax, Fredericton, Saint John, Sydney, and Glace Bay
- The incidence of drug use is increasing in women
- Gender differences exist in terms of power and control with women being used sexually when buying or selling drugs.
- The majority of injection drug users are socially marginalized and have not completed high school. The majority of injection drug users are between the ages of 25-34 years of age.
- Key informants in this study estimate the prevalence of booting at between 50 to 75% and sharing dirty needles at between 25% to 50% in their communities. (Health Canada, 2000)

Main Line Needle Exchange carried out a needs assessment in 1994 within the IV drug using community in Halifax. Some of the major themes in this needs assessment are as follows:

Box 3

- The attempt to bury pain through a drug of choice
- Feelings of guilt and shame
- Fear among women that if they admit to being an injection drug user their children will be apprehended
- A feeling of being treated as "less than equal" by many helping agencies
- A wish that relapse would be seen not as failure but as a step on the way to recovery
- The need for treatment programs to be more holistic and longer in duration

Although these themes were identified in Halifax it is likely they are also present in the New Brunswick area.

The following box contains suggestions for working with injection drug users. The suggestions are from *Innovative Approaches to HIV prevention: Selected case studies* (UNAIDS 2001b).

Box 4

- Concentrate on harm reduction as well as rehabilitation
- Advocate to protect the rights of injection drug users
- Organize drop-in services and outreach work
- Undertake HIV prevention activities when seroprevalence is still low
- Provide access to sterile injecting equipment and condoms
- Establish high levels of knowledge regarding how HIV is transmitted.

Women who live in poverty

Poverty along with income inequality is a reliable indicator of poor health (Colman, 2000). This is true with HIV as well as a variety of other diseases. Medical research supports this claim and notes that poor people are more likely to become ill than middle and upper class people (Doyal, 1995). Gagnon (1992) notes that economically marginalized people are infected and affected by HIV in greater numbers than those who are not economically disadvantaged. This has specific implications for Atlantic Canada where nearly one woman in five lives in poverty. Single mothers and the unattached elderly women have the highest poverty rates among women in this area (Coleman, 2000). Women in Atlantic Canada who work full-time year round earn 71 % of male wages with a quarter of these women earning less than \$8.00 an hour (Coleman, 2000).

The economic imbalances between men and women can lead to a lack of safety in sexual relationships. In addition many of the risk factors that make women vulnerable to HIV have a strong correlation with economic conditions (Zierler, Witbeck, & Mayer, 1996). Women may fear both violence and abandonment if they insist on safer sexual practices. In addition being poor may cause women to exchange sex for their economic survival (UNAIDS, 2001). This economic dependence on men seriously compromises women's ability to negotiate safer sex and leave risky relationships (Aggleton, 2000). In addition poverty can mean women are unable to afford items they could use in protecting themselves such as female condoms, clean needles and other devices (Zierler & Krieger, 1997).

Women are more likely to be poor in Canada than men (Gillis, 1999) "therefore poverty is a "gendered" determinant of HIV disease"(Kellington & Listen Up! Project Advisory Group, 1999).

The following box contains some recommendations for working with poor women in an effort to decrease vulnerability to HIV and AIDS.

Box 5

- Incorporate the social determinants of health into all Canadian research related to women, HIV, and poverty (Gillis, 1999).
- In conjunction with community-based groups develop and evaluate prevention efforts related to the economic factors that contribute to HIV infection (Gillis, 1999).
- Use a multi-pronged approach that recognizes that economic needs may take priority over HIV/AIDS prevention (UNAIDS, 2001) especially in developing countries.

Sex Workers

The role prostitutes play in the transmission of HIV has been highly over estimated whereas the clients of prostitutes have received little criticism for the role they play in this situation (Gorst, 1999-2001).

Sex workers, like other groups of individuals who are perceived to be at high risk of acquiring an HIV infection are not a homogeneous group (UNAIDS, 2001b). For example, women who practice prostitution and who work for escort services or from their homes are more likely to be involved in anal or vaginal intercourse than those prostitutes who work out of doors or on the streets. The higher rate of intercourse may impact on women's risk of HIV infection (Jackson, Highest, & Costes (1992).

Early in the epidemic the media often presented sex workers as "conduits of infection" (Alexander, 1996) or vectors of transmission (Gorsh, 1999-2001.) This is slowly changing and many studies within Canada examine the structures within society that leave sex workers vulnerable to acquiring HIV within the course of their work (Jackson, Highcrest, & Coates, 1992). This is also true in other parts of the world. For example Kiawi, Touko, Nyiama, and Kemmegne (2001) presented a poster at the AIDS Impact Conference suggesting that in that Yaounde, Cameroon, individually-oriented prevention programs among commercial sex workers are unlikely to be successful if structural inequalities are not also addressed. The literature suggests that in areas where prostitution is illegal sex workers have more difficulty insisting on condom usage (Stein, 1995) and may have little recourse if they become the victims of police violence (Jackson, Highest, & Costes, 1992).

In a recent report carried out in Lower Mainland British Columbia focus group participants described working in the sex trade as a barrier to health. Some of the barriers identified were as follows: the pace, the possibility of violent dates, and potential exposure to both STDs and HIV. Focus group participants also noted that "attitudes to prostitutes and prostitution combine with poverty, classism, and violence to create

conditions that work against women's safety, security, and ultimately, health" (Kellington and the Listen Up! Project Advisory Group, 1999, p. 15).

The following box contains suggestions for working with street workers.

Box 6

- Acknowledge the social, legal, and economic issues that concern street workers including the concerns they have about their children and family members.
- Address stigmatization and work to empower sex workers.
- Provide more accessible health services especially for the treatment of STDs.
- Seek the cooperation of bar owners and other employees of sex workers
- Provide financial incentives for peer-led work (UNAIDS, 2001b).

Lesbians

Many people perceive lesbians to be at extremely low risk of acquiring HIV. It is true that although women-to-women transmission is very rare (Peterson, Doll, White, and Chu, 1992) the perception that lesbians are not at risk may be faulty for the following reasons: a large number of lesbians have had unprotected sex with men (Gorna, 1996), some lesbians inject drugs and share needles (Gorst, 1999-2001), some lesbians have sex with men for reproductive reasons, (Gorna, 1996), some lesbians may be prostitutes and for either economic reasons or as a result of pressure from their pimp have unprotected sex with clients (Richardson, 1994). In addition, lesbians like other women may also be sexually abused or raped by men (Gorst, 1999-2001).

Gorna indicates the risk of transmission, during sex between women been exaggerated. She is critical of the emphasis on "latex lesbianism" and claims this not only unnecessarily restricts lesbians sex lives but also has more serious consequences such as the rejection of lesbian women within the lesbian community. Gorna claims that lesbian women who acknowledge having sex with men or using drugs have been stigmatized for bringing AIDS into the community and not being real lesbians (Gorna, 1996, 376-377).

Canadian HIV/AIDS prevention/education efforts for lesbian women has taken a risk reduction approach whereas the American approach has focused on complete risk elimination (Gaynor, 1993). Gillis (1999) indicates that Canadian prevention efforts have focused on the more high-risk activities such as blood play and anal fisting. Brabazon (1994) found that only 32 % of women used condoms when sharing sex toys.

Campbell (1999) in the *Environmental scan of sexual and reproductive health in the Atlantic provinces* notes that information and knowledge about the sexual and

reproductive health of marginalized groups such as lesbians is limited within Atlantic Canada.

The following box contains some recommendations for working with les/bi/queer women. These suggestions are from Gillis (1999) and Sussey (2000) and are not meant to be comprehensive.

Box 7

- Document the risk activities and cultural beliefs that place this group of women at risk (Gillis, 1999).
- Evaluate prevention interventions that already exist within the les/bi/queer community. If possible do this in conjunction with community-based organizations (Gillis, 1999).
- Develop a better understanding of the stigma associated with sleeping with men within the les/bi/queer community (Gillis, 1999).
- Develop broad-based campaigns in order to educate the public about both homophobia and heterosexism (Sussey, 2000).

Women in Correctional Settings:

Within prisons in Canada, women's seroprevalence consistently exceeds that of men. (Calzavara et al., 1995). This may reflect the relatively high percentage of women who are incarcerated due to drug related offences (Hankins, 1994).

HIV rates are high in many prison populations (UNAIDS, 1997a). At the same time inmates may also have tuberculosis and various strains of viral hepatitis (UNAIDS, 1997b). For example, in a Lower Saxony, Germany survey in a women's prison it was found that about a third of those sampled were injecting drugs. Of those injecting 4.9% were HIV positive. (UNAIDS, 1997b). The harm caused by this type of situation is sometimes increased as prisons are often overcrowded. They may also operate "in an ethos of punishment and of violence, and sometimes of systems of enslavement within prison hierarchies" (UNAIDS, 1997a, p. 3).

Within Canadian prisons for women as in prison systems in other parts of the world HIV infection is prevalent. This is especially true of those who inject drugs. HIV seroprevalance among women often exceeds that of male inmates (Canadian Strategy on HIV/AIDS, "n.d."). For example, in one provincial prison in Quebec 7.7 % of the women were HIV positive. In the same area the infection rate was 4.7 % and 2.0% for male inmates (Canadian Strategy on HIV/AIDS, "n.d.").

Another study in a Montreal medium security prison found that 73.3 % of all people used some form of drugs while in prison. Injection drugs were used by 6.2 % of men and 1.5 % of women (Canadian HIV/AIDS Legal Network, 1996). In a federal prison in New Brunswick it was found that 1% of all inmates use injection drugs.

Prevention initiatives and harm reduction programs are not consistent in the federal and provincial prison systems within Canada. For example, in the provincial correctional facilities in Prince Edward Island, New Brunswick, and Newfoundland both condoms and clean syringes are contraband. In federal prisons the situation tends to be a bit better however bleach kits or clean needles are not consistently available. The following box contains suggestions from Gillis (1999) which may be helpful in better understanding the needs of women who have been involved in the correctional system.

Box 8

- Develop a better understanding of the risks of exposure to HIV while in women's prisons
- Assess the social conditions which enhance ex-inmates vulnerability to HIV. Work with after care services to develop and evaluate effective prevention programs

Young Women

Young women in Atlantic Canada are at a high risk for acquiring both HIV and other sexually transmitted diseases due to high levels of unprotected sexual activity (Campbell, 1999). Studies indicate that Canadian adolescents are sexually active at an early age (Beazley, King, and Warren, 1988; Langille, Beazley, Delaney, Langille-Scott, 1997) and that they also place themselves at risk by having multiple partners (Langille, 2000).

Adolescents may engage in high-risk sexual activities due to difficulty in insisting on safer sex in certain relationships. They may also become involved in this type of activity in order to remain part of a peer group (Davis, 2001). In addition, they may have problems recognizing potential consequences of certain activities (Vermillion, Holmes, & Spoor, 2000). In addition, Rotheram-Borus, Mahler, & Rosario (1995) indicate that 90% of youths living in stressful situations such as those who were homeless, hospitalized in psychiatric facilities, runaways or incarcerated are sexually active.

The McCreary Centre Society (1993) conducted a province wide survey in British Columbia of students between Grades 7 and 12 and found that 52% of Grade Twelve females had sexual intercourse on at least one occasion. Also, in this study only 53 % of the females had used a condom the last time they had intercourse.

Street youth are highly sexually active and are at risk for acquiring HIV either through drugs or sexual activity (Gillis, 1999). Many of these youth are involved in sex work or selling drugs in order to pay for basic necessities (Shields, Doherty, & Houston, 1998). Many street youth have experienced sexual abuse (Gillis, 1999). Interventions need to take this into account if they are to be successful.

According to Dowsett and Aggleton (UNAIDS, 1999) "there really is no one population called 'young people' and no one strategy to be developed to provide for them" (p. 48). They suggest that in developing programs for young people their sexual behavior must be understood in the context of their immediate peers and surroundings. In addition local cultural forms, expectations of sex, physical attractions and sensations of sex must be addressed. This needs to occur within the larger socioeconomic context.

Anderson, Nyamathi, McAvoy, Conde, & Casey (2001) carried out a study among adolescents in juvenile detention in a large metropolitan-area in the United States. Adolescents in this study commented that courses which inspired them to relate HIV/AIDS to themselves were personal accounts from someone living with HIV, learning comprehensive health-related content instead of focussing exclusively on AIDS, and having the opportunity to talk with someone they trust.

Oakley et al. (1995) notes that chastity education is likely to encourage rather than discourage sexual experience. In addition she comments that information on its own rarely leads to behavior change and that "the expenditure of vast sums of money on the moral exhortation known as health education will stand out as both an ethical and a scientific scandal" (Oakley, 1995, p. 16).

The following box provides information about the sexual health of young people within Atlantic Canada. Sexual health has direct implications in HIV/AIDS prevention as it is well documented in the medical literature that STDs increase the risk of acquiring HIV infection (Wasserheit, 1992).

