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The Effects of Stigma on Aboriginal Women Living with HIV/AIDS

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ABSTRACT

Stigma has a serious impact upon the lives of HIV-positive Aboriginal women. The ways in which Western society presently addresses stigma, specifically that which is directed towards Aboriginal women living with HIV/AIDS are unacceptable. Their experiences in life are laden with discrimination, social rejection, marginalization, and violence against them—this needs to be changed. In this paper, we offer a critical view of three kinds of discourse around stigma, social, statistical reporting, and medicalization, that influence the ingrained societal ideologies around stigma. We will use the literature to critically analyze the dominant discourse around stigma and to briefly unfold common strategies for anti-stigma discourse. Through exposing these discourses, we hope to uncover the negative impact that stigma has on the lives of Aboriginal women with the intent to shift the perceptions of the public, thus assisting the women in the reconstruction of a healthier social and personal identity of self. The social contexts surrounding the discourse of stigma can, and must, transform for the benefit of women living with HIV/AIDS and their healthy identities.

INTRODUCTION

HIV has come to be known as a socially constructed illness that affects the most marginalized of people. HIV/AIDS is understood and experienced within social and cultural contexts. Society has learned to view the illness and HIV-positive people with stigmatizing attitudes, which, in turn, influence the ways people live with the illness (Clarke, Friedman & Hoffman-Goetz, 2005).

For Aboriginal³ peoples throughout Canada, the AIDS epidemic continues to rise at a disproportionate rate as compared to the rest of Canadians (Health Canada, 2003). Aboriginals accounted for 14.1 of AIDS cases reported in the first half of 2002, up from 5.3 percent in 2001, and 10 percent in 1999 (Public Health Agency, 2007). Aboriginal people are three times as likely to be HIV-infected than other Canadians with exposure occurring predominantly as a result of intravenous drug use (53 percent) (Public Health Agency, 2007). As many as 25 percent of all AIDS cases in Canada are Aboriginal, and of those, nearly half are Aboriginal women (Barrett and Bissel, 1999, Hill, 2003, Canadian Aboriginal AIDS Network [CAAN], 2003, Majumdar, Chambers, & Roberts, 2004). More and more Canadian women are being diagnosed with HIV-infection and Aboriginal women are most at risk (PHAC, 2005). Health Canada (2003) reports Aboriginal women represent a significantly higher proportion of HIV/AIDS diagnoses than non-Aboriginal women (45.3 percent vs. 19.9 percent).

The HIV epidemic in the Aboriginal community is not decreasing. There are multiple notions of why this is happening. Bucharski, Reutter, and Ogilvie (2006) found that fear of being judged by family, their community, and society often interferes with seeking testing resulting in delayed diagnosis. Judgments by society can make

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3 The term 'Aboriginal' is used to refer to First Nations, Métis, and Inuit Peoples in Canada, whereas the term 'Indigenous' refers to Aboriginal Peoples globally. These terms are used interchangeably depending on the language used by the author cited. (Kurtz, Nyberg, Van Den Tillaart, Mills, & Okanagan Urban Aboriginal Health Research Collective [in press]).

an individual feel shame for becoming infected or for living a 'risky' lifestyle. Self-shame is one stigmatizing attitude among others such as fear and denial. Poindexter (2004) describes stigma as: "labeling differences negatively or stereotyping based on cultural beliefs. ...HIV stigma, is a particular form of discrimination that causes social and emotional problems for persons with HIV and their associates" (p. 498). The ways in which Western society presently addresses stigma, specifically in relation to Aboriginal women living with HIV/AIDS, are unacceptable and need to change.

Before changes in the societal view can be made, we need to understand how stigma impacts the lives of Aboriginal women living with HIV/AIDS through a critical lens of the underlying societal ideologies of three kinds of stigma discourse. We define discourse as the communication of thought (discussion, dialogue) by written or conversational words. The three edged sword of stigma includes: 1) social stigma, 2) statistical or qualitative reporting of HIV/AIDS, and 3) the medicalization of stigma. In reality, these three kinds of stigma are often inextricably woven together and influence each other. Therefore, there may be some difficulty individually discussed discussing them without losing the depth of the significance of the individual and the interwoven impact on individuals.

To illustrate how social/public discrimination is intertwined with statistical reporting and the medicalization of HIV, we present a case study of one family's experience with a daughter's illness leading to HIV-diagnosis. The events immobilize the parents, and their young daughter, resulting in a two-year struggle preceding the HIV diagnosis. They face a multitude of issues related to stigma that are common for many people going through the question of infection and diagnosis of HIV. We contend that social discrimination, statistical reporting, and the medicalization of stigma are devastating and debilitating for those living with HIV/AIDS.

SOCIAL DISCRIMINATION

Poindexter's study (2004) of caregivers provides the case study of two parents, Peg and Mike, and their belief that their daughter Kate (pseudonyms) is free from contracting HIV because she did not fit the stereotype of a person at high risk for contracting HIV. This assumption delayed HIV-testing and her "gender, race, education, appearance, and socio-economic status contributed to her not receiving an accurate [HIV] diagnosis despite repeated medical examinations" (p.496).

Had Kate been Aboriginal, the events leading to her diagnosis may have been more severe. Bucharski et al. (2004) found that some Aboriginal women fear being tested because a positive diagnosis could lead to rejection by family and society, depression, suicide, and being stigmatized by their own communities. The women's past negative experiences with mainstream service agencies cause hesitancy in accessing healthcare services, which delay early diagnosis and treatment.

Western medicine relies on medical/professional/researcher scientific evidence for diagnosis of illness. "Physicians, charged with being efficient and accurate as they strive to diagnose quickly and treat appropriately, at times use epidemiological and prevalence data or consult profiles and protocols to determine who is most likely to have a particular ailment" (Poindexter, 2004, p. 496). These statistics can negatively impact women living with HIV/AIDS through the medicalization of stigma and social discrimination.

In Poindexter's study (2004), Peg and Mike are working class, Irish-American, ex-Catholics, with four grown children, the youngest of whom is their daughter Kate. What becomes evident in the story they share about their daughter Kate's illness is the fact that, they, along with the medical system, seemed to inadvertently add to the stereotypical images of their daughter. Kate, in everyone's eyes, did not fit the profile of someone needing to be tested for HIV. Peg's comments are stigmatically related to the picture of her daughter and "it" as not fitting the "lifestyle" of anyone with HIV/AIDS. "'It' seems to mean the possibility of HIV infection, and 'lifestyle' seems to refer to the antecedents: not too much drugging and not too much sex" (Poindexter, 2004, pp. 502-503). Peg often refers to "we," meaning her and her husband (and possibly Kate) as not understanding how the possibility of HIV-infection could have become a part of their lives.

Kate's mother, Peg, was aware that her daughter was having unprotected sex, but did not broach discussion of sexually transmitted infections (STIs) with her. Nor did she consider that any STIs could harm Kate, or ultimately, be the cause of her deteriorating health. Peg considered Kate's ability to stay working as traits of strength and courage, and as a rationale that she could not have such a serious infection as HIV.

The diagnosis of HIV for an Aboriginal woman has an additional impact on her life because of colonization and the history of government involvement in the apprehension of Aboriginal children (residential schools, foster care) (CAAN, 2004, Mill, 2000).

Many HIV infected women are primarily responsible for their own self-care, and the care of their children, partners and other family members who may also have HIV or AIDS. The day to day stress of living with HIV, being forced to survive on an inadequate income in poor living conditions with little or