Box 9

- Chlamydia and gonorrhea have been increasing steadily in all four of the Atlantic provinces in recent years;
- Chlamydia infections are reported three to five times more often in women than men within Atlantic Canada;
- Rates of reported pregnancies have declined in all four Atlantic provinces in the past decade, however, in both Nova Scotia and New Brunswick in 1994 it was close to the national rate of 49 per 1000 population.
- The fastest growing risk category for HIV infection in Atlantic Canada is heterosexual contact especially in NFLD and New Brunswick.
- Reported sexual assaults in Atlantic Canada are higher than in Canada as a whole.
- In 1997 there were approximately 3,100 sexual assaults reported to the police.
- Between 1992 and 1997 reported sexual assaults in New Brunswick dropped by one-quarter.

Source: Campbell, J. (1999). *Environmental scan of sexual and reproductive health in Atlantic Canada*. Health promotion and Programs Branch, Atlantic Regional Office, Health Canada.

The following box contains suggestions for working successfully with young people in order to slow down the spread of HIV/AIDS.

Box 10

- Abandon stereotypical images of young people and celebrate their diversity while understanding that all young people need accurate information about both HIV/AIDS and other STDs (UNAIDS, 2001b).
- Ensure the rights of young people are recognized. (UNAIDS 2001b)
- Educational institutions need to ensure a comfortable learning environment for diverse students including women, those of different religious faiths, and those who are gay and lesbian (Langille, Graham, and Marshall, 1999)
- Organize informal peer education opportunities that include drama, role plays, and video-tape production (Coleman & Ford, 1996).
- Involve members of the peer group in designing the educational program (Coleman & Ford, 1996).

Older Women

Older adults are no more immune to STDs including HIV than anyone else (Grigg, 2000) if they are sexually active, however, HIV and AIDS are seldom discussed within this community (Lieberman, 2000). Research focusing on HIV women over 40 is rare (Gillis, 1999). Unfortunately many people including health professionals view older people as asexual or as one part of a monogamous heterosexual relationship (Lieberman, 2000). If the older person internalizes the asexual view they may not make the association between sexual activity, STDs and HIV (Drench et al, 1996). In addition they may not be screened for sexual health problems if health care professionals also accept these stereotypes.

The following box describes some societal attitudes towards AIDS and aging.

Box 11

- Old people are no longer interested in sex and if they are interested, no one is interested in them.
- If they do have sex it is in the context of a monogamous heterosexual relationship.
- They are not drug users or abusers.
- If they ever were substance abusers, it was so long ago that it does not matter.

Source: Lieberman, R. (2000). HIV in older Americans: An epidemiologic perspective. *Journal of midwifery and women's health*, 45 (2), 176-182.

Currently in Britain there are over 1000 people over the age of fifty who have been diagnosed with HIV (Marshall, 1997). In America between 1992 and 1994 10 % of all reported AIDS cases were among people aged 55 and older (Lieberman, 2000).

Many older people with AIDS first present with neurological symptoms (Grigg, 2000). Some studies suggest that in 25% of the older people with AIDS, dementia is the only symptom they experience (Marshall, 1997).

Older women may be more at risk of acquiring an HIV infection than their younger counterparts due to thinning of the vaginal wall and reduced vaginal lubrication (Gillis, 1999).

Farkas and Dyson (1997) did a study on women who were over 40 but who as a result of being widowed, divorced, or single were still dating. This study was done in Ontario and discovered that women found negotiating safer sex difficult due to the strict taboo they had been brought up to respect about discussing sex with men. The following box provides recommendations for working with older women to prevent HIV infections.

Box 12

- Develop and evaluate prevention interventions which address older women's risk of infection (Gillis, 1999).
- Provide age breakdowns of research which relates to the knowledge, behavior, and attitudes of older women. (Gillis, 1999).

In a recent needs assessment carried out within Atlantic Canada it was identified that a general lack of information related to HIV education and safer sex exists for women over twenty-five (Sussey, 2000).

Aboriginal Women

Marginalization of Aboriginal people within Canada has left them vulnerable to HIV infection (Aboriginal Nurses Association of Canada, 1996). Oppression, racism, and colonization has dominated the historical relationship between Canada and the Aboriginal community (Matiation, 1999). Years of inequality with other populations within Canada has affected the communal well being, the health, and the economic situation of Aboriginal people (Canadian Aboriginal AIDS Network [CAAN], 2000). This situation continues today. Blue Moon Consulting (1999) notes that First Nations people within Atlantic Canada still must contend with issues of racism and cultural ignorance. One result of this marginalization is that Aboriginal people are over represented with respect to many risk factors associated with HIV such as high rates of STDs, drug and alcohol use, low socioeconomic status, teen pregnancy and incarceration in federal and provincial institutions (Laboratory Center for Disease Control [LCDC], 1998).

Although Aboriginal people make up only 2.8 % of the Canadian population they accounted for 5.5% of all prevalent infections and 8.8 % of all new infections in Canada in 1999 (Geduld and Archibald, 2000). In New Brunswick 1% of the population is aboriginal (The Health of Canada's Children, "n.d.").

The following statistics highlight the seriousness of HIV/AIDS within the Aboriginal population.

- the number of aboriginal persons living with HIV has increased from 1439 in 1996 to 2,740 in 1999 which represents a 91 % increase in a three year period (Geduld and Archibald, 2000);
- At the start of 1999 it was estimated that 370 aboriginal people were newly infected with HIV, at the end of 1999 an estimated 2,740 Aboriginal persons were living with HIV (Health Canada, 2001);

- the annual proportion of AIDS cases attributed to Aboriginal persons increased from 1 % before 1990 to 10.8 % in 1999 and 8.5 % in 2000 (Health Canada, 2001a).
- Aboriginal injection drug users are among the fastest group of new HIV cases in Canada (Canadian Aboriginal AIDS Network [CAAN], "n.d."),

Aboriginal women are also affected by the HIV/AIDS epidemic. For example

- Aboriginal women are more likely to become infected with HIV at a younger age than both Aboriginal men and non-aboriginal populations (CAAN, "n.d.").

Up to December 31, 2000 there were 93 aboriginal women with a reported AIDS diagnosis within Canada. Of those whose exposure was known 64.7 % were IDU, 30.7 % were heterosexual contact, 2.3 % had received blood/clotting factors, and 2.3 % had become infected through perinatal transmission (Health Canada, 2001).

When interpreting the statistics described in the preceding paragraphs it should be remembered the data is incomplete for several reasons. Not all of the provinces are required to report ethnicity when reporting positive HIV tests. For example, while PEI and Newfoundland must report this data New Brunswick and Nova Scotia are not obligated to do so. In addition, the data is incomplete as a result of misclassification of ethnic status and delays in reporting (Health Canada, 2000). It should be noted that statistics only represent those individuals who come forward for testing.

According to Campbell (1999) there are no reliable quantitative estimates of the incidence of HIV among Aboriginal people in Atlantic Canada. Aboriginal health organizations are concerned about the high rate of STDs and pregnancies among Aboriginal people as they are indicative of unprotected sex and increased risk of exposure to HIV (Campbell, 1999).

Allen (1994) conducted a focus group and one-on-one interviews with Mi'kmaq women within Nova Scotia. Some of the educational strategies identified during this research as being successful in the Mi'kmaq community were those which made connections between self-esteem, sexual assault, and addictions. This research also verified that HIV positive aboriginal people have played an important role in bringing HIV/AIDS education to the community. The women in this research project believe that "education needs to come from the community and be developed by the community" (Allen, 1994, p. 39) however they also saw a role for partnership and coordination between established "mainstream" AIDS organizations and culturally specific services.

Literature suggests that a better understanding of the migration patterns of Aboriginal people is needed (Gillis, 1999). It is felt that one result of migration between cities and reserves is that Aboriginal people who live in remote areas of this country are at increasingly high risk of being exposed to the HIV virus. In addition research which examines why Aboriginal women leave reserves, the type of support they obtain in urban centers, and how this correlates with substance use and victimization is needed (Stout and

Kipling, 1998). This type of research must be based on Aboriginal cultural values (Aboriginal Nurses Association of Canada (1996) and on community development principles (Gillis, 1999).

There are currently 10,250 Aboriginal people living in New Brunswick (Statistics Canada, 1996). The most common indigenous language spoken in this region is Mi'kmaq. (Blue Moon Consulting, 1999) although most individuals also speak either English or French.

It is noted that within the Atlantic Canadian region the needs of First Nations communities are quite diverse. Levels of knowledge and service requirements vary widely throughout the region (Blue Moon Consulting, 1999).

Blue Moon Consulting (1999) has identified some of the following needs as being important within First Nations communities. This is not meant to be a comprehensive list.

Box 1:

- Additional funding to deal with issues related to First Nations Communities and HIV;
- A more traditional approach to HIV/AIDS education, support, and treatment;
- Additional support for those infected and affected by HIV/AIDS;
- Resource materials in indigenous languages; and
- A staff member who speaks Mi'kmaq.

Black Women

The term "visible minority" can be defined as "persons, other than Aboriginal people who are non-Caucasian in race or non-white in color" (The Daily, 1998). Black women fit within this definition of visible minorities. Within New Brunswick 1.1% of the total population are members of visible minorities groups. Within Canada, generally, 11.2% of the population belong to a visible minority group (The Daily, 1998).

There is little research in Canada specifically related to black women and HIV. (Gillis, 1999). In addition it is important to recognize that black women come from many backgrounds and are not a homogenous group. This diverse group of women have a variety of needs with the result that different approaches may be more effective with one group of women than with another. For example, black women originating from countries such as Ethiopia generally do not encourage open discussions of sexuality whereas women from black communities in the north of Africa may be more open to such discussions (Gillis, 1999).

The impact of HIV/AIDS in black communities around the world is devastating (Enang, Edwards, Amaratunga, & Atwell, 2001). In Canada AIDS organizations have reported an increase in the number of HIV cases among blacks especially women (Douglas, 1995).

Enang (2001) recently carried out a synthesis of health research relative to Black people who live in Nova Scotia. Black women from Nova Scotia who participated in a workshop identified racism as one barrier they face in maintaining health. They described the following problems: lack of access to appropriate health care services, low economic status, lack of trust in institutions in which no black people are employed, and differential treatment of black people. They also noted that Black people may attain only low levels of education and have difficulty entering certain professions. In addition, they stated that black employees who are health professionals often experience a lack of trust from their colleagues.

Language barriers may affect the ability of non-English speaking black women to access appropriate health care services (Howard, 1997). This is compounded when medical terminology is not adequately explained with the result that Black women may be limited in their ability to participate in decisions affecting their health care (Enang, 1999).

The following box provides suggestions for working effectively with black women in New Brunswick.

- Consult with members of specific black communities in order to develop messages that are culturally relevant to Black women (Kalichman et al, 1993)
- Match outreach workers with the race and gender of the target audience whenever possible (Pitts, et al, 1989)
- Health professionals may need to increase their awareness of traditional healing practices and validate Afrocentric approaches
- Advocate for seroprevalence studies which include and identify information on Black communities (Gillis, 1998).

Women with disabilities

Mental Illness

Women with disabilities are vulnerable to HIV infection (Gillis, 1999). Seroprevalence data shows extremely high rates of HIV infection among mentally ill women in large urban centers (Cournos et al, 1991). In spite of this Gillis (1999) notes that no Canadian research has focused on preventing HIV infection in this group of vulnerable women.

Kellington and the Listen Up Project Advisory Group (1999) found women suffering from severe mental illness often felt they experienced sub-standard care from physicians and did not have their concerns taken seriously. One woman described this in the following way:

Sometimes I've noticed in the past with the doctors I've had, because I have a mental illness it seems like they don't want to listen and they kind of poo-poo anything you say. (p.31)

Starace (1998) notes that in both men and women with severe mental illness, education and prevention programs based on cognitive behavior theories coupled with social support and intensive skills building are effective in reducing HIV risk behaviors.

Although women with psychiatric disabilities are sometimes treated as asexual and childlike (Daskal, 1994) this perception often does not reflect the reality of these women's lives. For example, Carey et al (1997) reviewed papers published prior to 1996 on HIV-related risk behaviors among people with severe mental illness. They found twenty-eight studies on this topic and in this literature 54-74 % of the individuals with severe mental illness were sexually active in the year prior to the study. This compares with 88 % of the general population. In addition 20-40 % of the people in the study had more than one partner. Only 10-30 % of this population used condoms regularly.

Allen (1994) notes that persons with psychiatric difficulties may be vulnerable to HIV because traditionally psychiatric patients have been viewed as being unable to make decisions for themselves. In this context the idea of "negotiating safer sex practice" is almost non-existent, as people with severe mental illness may experience little choice or power within their own lives thus making it extremely difficult to negotiate safer sex. Allen (1994) also recommends that service providers working with this population including group home workers, psychiatrists, and hospital staff be educated in understanding the context of HIV/AIDS for people with disabilities.

Physical Disabilities

Women with physical disabilities may not have the physical ability to put a condom on another individual and like women in other situations they may lack the necessary knowledge or the power to insist that a condom be used (Daskal, 1994).

The Hearing Impaired

Deaf women may have limited access to much of the information on the TV and radio about HIV and AIDS because they are not able to hear these media messages (Allen, 1994). In addition toll free information lines or not anonymous for deaf people (Allen, 1994). Also American Sign Language is very visual and does not translate well into text messages further limiting the amount of information deaf women receive about HIV and AIDS (Gillis, 1999).

The Learning Disabled

There has been an increasing recognition and acceptance of the sexual rights of people with learning disabilities in the past three decades however real progress to enhance choice has been relatively slow (Atkinson, 2000). In some instances women with learning disabilities may not have had the same opportunities to learn about sexuality as those who do not have this type of disability (Fairbairn et al 1995). They have been denied access to sexual knowledge and experience. This may be related to the fact that people with learning disabilities are often viewed as asexual (Atkinson, 1998-2000). Parents of the learning disabled may fear the individual will become pregnant and not be able to

raise the child (Heyman & Huckle, 1995); that sex education will lead to an awakening of sexual desires (Fairbairn et al, 1995); and that they will either exploit someone or be exploited by another person (Heyman & Huckle, 1995). Often times parents deal with these fears by denying the sexuality of their adult children or treating them as asexual (Atkinson, 2000). This is not done out of malice but out of a desire to protect their adult children.

Suggestions for research related to women with physical and emotional disabilities are included in the following box:

Box 13

- The impact of different psychiatric diagnosis on both risk factors and the ability to understand and receive HIV/AIDS prevention/education information (Paniagua, O'Boyle, & Wagner, 1997)
- The development of innovative methods to combine life skills with structural and community support for people with cognitive impairments (Gillis, 1999)
- The development and evaluation of effective models of education for people with developmental delays (Gillis, 1999)

Best Practices

In previous sections of this literature review I have identified best practices for preventing HIV infection as well as suggestions for future research where appropriate. These suggestions will not be repeated in this part of this paper. However, due to the increasing incidence of HIV infections in those who use injection drugs or their partners I will devote this section of this paper to harm reduction principles specifically related to HIV/AIDS and injection drug use. Specifically I will talk about methadone maintenance programs and needle exchange programs.

Harm Reduction

Harm reduction programs are becoming popular worldwide although carrying out these activities has been the subject of much debate. Debates have occurred regarding whether abstinence based policies reduce harm more effectively than those programs focusing on safer behavior (Hawks and Lenton, 1998). Harm reduction is also referred to as harm minimization or risk minimization (CCSA, 1994). This approach has been shown to work in transitional economies as well as high-income countries (UNAIDS, 2000). A significant body of literature suggests this can be an effective approach to decreasing the number of people who acquire HIV through injection drug use.

Harm reduction is a value-neutral approach and makes no assumptions about drug use or persons who use drugs (Watershed Writing and Research, "n.d."). The major philosophical ideas behind harm reduction programs have been well described by Erickson, Riley, Cheung, and O'Hare (1997) in a document titled *Introduction: the search for harm reduction*. They are as follows: a value neutral view on drug use; a value-neutral view of the user; a focus on specific problems; the irrelevance of abstinence; the user's role in harm reduction; and community involvement. Loxley (2000) also suggests that information about safe administration practices is another harm reduction strategy.

The philosophy of harm reduction was first articulated at a medical conference in England in 1990. Harm reduction is a pragmatic approach to drug use which focuses on reducing the harm caused by drugs as opposed to taking a stance on abstinence or decriminalization (Watershed Writing and Research, "n.d.").

Typical harm reduction models involve condom distribution, needle exchanges, methadone maintenance programs, and counseling. (Watershed Writing and Research, "n.d."). Harm reduction approaches tend to focus on immediate and risk-free use (Kearns, 1994).

Health Canada (1998) describes the major objective of the harm reduction approach in a document-titled *Canada's Drug Strategy*. The fundamental objective is described as utilizing "a balanced approach between restricting the supply of drugs and reducing the demand" (p. 15). Health Canada does endorse the harm reduction approach (Watershed Writing and Research, "n.d."). As part of this in 1989 they legalized needle exchange programs.

The following two aspects of harm reduction will be discussed in this literature review: methadone maintenance programs and needle exchange schemes.

Methadone maintenance programs

The use of methadone was pioneered by Vincent Doyle and Marie Nyswander in the 1960's. They felt that once people became addicted to opiates they needed to maintain some level of opiate in their body to feel normal. Due to biological adaptation this need remains even after withdrawal (Correctional Services of Canada, 2000). A main value of methadone is that it competes with heroin for access to sites of action in the brain. Because of this, if injection drug users use heroin while on methadone they feel little effect from the heroin and thus have little incentive to use it.

Methadone maintenance programs now exist in many countries. The literature suggests there are both health benefits and risks to being on methadone. Kearns (1994) states methadone maintenance "...is harm reduction at its best..." (p. 36) and "has clearly demonstrated itself to be an effective management tool for narcotic addicts" (p. 36). Neale and Matheson (1998) offer a more balanced description of methadone programs and describe some of the benefits and risks of receiving methadone from a users' perspective. According to their research drug users were neither for or against the

prescribing of methadone. Overall they recognized methadone was a valuable substitute drug, however, they also acknowledged that it can create many problems for those who receive this type of treatment. The participants in this research felt the main advantage to methadone was that it helped participants both emotionally and physically. It also helped drug users through difficult heroin withdrawal. Participants also indicated this drug was beneficial in that it helped to prevent crime because large amounts of money was no longer needed in order to purchase illegal drugs. Additionally a methadone prescription was helpful because it prevented people from working as a prostitute, selling personal belongings or acquiring large debt in order to maintain their habit. Also, people receiving methadone felt they benefited, as methadone was cleaner and safer than street drugs.

Some of the disadvantages drug users identified about methadone were that it had negative physical effects such as damage to teeth. Other common difficulties were as follows: weight changes, hallucinations, sleep problems and tiredness. In addition some individuals felt methadone changed drug users' personalities making them violent and aggressive (Neale and Matheson, 1998).

Many drug users felt the problems caused by methadone were as severe as those caused by street drugs. For example, they felt methadone was extremely addictive and created severe withdrawal if people tried to get off it. In addition these users felt that methadone actually caused death in some instances as users became very depressed and choose to suicide (Neale & Matheson, 1998).

Rosenbaum and Murphy (1987) indicate methadone creates some specific problems for women and that many women who voluntarily enter treatment do so because they are pregnant, fearful of becoming pregnant, or are experiencing declining health. Some of the specific effects women have identified as a result of methadone are as follows: increased perspiration, amenorrhoea, sexual dysfunction, acne, memory loss, bladder infections, emotionality, and non-emotionality.

Correctional Services of Canada (2000) suggest that many negative evaluations of methadone programs relate to the actual dosage which is administered. They suggest the dose needs to be at least 60 mg per day in order for it to be fully effective in reducing heroin use.

Brands and Marsh (1997) note that there are many barriers to methadone maintenance treatment. These barriers may include stigmatization of clients by service providers and the need to provide this treatment in specialized clinics. Other problems identified by Correctional Services of Canada (2000) are that methadone programs are often poorly planned and managed, addicts are treated disrespectfully, and that arbitrary rules exist which may include being dismissed from the program if an infraction occurs.

In North America methadone maintenance programs are slightly different from those in other areas such as Great Britain, Europe, or Australia. For example, oftentimes in North America methadone is restricted to those severely addicted to heroin and withdrawal rather than maintenance may be the goal of treatment (Correctional Services of Canada, 2000).

In Canada methadone is a controlled substance and is subject to both federal and provincial regulation. The regulations vary greatly from province to province (Correctional Services of Canada, 2000). This can create problems for tourists and people who are migrating from one province to another.

Needle Exchange Programs

One of the approaches to harm reduction and injection drug use which has been used within Canada and internationally is needle exchange programs (Canadian HIV/AIDS Legal Network, 1999).

There is ample evidence to suggest that needle exchange programs are effective in preventing HIV without causing an increase in drug use (Hurley, Jolley, and Kaldor, 1997). In contrast no evidence exists to suggest that needle exchange programs cause people to start injecting drugs (Gold, Gafni, Nelligan, & Millson, 1997). Despite this needle exchange programs are often criticized on the basis they encourage drug use by providing people with the means to inject (Curtis, 1998). In the United States this concern was so strong that before federal funding could be provided to needle exchange programs the United States Surgeon General had to certify that needle exchange programs did not lead to more drug use among injection drug users or the general public (Bluthenthal, Gogineni, Longshore, and Stein, 2001).

However, there is also little evidence to suggest that single interventions such as needle exchange programs without counseling or methadone serve a protective effect (van Ameijden, van den Hoek, Hortgers, & Coutinho, 1994). For example, Vancouver, British Columbia has the most active needle exchange program in North America (Loxley, 2000) and has recently seen a rapid increase in injection drug use in their community. It is felt this might be occurring not due to the needle exchange program but due to other gaps in services such as inadequate access to drug treatment and inadequate counseling services (Strathdee et al., 1997).

Needle exchange programs help to eliminate the need to share syringes and needles by making them more readily available. Some of the difficulties which currently make it difficult to obtain clean needles are distributional policies, legal difficulties, and difficulty obtaining needles when necessary (Canadian Centre on Substance Abuse [CCSA], 1994).

Sex, age, serostatus, and ethnic background all affect whether or not someone will choose to use a needle exchange program (Brown, 1998).

Recent research within Vancouver, Canada, has shown that factors associated with borrowing needles include injecting more than four times a day, a history of sexual abuse, multiple drug use and having experienced non-consensual sex (Strathdee et al., 1997).

One major problem for needle exchange programs is the high turnover rate at most centers. This may be occurring due to positive effects such as coming off injection drugs

or negative outcomes such as death or imprisonment (Canadian HIV/AIDS legal Network, 1999).

According to the Canadian HIV/AIDS legal network (1999) needle exchange programs face the following limitations: lack of public education related to the benefits of such programs, less success attracting female injectors than male users, and insufficient attention placed on helping people change behavior. In addition, Sussey (2000) notes that in Atlantic Canada many injection drug users do not access needle exchanges due to fear of being seen entering the building and homophobia among staff and volunteers.

The Gendered Epidemic

Gender refers to the socially constructed roles and features of our society that defines male and female behavior. Power is central to the construction of gender and affects individual autonomy, the opportunities one enjoys, the sense of self one develops and how sex is experienced. Gender should be viewed as an issue that has implications for all phases of the HIV/AIDS epidemic (Aggleton, 2000).

One result of gender inequity is that women are susceptible to the HIV virus at every stage of their lives (Nath, 2001). This is reflected in the fact that approximately 3000 women contract the HIV virus everyday (CIDA, 2000). The proportion of women infected is greater than that of men under the age of 25 (MAP, 2000).

On January 10, 2000 the UN Security Council turned its attention to HIV/AIDS and declared the HIV/AIDS epidemic an issue of human security as well as a health issue. However according to Nath (2000) the entire debate which followed remained blind to the gendered nature of the epidemic (2001).

This is disturbing as many of the representatives at the United Nations Security Council Meeting had been present less than one year earlier (March 1999) when Resolution 4/32 was passed - "Women, the Girl Child, and the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome." This resolution was endorsed by 45 member states and called on the International Community to support national efforts against HIV/AIDS particularly in favor of women and girls. This support could include long-term public information and education programs specifically tailored to the needs of women and girls keeping in mind the various socio-cultural contexts in which they are living (Nath, 2001). There is a strong link between the violation of the human rights of women and the HIV/AIDS pandemic (Aggleton, 2000). This is particularly evident in times of war or other armed conflicts. During these times of political instability girls and women may experience systemic rape and or war crimes. In periods of postconflict females may be forced to sell sex for survival thus placing themselves at increased risk of acquiring an HIV infection (Aggleton,2000).

In many countries women are blamed for the HIV/AIDS epidemic as well as having a heavier burden than men in terms of providing family support and caring for the ill and dying (Aggleton, 2000, Nath, 2001, UNAIDS, 1999). For example in many countries young girls are taken out of school early in order to care for sick family members who are

dying of AIDS. This has long-term implications for their future including that of being financially unable to care for themselves.

HIV/AIDS stigmatizes men and women in gender specific ways (Aggleton, 2000). For example, when HIV or AIDS is referred to as a "prostitutes disease" this reinforces unequal sexual stereotypes in which HIV positive women may be labeled as morally unworthy.

In certain parts of the world gender determines how much women are supposed to know about sex and sexual matters (UNAIDS, 1999). Society may view ideal feminine attributes as including motherhood, sexual innocence, and virginity. This construction of femininity impacts on the ability of women to verbalize their sexual desires and their need for safety within sexual encounters. Similarly norms regarding masculinity encourage men to seek multiple partners and participate in high risk sexual activity. (Aggleton, 2001).

The high value placed on virginity in some cultures encourages both women and men to engage in high risk activities such as anal sex (UNIDS, 1999). This situation is worsened as in many cultures men may seek out very young women in the belief that having sex with a virgin will protect them from STDs or HIV (deBruyn, 1992).

Women's economic dependence on men seriously compromises their ability to negotiate protection and leave risky relationships (Aggleton, 2000). This is often perpetuated by laws and policies which may prevent women from owning property (UNAIDS, 1999).

It is the combination of the following gendered factors which makes women vulnerable to acquiring an HIV infection: physiology (International Centre for Research on Women, 1999), poverty, lack of power over their bodies and their sexual lives, sex trafficking, cultural and religious practices (Aggleton, 2000) unequal access to education, power differentials between men and women (Mane, Gupta, and Weiss, 1994) and war (Canadian HIV/AIDS Legal Network, 2001).

Interventions targeting gender and social vulnerability include: allowing women to help design health projects which affect them, ensuring women receive antibiotics for STDs (Nath, 2001), combining various kinds of care for women with support (UNAIDS, 1999), improving women's social and economic status, and providing female sex workers with other opportunities for making an income (Aggleton, 2000). In addition, programs which target couples rather than individuals and those which work with men and young boys to challenge gender inequalities may prove effective (Gupta, 2000).

Conclusion

This selective literature review has attempted to provide an overview of issues related to women and HIV. It is not intended to be comprehensive in nature but it is hoped it will stimulate discussion about the needs of various groups of women in relation to HIV/AIDS prevention education within Atlantic Canada. Both commonalities and differences exist among women. It is anticipated that by increasing our understanding of this complex situation new programs in HIV/AIDS education for women will be developed.

METHODOLOGY

This research is based on quantitative and qualitative methodologies.

Its general objective is to determine the needs of women at risk of getting HIV. The more specific goals are to:

1. Evaluate the level of knowledge among women with HIV/AIDS
2. Identify unsafe practices among women
3. Determine whether women perceive themselves as persons at risk;
4. Explore the sexual health practices of women
5. Explore the experiences of women in terms of how they use sexual health and HIV/AIDS prevention services.
6. Identify the services required to prevent HIV/AIDS among women

To achieve all of these objectives, we decided to adopt the viewpoint of women.

The population under review and the sample

The research primarily concerned women age 18 years or more at risk of HIV infection. As shown earlier in the literature survey, the characteristics of some women can make them more vulnerable to this risk: IV-drug users, poor women, sex-trade workers, women in correctional facilities, young women, older women, Aboriginal women, black women, disabled women and lesbians. We also decided to include young women attending university as a group at risk because we believe they are usually experiencing a new level of freedom surrounded by different groups of people for the first time.

We therefore targeted organizations that these women were likely to have contact with. In all, 201 questionnaires were sent to the following locations:

- Safe Spaces/Sain et Sauf (a support organization for gay youth and lesbian youth)
- The Elizabeth Fry Society (a support organization for women confronting the criminal justice system)
- Greenfield House (a support organization for parolees)
- Centre de prévention de la violence familiale de Kent (centre for the prevention of family violence)
- The Beauséjour Family Crisis Resource Centre
- Addiction Services
- Université de Moncton
- Mental Health Centre
- Karing Kitchen (soup kitchen)
- Keats and Associates (general distribution)
- Private psychotherapy practice

- Family Services Moncton
- Lion's Tower (senior citizen's residence)
- Headstart Recycles (a support agency for families in need; furniture, clothing and so on)
- Sexual Health Centre
- Mount Allison University
- MAGMA (a support organization for new immigrants and refugees)
- SIDA/AIDS Moncton

In all, 94 questionnaires were returned (response rate: 47%); one of them had to be discarded because too many of the answers were incoherent. Therefore, the final sample comprised 93 women.

The following is a list of the questionnaires returned and retained by organization where the questionnaires were sent:

Université de Moncton (n=17)
 Sexual Health Centre (n=8)
 Mount Allison University (n=9)
 MAGMA (n=7)
 Headstart Recycles (n=6)
 Addiction Services (n=2)
 Lion's Tower (n=1)
 Family Services Moncton (n=4)
 SIDA/AIDS Moncton (n=3)
 Mental Health Centre (n=10)
 Wendy Keats (n=6)
 The Beauséjour Family Crisis Resource Centre (n=3)
 Private psychotherapy practice (n=3)
 Safe Spaces (n=2)
 Karing Kitchen (n=4)
 Elizabeth Fry Society (n=8)

Data gathering and research questionnaire

Data were gathered in the Greater Moncton Area from May 2003 to December 2003. The research sample consisted of volunteers; women were recruited through advertisements posted with the targeted organizations and groups. Data were gathered using a self-administered research questionnaire that included open and closed questions. Since some of the questions are personal and concern sexuality (for example, wearing condoms during sex), a self-administered questionnaire helped the women feel more comfortable about answering the questions honestly.

One person per target organization and group was in charge of distributing the questionnaires to women interested in responding. Once the questionnaire was completed, the woman would place it in a pre-stamped, pre-addressed envelope and return it by mail. This applied in every case except the effort to recruit sex-trade workers. They were approached by a SIDA/AIDS Moncton volunteer using the snowball method.

The research questionnaire is divided into six sections³ (see Appendix A):

- ❖ Knowledge of HIV/AIDS
- ❖ Assessment of practices
- ❖ Experience with violence, alcohol and drugs
- ❖ Perception of the risk
- ❖ Experience with HIV/AIDS and health-sexuality services

The first section of the questionnaire evaluates the knowledge of women concerning HIV/AIDS transmission and when an HIV test is necessary. The second section concerns behaviour that places women at risk, such as trading sex for money or drugs, sharing IV drug paraphernalia, using condoms, and so on. The third part asks women about their experience of spousal violence, and how often they use alcohol or drugs (cocaine, heroin, IV drugs, etc.). The fourth section evaluates whether women perceive themselves as being at risk and the reasons underlying their perception of the risk. The fifth section concerns the sexual health practices of women (HIV and STD detection tests), the services and information they have been given about their sexual health, the adequacy of any such services received and the obstacles to obtaining access to services. Lastly, the final section gathers socio-demographic data: age, ethnic background, education, number of children, family income, type of employment and housing situation.

Data analysis

Once the questionnaires were returned, the data was entered in SPSS software. The answers to the open questions had to be analyzed first. This content analysis consisted of five steps (L'Écuyer, 1988):

- ❖ reading of all the material, selecting the type of information units to retain and developing the code list
- ❖ analyzing each interview to identify units of meaning and assign them a code
- ❖ analyzing encoded segments by topic to establish a new categorization for the data and sort them

³ In all, the questionnaire contained more than 6 sections, but this report presents only some of the data gathered using the questionnaire.

- ❖ interrelating the data grouped into different categories based on the relationships detected among them
- ❖ integrating different components of the analysis to determine guidelines for the research questions

Ethical factors

A list of names and telephone numbers of community resources accompanied the questionnaire. Women who so wished could contact any of these resources. To protect the anonymity of respondents and the confidential nature of the information provided, none of the participant's names appeared on any document. Instead, a code was assigned to each questionnaire. Participants also received a consent form (see Appendix B). Lastly, before the research began, the researchers submitted the project to the Ethics Committee of the Université de Moncton and obtained its approval.

Respondent profile

Table 1 presents the characteristics of respondents. It shows that most were between 18 to 24 years of age. The majority had graduated from grade 12 or held a university degree. Also, more than one-half of respondents had one or two children. Family income was relatively low: 65% were living on an income of \$30,000 or less. Most described their housing situation as stable or very stable.

Table 1: Respondent characteristics⁴			
		N	%
Age	18 to 24 years	24	36.6
	25 to 29 years	8	8.6
	30 to 45 years	26	28
	46 to 65 years	22	23.7
	66 years or more	2	2.2
Education	Grade 12 not completed	12	12.9
	Grade 12 completed	23	24.7
	Attended college or trade school but did not graduate	4	4.3
	Graduated from college or a vocational school	13	14.0
	Attended university but did not obtain diploma	14	15.1
	Obtained a university diploma	23	24.7
Children	0	46	49.5
	1 or 2	29	31.2
	3 or 4	16	27.2
	5 or more	2	2.2
Income	Under \$15,000	37	39.8
	Between \$15,000 and \$30,000	23	24.8
	Between \$30,000 and \$45,000	8	8.6
	Between \$45,000 and \$50,000	9	9.7
	Over \$50,000	9	9.7
Housing situation	Unstable	2	2.2
	Relatively stable	10	10.8
	Room for improvement	12	12.9
	Stable	25	26.9
	Very stable	16	17.2

⁴ Some data was missing.

FINDINGS

This section of the report is divided into five parts. The first part concerns the practices and characteristics of respondents at risk. The second part presents the level of knowledge among the women about HIV/AIDS. The third part reports perceptions among the women concerning their risk of contracting HIV and the reasons underlying these perceptions. The fourth part describes the sexual health practices of the women. The final part focuses more specifically on HIV/AIDS prevention services.

A. Unsafe practices and risk characteristics

Among respondents, some women's sexual behaviour can make them vulnerable to the risk of contracting HIV or other sexually transmitted diseases. Twenty women reported having unprotected sex with more than one partner in the past year. Eight women said that they shared sex toys with one or more partners without using condoms. As well, three women reported that they had traded sex for alcohol or drugs. In addition, five women said that they had had sex with partners at risk, i.e., a partner who had had unprotected sex with others. One of these women also reported that her partner used IV-drugs and shared his paraphernalia with others.

Other women presented certain characteristics that could make them vulnerable to the risk of HIV or other sexually transmitted diseases (these categories are not mutually exclusive):

- 2 women had obtained tattoos or piercings under unsanitary conditions
- 11 women were being physically or sexually abused by their current partner
- 2 women injected illegal drugs
- 10 women drank alcohol often, i.e., 2 or 3 times a week or daily
- 3 women used cocaine or heroin
- 35 women had a family income of less than \$15,000 per year

In this report, all of the women who engaged in unsafe practices or presented risk characteristics were combined into the single category of women at risk. Despite our extensive recruitment efforts, we were unable to obtain a sample including women considered to be at risk according to the literature survey. It was also difficult to reach women who use drugs.

In terms of their sexual practices, the women were asked whether they or their partner had used a condom the last time they had sex. Our aim was to verify whether any differences would emerge between women at risk and women not at risk. Table 2 shows that there are very few differences, proportionally speaking, between women at risk and women not at risk in relation to condom use; most do not use a condom.

	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Used a condom	12	20.7	8	22.9
Did not use a condom	44	75.9	22	62.9

According to the women, the main reason reported for not using a condom was that the sex involved a regular partner (see Table 3). The two other reasons most often reported were: the partner did not want to use a condom and condoms are uncomfortable. Other reasons given included: embarrassment, unable to obtain condoms, high cost of condoms, partner is not a sex-trade worker, habit, and a mutual decision by both partners. Table 3 shows that very few differences distinguish women at risk from women not at risk in terms of the various reasons they gave.

	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Regular partner	31	53.4	21	60.0
Partner refused	4	6.9	1	2.9
Condom not available	4	6.9	1	2.9
Embarrassed	2	3.4	1	2.9
Condom uncomfortable	4	6.9	1	2.9
Condoms too expensive	1	1.7	0	0
Partner is not a sex-trade worker	1	1.7	1	2.9
Habit	1	1.7	0	0
Decision by both partners	1	1.7	0	0

The women were also asked whether they felt confident that they could convince their partner to wear a condom. Table 4 shows that most of the women felt confident or very confident that they could persuade their partner to wear a condom. Approximately 15% of the women at risk and women not at risk felt little or no confidence in this regard. There were very few differences in confidence levels between women at risk and women not at risk.

⁵ Data may be missing from the charts in this chapter of the report.

Table 4: Confidence in ability to persuade partner to use a condom				
	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
No confidence	5	8.6	3	8.6
Some confidence	4	6.9	3	8.6
Confident	10	17.2	4	11.4
Very confident	25	43.1	16	45.7

Lastly, respondents had to state how they would react if their partner refused to wear a condom. The analyses show that most of the women would discuss the matter with their partner (Table 5). Some women would have sex anyway, while others would abstain. A very few of the women said that they did not know how they would react. A comparison of women at risk and women not at risk shows that more women at risk would have sex anyway, but the chi-squared test shows that this difference is not statistically significant ($X^2 = 1,364$; $p > .05$).

Table 5: Reactions of women to partner's refusal to wear a condom				
	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Have sex without a condom	10	17.2	3	8.6
Discussion	14	24.1	7	20.0
Abstinence	9	15.5	5	14.3
Do not know/unsure	5	8.6	6	17.1

To summarize, some of the respondents' practices or characteristics could expose them to the risk of HIV or other sexually transmitted diseases. Among these women, 20 had engaged in unprotected sex with more than one partner; 8 had shared sex toys with one or more partners without using a condom; 3 reported having traded sex for alcohol or drugs; 5 had had sex with partners at risk; two had received tattoos or piercings in unsanitary conditions; 11 had experienced spousal abuse; 2 used illegal injection drugs; 10 drank alcohol often, either 2 or 3 times a week or daily; and 3 used cocaine or heroin. Furthermore, 35 of them lived in surroundings at risk because their family income amounted to less than \$15,000 per year.

Most of the women had not used a condom the last time they had sex, and no significant differences were noticed between women at risk and women not at risk. The reasons most often mentioned for not using a condom are: the sex involved the woman's regular partner, the partner refused or the condom was uncomfortable. We should mention that women at risk are more likely to feel they have little say in the decision to use a condom: almost 20% of these women (compared to 9% of women not at risk) said that they had not used a condom because their partner had refused, were unable to obtain one or were embarrassed to make the suggestion. If their partner refused to wear a condom, the women would discuss the matter with their partner, but some, particularly women at risk, would go ahead and have sex anyway.

Most of the women felt confident or very confident that they could persuade their partner to use a condom. However, about 15% of women at risk and women not at risk felt little or no confidence in this regard.

B. Women's knowledge of HIV/AIDS

Another part of the questionnaire was designed to measure the women's knowledge of HIV/AIDS. First of all, some questions aimed to determine the knowledge of women about how HIV is transmitted. Table 6 shows that one-half of women at risk and women not at risk failed to provide at least 10 correct answers of a total of 11 possible answers.

Table 6: Knowledge of HIV transmission by women at risk / not at risk		
	At least 10 correct answers	
	N	%
Women at risk (n=58)	29	50.0
Women not at risk (n=35)	18	51.4

The women were also asked questions that tested their knowledge of when an HIV detection test was necessary. Table 7 shows that almost all of the women knew when they had to take the test. Almost all of the women scored at least 3 correct answers of a total of 4 possible answers.

Table 7: Knowledge about HIV testing by women at risk / not at risk		
	At least 3 correct answers	
	N	%
Women at risk (n=58)	57	98.2
Women not at risk (n=35)	32	91.4

To summarize, concerning their knowledge of HIV transmission, only one-half of the women at risk and women not at risk scored 10. Only 19.4% of the entire sample answered all of the questions correctly. However, the women knew when they had to take an HIV detection test.

C. Perception of the risk

Another question that the women were asked was whether they perceived themselves to be at risk. Table 8 shows that most of the women did not consider themselves at risk or at much risk. More women at risk (13.8%) considered themselves at risk compared to women not at risk (5.7%), but this difference is not statistically significant ($X^2 = 1,512$; $p > .05$). A significant percentage of women at risk perceived themselves to be at little or no risk (82.8%). Also, almost all of the women not at risk perceived themselves to be at little or no risk (91.4%).

	Women at risk (n=58) ⁶		Women not at risk (n=35) ⁷	
	N	%	N	%
Little or none	48	82.8	32	91.4
Moderate to high	8	13.8	2	5.7

Women were also asked to explain their perception of the risk. The most frequent explanation for why they felt little or no risk was the fact that their sexual activity was limited to one partner (see Table 9). Other frequently mentioned reasons were: a faithful partner and abstinence from sex. Other reasons given included: condom used; injection drugs not used; recently tested for HIV; oral contraceptives used; traditional medicine used and the belief that it only happens to other people. Finally, a few people were unable to state why they felt they were at little or no risk.

Among the three most popular answers (only one sex partner; a faithful partner and no sex), a comparative analysis of women at risk and women not at risk shows that women who are not at risk were significantly more likely to report that they were not having sex ($X^2 = 1,512$; $p < .001$).

⁶ Missing data (2)

⁷ Missing data (1)

Table 9: Reasons why women do not feel at risk				
	Women at risk (n=58) ⁸		Women not at risk (n=35) ⁹	
	N	%	N	%
Only one partner	30	51.7	22	62.9
Faithful partner	18	31.0	13	37.1
Abstinence / no sex	6	17.1	14	40.0
Condom used	7	12.1	3	8.6
Injection drugs not used	1	3.4	2	5.7
Recent HIV test with negative result	1	3.4	0	0
Oral contraceptives used	2	3.4	3	8.6
Traditional medicine practiced	2	3.4	0	0
Denial (it won't happen to me)	2	3.4	0	0
Unsure	1	3.4	0	0

The perception of women who reported a moderate to high risk was usually based on the fact that they had engaged in unprotected sex. The second most frequent reason given was the fact that they were having sex with several partners. Some women also believe they are at risk because they use drugs. A comparison of women at risk and women not at risk reveals only one significant difference between the two groups of women: only women at risk reported that they believed they were at risk because they had had sex with several partners or used drugs (see Table 10).

Table 10: Reasons why women do not feel at risk				
	Women at risk (n=58) ¹⁰		Women not at risk (n=35) ¹¹	
	N	%	N	%
Unprotected sex	8	13.8	4	11.4
Sex with multiple partners	3	5.2	0	0
Drug use	1	1.7	0	0

In other words, few women perceive themselves to be at risk. Slightly more women at risk (13.8%) considered themselves at risk compared to women not at risk (5.7%), but this difference is not statistically significant ($X^2 = 1,512$; $p > .05$).

⁸ Missing data (4)

⁹ Missing data (3)

¹⁰ Missing data (4)

¹¹ Missing data (3)

The reasons that women gave most often to explain why they feel they are at little or no risk are: sex with only one partner, a faithful partner, or sexually inactive at present. Some of the answers were disturbing: a few women believe that they are at little or no risk because they use oral contraceptives or practice traditional medicine. Some women also expressed a kind of denial: AIDS only happens to other people. Women who are not at risk are more likely to perceive that they are not at risk and base their perception on the fact that they are not sexually active at present.

The perception of women who reported a moderate to high risk was usually based on the fact that they had engaged in unprotected sex. Some women also believe they are at risk because they use drugs.

D. Sexual health practices

D.1 STD-detection testing

Another portion of the questionnaire concerned sexual health practices among women. We wanted to establish whether women had taken STD-detection tests. Among all of the women, 50 (55.6%) had taken a test to detect sexually transmitted diseases. A comparison of women at risk and women not at risk reveals a significant difference between the two groups ($X^2 = 6,638$; $p < .01$); women at risk are significantly more likely to take an STD-detection test (see Table 11).

	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Tested	37	63.8	13	37.1
Not tested	19	33.9	21	61.8

Most women who have not taken an STD-detection test said that they did not believe they were at risk of such diseases. Others said that they had not had sex or that they trusted their partner. Some said that they did not take a test because one had never been suggested to them or they had never thought of it. Lastly, one person said she was unaware of the resources available. Table 12 contains examples of comments by the women for each category of answer.

Category	N	%	Examples of comments
Believes she is not at risk of STD	15	30	• <i>No need for it</i>
			• <i>Ne voyait pas la nécessité</i>
Test never suggested / considered	5	10	• <i>Never thought about it</i>
			• <i>Ils ne m'ont jamais été offerts</i>
Abstinence	3	6	• <i>Not sexually active</i>
Trust in partner	2	4	• <i>I trusted my partner</i>
Not familiar with available resources	1	2	• <i>Je suis prête à le faire, si seulement je savais où le faire gratuitement.</i>

D.2 HIV detection testing

Concerning the HIV detection test, Table 13 shows that women at risk are slightly more likely to have taken an HIV detection test, proportionally speaking. **Incidentally, the chi-squared test reveals no significant difference between the two groups of women: $X^2 = 3.03$; $p > .05$.**

	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Tested	34	58.6	14	40.0
Not tested	21	38.2	20	58.8

In all, 48 women (53.9% of the entire sample) had been tested for HIV. Most of the women who had taken the test said that they took it regularly or had taken one recently (n=31). Some of them had been tested over four years ago (n=14).

One-half of the women reported that they had taken the test for preventive reasons. Other women took the test for the following reasons: unprotected sex; partner had sex with someone else, sexual assault, multiple sexual partners or shared injection drug paraphernalia. Some women were tested when they had blood tests (medical examination) or donated blood. Table 14 shows the various categories of answers with examples of comments by the women.

Category	N	%	Examples of comments
Prevention / precaution	24	50	<ul style="list-style-type: none"> • <i>Avant mon mariage (fiançailles) au début de ma grossesse</i>
			<ul style="list-style-type: none"> • <i>Je venais de connaître un nouveau partenaire</i>
Unprotected sex	9	18.8	<ul style="list-style-type: none"> • <i>Had unprotected sex</i>
			<ul style="list-style-type: none"> • <i>Several partners high risk; unprotected sex</i>
			<ul style="list-style-type: none"> • <i>Cause of sex unprotected</i>
Blood test or blood donation	13	27.1	<ul style="list-style-type: none"> • <i>Protocole (don de sang)</i>
			<ul style="list-style-type: none"> • <i>Sick-physical</i>
Partner had sex with someone else	4	8.3	<ul style="list-style-type: none"> • <i>Doute sur mon x partenaire qui m'était pas fidèle</i>
			<ul style="list-style-type: none"> • <i>Parce que mon conjoint avait des relations sexuelles avec d'autres partenaires</i>
Sexual assault	3	6.3	<ul style="list-style-type: none"> • <i>Got sexually assaulted</i>
Sex with multiple partners	2	4.2	<ul style="list-style-type: none"> • <i>Have had a few sexual relationships in the past (before AIDS) was tested for peace of mind</i>
Shared injection drug paraphernalia	1	2.1	<ul style="list-style-type: none"> • <i>... shared needles</i>

Among all of the women who had been tested for HIV, none had tested positive. Four of the women said that they were not aware of their results.

In all, 41 of the respondents (46.1% of the entire sample) had not been tested for HIV. By way of explanation, these women usually reported that they did not consider themselves at risk (see Table 15). It is disturbing to note that some women were not tested because of embarrassment or fear of knowing the outcome. Others never considered taking the test. Two women reported that they did not know where to go to take the test, and one woman said she did not have the time.

Category	N	%	Examples of comments
Does not perceive herself to be at risk	31	75.6	• <i>I have never felt at risk</i>
			• <i>Puisque 2 de mes partenaires n'avaient jamais fait l'amour avec une fille avant moi et j'avais confiance en l'autre (le 3^{ième})</i>
			• <i>I've just begun having sex. I've never used drugs or had a blood transfusion</i>
			• <i>Always had the same partner</i>
Embarrassment or fear of judgement	4	9.8	• <i>J'ai presque été mais à la dernière minute ça me gênait et je n'ai pas rentré à l'hôpital pour la prise de sang</i>
			• <i>Peur d'être jugé pour en demander un</i>
Does not want to know/ afraid of knowing	4	9.8	• <i>Afraid to know</i>
			• <i>Afraid, fear, uncertainty</i>
Never thought of going	2	4.9	• <i>Never thought of it</i>
Does not know where to go	2	4.9	• <i>Ne sait pas où sont les services</i>
No time	1	2.1	• <i>Pas le temps</i>

D.3 Sexual health services

Among all of the women, 24 (29.6% of the entire sample) were currently using health services for their sexual health needs (family doctor, gynaecologist, nurse, etc.). A comparison of women at risk and women not at risk reveals no significant difference between the two groups in terms of how they use these services ($X^2 = .25$; $p > .05$) (see Table 16).

	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Uses sexual health services	15	25.9	9	25.7
Does not use sexual health services	34	63.4	23	71.8

Most women who do not use sexual health services report that they do not feel the need or are sexually inactive. Other reasons given included: not aware of the services available, does not take the time to go, and embarrassment (see Table 17).

Table 17: Reasons for not using sexual health services			
Category	N	%	Examples of comments
Feels no need	32	56,1	<ul style="list-style-type: none"> • <i>I don't have any specific sexual health problems</i>
			<ul style="list-style-type: none"> • <i>Je n'en ressens pas le besoin</i>
Abstinent / not sexually active at present	7	12.3	<ul style="list-style-type: none"> • <i>Because I'm planning not to have sex with nobody unless I get into a serious relationship</i>
			<ul style="list-style-type: none"> • <i>Widow – abstinence of sex for last 2 ½ years</i>
Not aware of services available	3	5.3	<ul style="list-style-type: none"> • <i>Je viens d'aménager dans une nouvelle ville alors je ne connais pas encore tout les recours</i>
			<ul style="list-style-type: none"> • <i>Cannot find services in Moncton</i>
Does not take the time	2	3.5	<ul style="list-style-type: none"> • <i>Je ne prends pas le temps, mais je devrais</i>
Embarrassment	1	1.2	<ul style="list-style-type: none"> • <i>Ça me gêne tellement</i>

Some women stated that they would need certain services for their sexual health but are not currently receiving them. The services that these women require are: free detection testing for STDs and HIV; more detailed information about STDs and AIDS; free, easily available information about STDs and birth control; free contraceptives; and services in rural areas.

Table 18: Services considered necessary			
Category	N	%	Examples of comments
Free, confidential STD and HIV tests	3	3.2	<ul style="list-style-type: none"> • <i>More confidential testing for HIV and other STDs would help. Also, a less costly way of getting tested would be good</i>
Information about STDs/ AIDS	2	2.2	<ul style="list-style-type: none"> • <i>De l'information plus détaillée et à jour concernant toutes les maladies qu'on peut contracter sexuellement.</i>
Access to free, easily available information about STDs and birth control	3	3.2	<ul style="list-style-type: none"> • <i>It would be nice to have cheap or free access to information about birth control, STDs, etc. within walking distance of the campus.</i>
			<ul style="list-style-type: none"> • <i>... provide me with information on new forms of birth control</i>
Free contraceptives	1	1.1	<ul style="list-style-type: none"> • <i>Free oral contraceptives</i>
Access to services in rural areas	1	1.2	<ul style="list-style-type: none"> • <i>Would be nice to have better access to Sexual Health Services in ...</i>

Depending on these women's point of view, the obstacles to obtaining these services are: lack of government funding, reluctance among teachers to talk about HIV in the classroom, embarrassment and fear of judgement that prevent people from seeking out services, lack of research on the topic, lack of access to doctors and lack of resources (transportation to seek out services, money, etc.).

Category	N	%	Examples of comments
Lack of government funding for services	5	50.0	<ul style="list-style-type: none"> • <i>Poor government organization and funding</i>
Embarrassment / fear of judgement preventing people from seeking out services	5	50.0	<ul style="list-style-type: none"> • <i>I'm too shy</i>
			<ul style="list-style-type: none"> • <i>Wouldn't want to embarrass my husband</i>
Lack of resources	5	50.0	<ul style="list-style-type: none"> • <i>Transportation, money</i>
			<ul style="list-style-type: none"> • <i>l'argent, le manque de médecin de famille</i>
Poor access to doctors	3	30.0	<ul style="list-style-type: none"> • <i>Doctor availability</i>
Teachers reluctant to discuss it in class	1	10.0	<ul style="list-style-type: none"> • <i>Je ne sais pas; les professeurs ne sont peut-être pas à l'aise d'en parler, ce n'est pas compris dans le cadre du cours</i>
Lack of research on the topic	1	10.0	<ul style="list-style-type: none"> • <i>Les recherches sur le sujet manques</i>

In short, a comparison of women at risk and women not at risk shows that women at risk are proportionally more likely to have taken an STD or HIV detection test; a significant difference exists between these two groups of women for STD testing, but not for HIV testing. Most women who took HIV detection tests said that they did so for the following reasons: as a preventive measure; unprotected sex; partner had sex with someone else, sexual assault; multiple sexual partners; or shared injection drug paraphernalia. Incidentally, most women who did not take an HIV or STD detection test said it was not necessary because they are not at risk. However, some of the findings are disturbing: approximately 10% of these women say they are too embarrassed to ask for these tests, and another 10% avoid taking it for fear of the results.

One-third of the women in the sample have used health services to address sexual health issues (family doctor, gynaecologist, nurse, etc.) and no significant difference emerged between women at risk and women not at risk. Most of the women who had not used sexual health services said that they had not needed them. Some mentioned that they are not sexually active.

Some women reported that they would like to have free detection testing for STDs and HIV; more detailed information about STDs and AIDS; free, easily available information about STDs and birth control; free contraceptives; and services in rural areas.

E. HIV/AIDS prevention services

The women were asked to state whether they were aware of the locations where they could get information about HIV/AIDS. Most of them, i.e., 73 of the questionnaire respondents (78.5%) stated that they knew where to go for this information. Also, as Table 20 shows, there is very little difference between women at risk and women not at risk in this regard.

	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Knows where to go	46	79.3	27	77.1
Does not know where to go	10	17.2	6	17.1

The locations usually specified by women who know where to go for information on HIV/AIDS are health services (doctor, nurse, sexual health centre, hospital or clinic) (see Table 21). Next come community groups active in the HIV/AIDS field and pamphlets, books and so on. Lastly, the locations mentioned least often were school, friends and acquaintances and help lines.

Category	N	%
Doctor, nurse, sexual health centre; hospital or clinic	65	85
HIV/AIDS group	22	30.1
Pamphlets, books, TV and Internet	22	30.1
School	3	4.1
Friends/acquaintances	2	2.7
Help lines	2	2.7

Among all of the women, 71 (76.3%) said that they had received information about HIV/AIDS. As Table 22 shows, there is very little difference between women at risk and women not at risk.

	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Obtained information	44	75.9	27	77.1
Did not obtain information	8	13.8	6	17.1

Women were also asked about the places where they would most like to obtain information about HIV/AIDS. Table 23 shows that the source preferred by women is a doctor or nurse. They also prefer printed materials, HIV/AIDS related groups, 1-800 lines or educational institutions. The locations mentioned the least often by women are the workplace and relatives. Table 23 also reveals little difference between women at risk and women not at risk.

Table 23: Locations where women would like to obtain information on HIV/AIDS				
	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Doctor or nurse	32	55.2	21	60.0
Printed materials (brochure, pamphlets, etc.)	29	50.0	16	45.7
AIDS service groups	27	46.6	17	48.6
1-800 information lines	19	32.8	9	25.7
Training at school / university / college	17	29.3	15	42.9
Videos	12	20.7	6	17.1
Workplace training	6	10.3	5	14.3
Relatives	4	6.9	4	11.4

When asked whether they had any difficulty obtaining information about HIV/AIDS, only 10 (10.8%) of the women answered in the affirmative. Once again, we see little difference between women at risk and women not at risk (see Table 24).

Table 24: Women who have difficulty obtaining information about HIV/AIDS				
	Women at risk (n=58)		Women not at risk (n=35)	
	N	%	N	%
Women who have difficulty obtaining information about HIV/AIDS	7	12.1	3	8.6

Some of the women said that obtaining information about HIV/AIDS is difficult because the subject is still taboo and they are ashamed or embarrassed to ask for relevant information (see Table 25). Others believe that they are denied access to services because of their age. One woman said that she was not aware of the services available.

Category	Number	Examples of comments
Embarrassment / shame / taboo subject	6	<ul style="list-style-type: none"> • <i>C'est un peu un sujet tabou. C'est difficile d'en parler</i>
Deprived access to services because of age	2	<ul style="list-style-type: none"> • <i>was turned away from the sexual health centre because I was too old</i>
		<ul style="list-style-type: none"> • <i>In most cases you only get a number to call. This does not work on your parents' phone bill</i>
Not aware of services available	1	<ul style="list-style-type: none"> • <i>Je ne sais pas où aller</i>

Among all of the women, 7 (7.5%) said that they had used the services of an HIV/AIDS group. Table 26 shows that only the women at risk had consulted this kind of group.

Women at risk (n=58)		Women not at risk (n=35)	
N	%	N	%
7	12.1	0	0

Women who did not use the services of this kind of group generally said they did not feel a need. Others said it was because they do not have AIDS. Some women said that they had gone elsewhere for the information. Others did not know where these groups were located, or said that they would be too embarrassed to make initial contact with them. Lastly, two women were unable to explain why they do not use the services of these groups.

Category	N		Comments
No need	34	39.5	<ul style="list-style-type: none"> • <i>Je n'en ressens pas le besoin</i>
Does not have AIDS	5	5.8	<ul style="list-style-type: none"> • <i>J'ai jamais eu le sida</i>
Went elsewhere for information	3	3.5	<ul style="list-style-type: none"> • <i>j'ai eu mon information à l'école</i>
			<ul style="list-style-type: none"> • <i>Always found what I needed through family physician</i>
Does not know where the groups are located	3	3.5	<ul style="list-style-type: none"> • <i>Je ne sais pas où ils sont</i>
Embarrassed to make initial contact / fear	2	2.3	<ul style="list-style-type: none"> • <i>J'ai de la difficulté à téléphoner</i>
			<ul style="list-style-type: none"> • <i>Scared</i>
Unsure	2	2.3	<ul style="list-style-type: none"> • <i>Ne sais pas</i>

To summarize, approximately 80% of the women respondents knew where to go for information about HIV/AIDS and there was very little difference between women at risk and women not at risk in this regard. They usually reported health services (doctor, nurse, sexual health centre, hospital or clinic) as the place where they could find this information. Next, in order of importance, come community-based HIV/AIDS groups, pamphlets, books and so on, school, friends and acquaintances and help lines. Almost 75% of the women said that they had obtained information about HIV/AIDS and, once again, very little difference set the women at risk apart from women not at risk. Furthermore, these women prefer to obtain information on HIV/AIDS from a doctor or nurse. They also prefer printed materials, HIV/AIDS-related groups, 1-800 information lines or educational institutions. The locations mentioned the least often by women are the workplace and relatives.

Only 10% of women experience problems finding information about HIV/AIDS. According to most of these women, obtaining this information is difficult because HIV/AIDS is still a taboo topic that triggers shame and embarrassment.

Among all of the women, only a few at risk had used the services of a community-based HIV/AIDS group, or approximately 8% of the entire sample. Most of the women said that they had not used these services because they felt no need and did not consider themselves at risk. Other reasons given for not having sought services from these groups are: do not have AIDS; went elsewhere for information; do not know the location of the services; too embarrassed or afraid to make initial contact with the group.

Conclusion

The primary goal of this research-action project was to identify the needs of women at risk of HIV, namely, women who use injection drugs, women living in poverty, sex-trade workers, women in correctional facilities, young women, older women, Aboriginal women, black women, disabled women and lesbians. The questionnaires were therefore distributed through groups likely to encounter these women. Despite repeated effort, it was difficult to reach some groups of women at risk.

More specifically, the study's objectives were to:

1. Evaluate the level of knowledge among women with HIV/AIDS
2. Identify unsafe among women
3. Determine whether women perceive themselves as persons at risk;
4. Explore the sexual health practices of women
5. Explore the experiences of women in terms of how they use sexual health and HIV/AIDS prevention services
6. Identify the services / programs required to prevent HIV/AIDS among women

The results described in this research report lead us to the following conclusions:

Sexual practices:

- ❖ Many of the women included in the sample display characteristics or engage in practices that can expose them to the risk of HIV. These characteristics or practices are: unprotected sex with more than one partner; sharing sex toys with one or more partners without using a condom; trading sex for alcohol or drugs; sex with multiple partners at risk; tattooing or piercing under unsanitary conditions; victim of spousal violence; illegal injection-drug use; frequent drinking (2 to 3 times a week or daily); use of cocaine or heroin; and family income under \$15,000 a year.
- ❖ Most of the women had not used a condom the last time they had sex.
- ❖ The main reason reported by the women for not using a condom was that the sex involved their regular partner. The other reasons mentioned most often by the women are: their partner refused, the condom was uncomfortable, embarrassment, they could not get a condom.
- ❖ Women at risk seem the most likely to feel somewhat powerless over the decision to use a condom; almost 20% of them (compared to 9% of women not at risk) stated that they had not used a condom because their partner refused, they were unable to get one or they were embarrassed.
- ❖ When faced with a partner who refused to use a condom, the women usually tried to discuss the matter with the partner and persuade their partner to use it. Some women, especially women at risk, went ahead and had sex anyway.

- ❖ Approximately 15% of women at risk and women not at risk felt little or no confidence in their ability to persuade their partner to use a condom.

Knowledge among women about HIV/AIDS

- ❖ Most of the women in the research sample lacked information about HIV/AIDS transmission; almost 20% of the women in the sample correctly answered all of the statements designed to test this knowledge.
- ❖ Almost all of the respondents knew when it was necessary to take an HIV detection test.

Perception of the risk:

- ❖ Most of the women at risk did not perceive themselves to be at risk.
- ❖ The women explained that they are at little or no risk because they have sex with only one partner or a faithful partner, or they are not sexually active at present.
- ❖ It is disturbing that some women do not believe they are at risk because they use oral contraceptives or practice traditional medicine. Others believe that it will not happen to them. Therefore, some women display a form of denial: AIDS only happens to other people.
- ❖ The perception of most of the women who reported a moderate to high risk was usually based on the fact that they had engaged in unprotected sex.

Sexual health practices:

- ❖ Most of the women had taken STD and HIV detection tests. A comparison of women at risk to women not at risk indicates that women at risk are proportionally more likely to have taken these tests.
- ❖ Most of the women specified that they had taken an HIV detection test as a preventive measure. Also, some took the test because they had had unprotected sex, were afraid that a partner had been unfaithful, were sexually assaulted, had had multiple sexual partners or had shared injection drug paraphernalia.
- ❖ Most of the women who had not taken an HIV or STD detection test said it was not necessary because they did not consider themselves at risk.
- ❖ It is disturbing that approximately 20% of the women who had not been tested for HIV said they were prevented from doing so out of embarrassment or fear of the test results.

- ❖ Only one-third of the women in the sample had consulted health services concerning their sexual health (family doctor, gynaecologist, nurse, etc.).
- ❖ Most women who do not use sexual health services reported that they do not feel the need or are not sexually active.
- ❖ Some women said that the following services should be available: free detection testing for STDs and HIV; more detailed information about STDs and AIDS; free, easily available information about STDs and birth control; free contraceptives; and services in rural areas. According to the women, obstacles preventing them from obtaining these services are: lack of government funding, reluctance among teachers to talk about HIV in the classroom, embarrassment and fear of judgement that prevents people from seeking out services, lack of research on the topic, lack of access to doctors and lack of resources (transportation to seek out services, money, etc.).

HIV/AIDS prevention services:

- ❖ Most of the women knew where to go for information about HIV/AIDS, but 20% said that they did not know where to find this information.
- ❖ The women usually reported health services (doctor, nurse, sexual health centre, hospital or clinic) as a potential source of information about HIV/AIDS. Next, in order of importance, they mentioned community-based HIV/AIDS groups, pamphlets, books and so on, school, friends and acquaintances and 1-800 help lines.
- ❖ Most of the women said that they had obtained information about HIV/AIDS, although 25% had not.
- ❖ The women indicated the locations where they would prefer to receive HIV/AIDS information. In order of importance, they mentioned doctors or nurses, printed materials, community-based HIV/AIDS groups, 1-800 information lines and educational institutions. The locations mentioned the least often by women are the workplace and relatives.
- ❖ Only 10% of the women experience problems finding information about HIV/AIDS. According to most of these women, obtaining this information is difficult because HIV/AIDS is still a taboo topic that generates shame and embarrassment.
- ❖ Among all of the women, only a few at risk had used the services of a community-based HIV/AIDS group, or approximately 8% of the entire sample.

- ❖ The reason most often mentioned by women who had not tried to obtain services from community-based HIV/AIDS groups was the fact that they did not feel the need or did not consider themselves at risk. Other reasons given included: do not have AIDS; went elsewhere for information; do not know the location of the services; too embarrassed or afraid to make initial contact with the group.

These main findings lead us to a few courses of action:

- ❖ Pursue efforts in progress to raise awareness among women 18 years of age or more to promote a better knowledge of HIV/AIDS transmission and the associated risk factors, as well as different ways of preventing HIV infection.
- ❖ Develop a range of strategies for alleviating the embarrassment associated with discussing HIV or suggesting the use of a condom.
- ❖ Create strategies for action that foster feelings of empowerment in women, especially women at risk, to help them gain a better sense of control over the decision to use a condom.
- ❖ Inform women, especially women at risk, about the importance of regular HIV detection tests and sexual health services.
- ❖ Educate women about resources that can provide them with sexual health services and information about HIV/AIDS.
- ❖ Establish or promote the following services: free detection testing for STDs and HIV; more detailed information about STDs and AIDS; free, easily available information about STDs and birth control; free contraceptives; and services in rural areas.
- ❖ Keep in mind that women prefer to obtain information about HIV/AIDS from medical workers, written materials, HIV/AIDS groups, 1-800 information lines and educational institutions.
- ❖ Develop a series of actions to promote access to community-based HIV/AIDS groups.

Research limitations

This study is subject to certain limitations. First of all, despite repeated effort, it was difficult to reach some groups of women at risk. Therefore, some groups at risk are not represented or are under-represented in this research. Another limitation concerns the fact that certain women did not answer the entire questionnaire, which sometimes produced a significant number of missing data. This may have resulted from the fact that the questionnaire was self-administered or the sensitive nature of certain questions. This research study is the first of its kind in the Greater Moncton Area and will lead to the development of strategies for lowering the risk of HIV among women in the area.

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Women and HIV/AIDS

This questionnaire asks questions related to knowledge, attitudes and behaviours on sensitive issues such as HIV/AIDS and sexual experience. Some questions pertain to experiences with violence, drugs and alcohol. The purpose is to help us better understand women and their needs related to HIV/AIDS.

Your answers are *CONFIDENTIAL* and we do not need to know your name. Answering this questionnaire will help us plan better services for women regarding the prevention and treatment of HIV/AIDS.

This questionnaire takes approximately 30 minutes to answer.

Please answer accurately and do not worry about whether there is a correct answer. As mentioned above, this information is confidential, only the researchers can access the data.

****Thank you for your good cooperation****

THE QUESTIONNAIRE

A. Knowledge about HIV/AIDS and risk factors

A.1. Here are some questions about HIV, the virus that causes AIDS. Don't worry about getting the right answers just indicate what you think. For each statement, PLEASE PUT AN X to indicate your point of view: Yes; No; Don't know

	Yes	No	Don't know	No answer
A1.1 Do you think a person can get HIV by having oral sex without protection?				
A1.2 Do you think a person can get HIV by having anal sex without protection?				
A1.3 Do you think a person can get HIV by having vaginal sex without protection?				
A1.4 Do you think that a person who looks healthy can be infected with the HIV virus?				
A1.5 Do you think that people can protect themselves from HIV by using a condom correctly every time they have sex?				
A1.6 Do you think that people can protect themselves from getting infected with HIV by having one uninfected sex partner who also has no other partners?				
A1.7 Do you think that people can protect themselves from getting infected with HIV by not having sexual intercourse?				
A1.8 Do you think that a person can get infected with HIV by getting injections with a clean, sterile needle?				
A1.9 Do you think that a person can get HIV by sharing injection drug equipment?				
A1.10 Do you think that a person can get HIV by sharing sexual toys without a using a condom?				
A1.11 Do you think that HIV can be passed from a mother to her child?				

A.2. When should someone be tested for HIV/AIDS? PUT AN X in the boxes that best represent your opinion.

	Yes	No	Don't know	No answer
A2.1 When a person had vaginal, oral or anal sex without protection with a partner who had unprotected sex with other partners				
A2.2 When a person shares a needle and/or drug paraphernalia (drug equipment)				
A2.3 When a person had a tattoo or ear piercing in an unsanitary environment (meaning that the needles are not sterilized and/ or that there's not new bottle of paint used for each new client)				
A2.4 When a person is ready to have sexual intercourse with a new partner				

B. Evaluation of practices

B.1 PUT AN X in all the boxes that apply **and if you put an X in the yes box, answer the following question. During the last year, did you?**

Activities	No	Yes	No answer
B1.1 Exchange sex for money and/or drugs			
B1.2 Inject illicit or illegal drug			
B1.3 Share injection drug equipment with one person			
B1.4 Share injection drug equipment with more than one person			
B1.5 Have unprotected sex with one partner (includes anal, vaginal and oral sex)			
B1.6 Have unprotected sex with more than one partner (includes anal, vaginal and oral sex)			



If yes, why?	No answer

B1 (continued)

Activities	No	Yes	No answer
B1.7 Share sexual toys with partner without using a male condom or female condom			
B1.8 Had a tattoo or piercing in an unsanitary environment (meaning needles are not sterilized and/or that there's not a new bottle of paint used for each new client)			



If yes, why?	No answer

B.2 The following questions pertain to your sexual experiences.

No	Questions	Coding categories
B2.1	In the last 4 months , have you had sexual intercourse? (including vaginal, oral or anal sex). <u>Circle yes or no.</u>	No SKIP to B4
		Yes
		No answer
B2.2	In the last 4 months , how many times have you had vaginal sex? <u>Indicate the number of times.</u>	Number of times:
		Not sure
		No answer
B2.3	In the last 4 months , how many times have you had oral sex? <u>Indicate the number of times.</u>	Number of times:
		Not sure
		No answer
B2.4	In the last 4 months , how many times have you had anal sex? <u>Indicate the number of times.</u>	Number of times:
		Not sure
		No answer
B2.5	In the last 4 months , how many sex partners have you had? <u>Indicate the number of partners.</u>	Number of partners:
		Not sure
		No answer

B.3. In the last 4 months, have you ever had sex with the following partners? If so, how often did you use a condom? CHECK YES OR NO AND HOW OFTEN YOU USED A CONDOM (never, few times, half the time, most of the times and every time).

Person	No	Yes	No answer
B3.1 Husband, someone you live with in common law, girlfriend or boyfriend			
B3.2 Friend			
B3.3 Acquaintance			
B3.4 Male/ female sex workers			
B3.5 Someone who you think has had sex with a lot of other people (same sex or not)			
B3.6 Someone who gave you gifts, drugs or money in exchange for sex			
B3.7 Other (specify) _____			



Condom use in the last 4 months					No answer
Never	Few times	Half the time	Most times	Every time	

B.4 The following questions pertain to your most recent sexual experience. If you never had a sexual experience, skip to section C.

No	Questions	Coding categories	Skip to
B4.1	The last time you had sex with someone did you or your partner use a condom? <u>Circle yes or no.</u>	No	If no, SKIP to B4.3
		Yes	
		No answer	
B4.2	What were the reasons you used a condom? <u>(Select all that apply)</u>	Own concern to prevent pregnancy	SKIP to B4.4
		Own concern to prevent sexual transmitted diseases (STD), including HIV	
		Partner insisted/ partner's choice	
		Other (specify) _____	
		No answer	

B4 (Continued)

B4.3	<p>What were the reasons you did not use a condom? <u>(Select all that apply)</u></p>	<p>Condoms are uncomfortable Embarrassing to use condoms Unable to get condoms Condoms are too expensive Had sex with partner who was not a sex worker Had sex with my regular partner Partner did not want to Other (specify) _____ _____ No answer</p>	
B4.4	<p>At your last sexual intercourse, who decided to use or not use condom?</p>	<p>Self Partner Both Other No decision Not sure No answer</p>	-
B4.5	<p>How confident are you that you could convince your partner that he or she should use a condom if you wanted to use one?</p>	<p>Not at all confident Somewhat confident Confident Very confident No answer</p>	-
B4.6	<p>What would you do if your partner declined or refused to use condom?</p>	<p>Have sex without condom Talk it over and use condom Talk it over but not use condom Withdrawal Other (specify) _____ _____ Don't know/ not sure No answer</p>	-

B. 5. If you practice prostitution / escort service, please answer questions B5.1 to B5.7. If you don't engage in prostitution / escort service, go to questions pertaining to number B.6.

B5.1	On the last <i>day</i> you worked, how many clients did you have? <u>INDICATE THE NUMBLER OF CLIENTS</u>	Number of clients <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW NO RESPONSE	
B5.2	The last time you had sex with a client, did you and your client use a condom? <u>CIRCLE YES OR NO</u>	YES NO DON'T KNOW NO RESPONSE	If no, SKIP to B5.4
B5.3	Who suggested condom use that time? <u>CIRCLE ONE</u>	Myself Client Joint decision DON'T REMEMBER NO RESPONSE	SKIP to B5.5
B5.4	Why didn't you and your client use a condom that time? <u>CIRCLE ALL THAT APPLY</u>	Y N Not available Too expensive Partner objected Don't like them Used other contraceptive Didn't think it was necessary Didn't think of it Other _____ DON'T KNOW NO RESPONSE	
B5.5	In general, with what frequency did you and your clients use condoms over the last 30 days?	EVERY TIME ALMOST EVERY TIME SOMETIMES NEVER DON'T KNOW NO RESPONSE	

B.6. Now we would like information on your partner(s), meaning partner(s) that you are currently having sexual relations with. If you are not currently having sexual relations with someone, skip to section C.

B6.1 What sex is/are your partner(s)?	Male Female No answer	
B6.2 Does your partner(s) inject any illegal drugs?	Yes No SKIP to B6.5 No answer	
B6.3 Does your partner(s) share injection drug equipment with you?	Yes No No answer	
B6.4 Does your partner(s) share injection drug equipment with other people?	Yes No No answer	
B6.5 Does your partner(s) engage in prostitution?	Yes No No answer	
B6.6 Does your partner(s) have unprotected sex with one or more other partners?	Yes No No answer	
B6.7 Does your partner(s) have sex with men?	Yes No No answer	

C. Experiences with violence, alcohol and drugs

C1. The following questions relate to your most recent experiences with violence. For those questions, the term “partner” may pertain to a conjugal relationship or a boyfriend or girlfriend.

<p>C1.1 How many partners have you had who have called you names or yelled at you at least once a week?</p>	<p>None SKIP to C1.3 One 2-3 4 or more Don't know SKIP to C1.3 No answer SKIP to C1.3</p>	
<p>C1.2 By whom?</p> <p><u>CIRCLE ALL THAT APPLY</u></p>	<p>A current male partner</p>	
	<p>A current female partner</p>	
	<p>A former woman partner</p>	
	<p>A former man partner</p>	
	<p>Other, specify: _____</p>	
	<p>Don't know</p>	
	<p>No answer</p>	
	<p>NA</p>	

C1. (Continued)

<p>C1.3 How many partners have you had who have hit you or hurt you physically in any way?</p>	<p>None SKIP to C1.5 One 2-3 4 or more Don't know SKIP to C1.5 No answer SKIP to C1.5</p>	
<p>C1.4 Who was this?</p> <p><u>CIRCLE ALL THAT APPLY</u></p>	<p>A current male partner A current female partner A former woman partner A former man partner Other, specify: _____ Don't know No answer NA</p>	
<p>C1.5 How many partners have you had who have physically forced you into sexual activity against your will?</p>	<p>None SKIP to C2 One 2-3 4 or more Don't know SKIP to C2 No answer SKIP to C2</p>	
<p>C1.6 Who was this?</p> <p><u>CIRCLE ALL THAT APPLY</u></p>	<p>A current male partner A current female partner A former woman partner A former man partner Other, specify: _____ Don't know No answer NA</p>	

C2. Now, we would like to ask you a few questions about abuse that you may have experienced while you were a child. You may find these questions to be sensitive, so please remember that you can skip any question that makes you feel uncomfortable.

<p>C2.1 Before the age of 12 do you remember if any person older than you, at any time touched you sexually or did anything sexually to you?</p>	<p>No SKIP to C3</p> <p>Yes, once</p> <p>Yes, 2-3 times</p> <p>Yes 4-10 times</p> <p>Yes, more than 10 times</p> <p>I cannot remember</p> <p>Don't know</p> <p>No answer</p>	
<p>C2.2 Who was the person that did this?</p> <p><u>CIRCLE ALL THAT APPLY</u></p>	<p>Father</p> <p>Step-father</p> <p>Mother</p> <p>Step-mother</p> <p>Another member of the family</p> <p>A boy or girl from school</p> <p>A house boy</p> <p>Teacher</p> <p>Friend of the family</p> <p>Stranger</p> <p>Other, specify: _____</p> <p>Declined</p> <p>Don't know</p> <p>NA</p>	

C3. The following questions ask about your consumption of alcohol and drug. Please feel free to answer these questions honestly and do not worry about any negative impact from answering. Do not forget, your responses are anonymous.

<p>C3.1 Did you drink alcohol or use drugs before you had sexual intercourse the last time?</p>	<p>I never had sexual intercourse Yes No Don't know No answer</p>	
<p>C3.2 In the last 30 days, how often have you drunk alcohol (do not consider drinking a few sips of wine for religious purposes)?</p>	<p>did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day</p>	
<p>C3.3 In the last 30 days, how many times did you use marijuana (also called grass or pot)?</p>	<p>did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day</p>	
<p>C3.4 In the last 30 days, how many times have you used any form of cocaine, including powder, crack, or freebase?</p>	<p>did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day</p>	

<p>C3.5 In the last 30 days, how many times have you sniffed glue or inhaled any paints or sprays to get high?</p>	<p>did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day</p>	
<p>C3.6 In the last 30 days, how many times have you used heroin (also called smack, junk, or China White)?</p>	<p>did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day</p>	
<p>C3.7 In the last 30 days, how many times have you used methamphetamines (also called speed, crystal, crack, or ice)?</p>	<p>did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day</p>	
<p>C3.8 In the last 30 days, how many times have you taken steroid pills or shots without a doctor's prescription?</p>	<p>did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day</p>	

C3 (Continued)

C3.9 In the last 30 days, how many times have you used a needle to inject any illegal drug into your body?	did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day	
C3.10. In the last 30 days, how many times have you taken prescription drugs for recreational use?	did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day	
C3.11. In the last 30 days, how many times did you use Methadone?	did not use 1 time 2-3 times 1 time per week 2-3 times per week Every day	

C4. The following questions pertain to your experiences if you have ever been in jail.

C4.1 Have you been or are you in jail?	Yes No Skip to D No answer	
C4.2 Did you go to jail for drug related offences?	Yes No What was the offence(s)?: _____ _____ No answer	
C4.3 While you where in jail, did you do drugs?	Yes No No answer	
C4.4 While you where in jail, did you use a needle to inject any illegal drug into your body?	Yes No No answer	

C4 (Continued)

<p>C4.5 While you were in jail, did you share needles?</p>	<p>Yes No No answer</p>	
<p>C4.6, Which, if any of these things, do you think, should be made available in jail?</p> <p><u>CIRCLE ALL THAT YOU THINK SHOULD BE AVAILABLE.</u></p>	<p>Condoms Needles Bleach (for cleaning needles) Methadone Other (specify):</p>	
<p>C4.7 Did you get education on HIV/AIDS in jail?</p>	<p>Yes No No answer</p>	
<p>C4.7 Do you think that HIV/AIDS education should be given upon entering jail?</p>	<p>Yes No No answer</p>	

D. Perception of risk

D. These questions relates to your perception concerning your risk of HIV infection.

D1 What do you think your risk of HIV infection is?	No risk	
	Low	
	Medium	
	High	
	No answer	
D2 Why do you think that you have risk in that level?	Abstinence/ no sex	
	Have only one partner	
	Always use condoms	
	Uses contraceptive pill	
	Uses traditional medicine	
	Partner is faithful	
	There is no such thing as AIDS	
	It can't happen to me	
	Have multiple partners	
	Partner is infected	
	Have unprotected sex	
	Drug use	
	Other (specify) _____	

No answer		

E. Experience with HIV / AIDS and services regarding sexual health

E.1 We want to know your own personal experience with having been tested for HIV/ AIDS or other sexual transmitted diseases.

<p>E1.1 Have you ever been tested for HIV?</p>	<p>Yes</p> <p>1a) Where? _____</p> <p>No</p> <p>Why did you never get tested? (Answer than skip to question E1.7): _____</p> <p>_____</p> <p>_____</p> <p>No answer</p>	
<p>E1.2 Why did you get tested?</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>E1.3 When did you get tested?</p>	<p>_____</p>	

<p>E1.4 Do you feel you received what you considered to be good pre and post test counselling when you got tested for HIV?</p>	<p>Yes</p> <p>What did you receive? _____</p> <p>_____</p> <p>_____</p> <p>No</p> <p>What do you feel was lacking? _____</p> <p>_____</p> <p>_____</p> <p>No answer</p>	
<p>E1.5 What was the result of your test?</p>	<p>Positive</p> <p>Negative SKIP to E1.7</p> <p>Don't know SKIP to E1.7</p> <p>No answer</p>	
<p>E1.6 How do you think you contracted HIV/ AIDS?</p>	<p>_____</p> <p>_____</p> <p>_____</p>	
<p>E1.7 Have you ever been tested for other sexually transmitted diseases?</p>	<p>Yes</p> <p>No</p> <p>Why did you never get tested? _____</p> <p>_____</p> <p>No answer</p>	

E2. We now would like to have your perception on services regarding sexual health (these may include hospital services, family doctors, emergency room, etc.).

<p>E2.1 Are you accessing services now for yourself regarding sexual health?</p>	<p>Yes Which ones? _____ _____ _____</p> <p>No Why not? (Answer than skip to question E2.3) _____ _____</p> <p>No answer</p>	
<p>E2.2 If you are accessing services regarding sexual health, which ones are adequate and which ones are not adequate and why?</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

E3 (Continued)

<p>E3.2 Did you ever receive information on HIV / AIDS?</p>	<p>Yes</p> <p>Where? _____</p> <p>_____</p> <p>_____</p> <p>What did you receive? _____</p> <p>_____</p> <p>_____</p> <p>Are you satisfied with the information received?</p> <p>Why? _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>No</p> <p>No answer</p>	
<p>E3.3 From who or what organization or service would you prefer to have information about HIV/AIDS?</p>	<p>1 –800 Information Line (confidential)</p> <p>Workplace education</p> <p>School education</p> <p>Parents</p> <p>Printed materials (Pamphlets, books)</p> <p>Videos</p> <p>Doctor or nurse</p> <p>AIDS Service Organization</p> <p>Other (specify):</p>	

<p>E3.4 Is it hard to get information on HIV / AIDS?</p>	<p>Yes Why? _____ _____ _____</p> <p>No Why? _____ _____ _____</p> <p>No answer</p>	
<p>E3.5 Did you ever use services from an AIDS Service Organization?</p>	<p>Yes Where? _____</p> <p>What did you receive? _____ _____ _____</p> <p>Are you satisfied with the service(s) received? Why? _____ _____ _____</p> <p>No Why? _____ _____</p> <p>No answer</p>	
<p>E3.6 Did you have access to a service or organization to get free condoms?</p>	<p>Yes Why? _____</p> <p>No Why? _____ _____</p> <p>No answer</p>	

F. GENERAL INFORMATION

This is the last section of the questionnaire. We would like to have some general information.

F1. What is your age group? PUT AN X TO INDICATE YOUR AGE CATEGORY

- 18 to 24 years of age
- 25 to 29 years of age
- 30 to 45 years of age
- 46 to 65 years of age
- over 65 years of age

F2. Are you a visible minority?

- a) Yes
- b) No

If yes, how? _____

F3. What type of community do you live in?

- Urban (Greater Moncton Area; Moncton, Dieppe, Riverview)
- Rural

F4. If you are currently at school, which grade or program are you in?

F5. What was the last grade you reached in school?

1. None or only kindergarden
2. Went to school but did not complete up to grade 6
3. Did complete grade 6
4. Did complete grade 6 but did not obtain grade 12 diploma
5. Did complete grade 12 diploma or the equivalent
6. Went to college or technical school but did not obtain diploma
7. Went to college or technical school and obtain diploma
8. Went to university but did not obtain a diploma
9. Went to university and obtained a diploma
10. Other (specify):

F6. What is your sexual orientation?

1. heterosexual
2. lesbian or gay
3. bisexual
4. Transgender

F7. Do you have children?

- a) Yes
- b) No

If yes, how many? _____

And how old are they? _____

F8. Do you live with anyone else?

- a) Yes
- b) No

If yes, with which of the following:

1. roommate
2. partner
3. parents or parental figure (grandparents, foster home, etc.)
4. friends
5. childrens
6. other persons (specify): _____

F9. Overall, are you financially dependent on your parents or parental figure or partner or anyone else:

1. Yes

Who? _____

2. No (Skip to F10)

If yes, what is the overall family income (for one year). Put an X to indicate your family's income category

- ___ less than 15 000\$
- ___ 15 000\$ to 30 000\$
- ___ 30 000\$ to 45 000\$
- ___ 45 000\$ to 50 000\$
- ___ over 50 000\$

If yes, does the person you are financially dependent on receive social assistance:

Yes

No

The following questions are answered by those who don't live with their parents and/ or not financially dependent on their parents or other persons. If you are financially dependent on someone, you have completed the questionnaire. If you are not financially dependent on someone, you have five other questions.

F10. Do you receive social assistance?

a) Yes

b) No

F11. If you work, what type of work do you do?

F12. What is your annual income? Put an X to indicate your income category

less than 15 000\$

15 000\$ to 30 000\$

30 000\$ to 45 000\$

45 000\$ to 50000\$

over 15 000\$

F13. After you pay your rent/ utilities, do you feel you have enough money left for food for yourself and/or your family?

a) Yes

b) No

F14. How stable is our housing situation?

a) unstable

b) somewhat stable

c) need improvement

d) stable

e) very stable

*****The questionnaire is now complete... thanks again for your precious collaboration*****

Appendix B: Consent Form

Study on Women and HIV/AIDS

CONSENT FORM

Hello,

A study is currently underway in the Greater Moncton area dealing with Women and HIV/AIDS. The study will be completed by means of a questionnaire provided to women 18 years of age and older. The intent of the questionnaire is to collect information regarding attitude, behaviour and knowledge regarding HIV. Some questions deal with actual experiences pertaining to violence, drugs and alcohol. Other questions are designed to collect information on access to sexual health services. Your participation in this study is important as it could contribute to the implementation of services which better serve the needs of women. The study is conducted by SIDA AIDS Moncton in collaboration with Chantal Bourassa, a professor of social work at the Université de Moncton.

The following measures are implemented to insure the anonymity of respondents and the confidential nature of the information presented in the questionnaire:

- **Your name will not appear on any document.**
- **In no event will the individual results of participants be shared with anyone.**
- **Only researchers will have access to the questionnaires.**

As some of the questions deal with delicate situations such as violence, you may feel the need to talk with someone. Do not hesitate to seek help. A list of organisations and their telephone numbers appear on the final page of the questionnaire. We encourage you to contact any of these organisations should you feel the need to do so. You may, at any time, choose to stop answering the questionnaire.

Please check one of the following:

I have read and understood the information displayed on this page. I'm at least 18 years of age and I accept to participate in the research by completing the questionnaire. *In this case, you may begin to complete the questionnaire. Once you're done, please put everything in the envelope, seal it and mail it directly to the researchers.*

I have read and understood the information displayed on this page. *I'm not at least 18 years of age and/or I do not wish to complete this questionnaire. In this case, please put everything in the envelope, seal it and mail it directly to the researcher.*

Thank you!

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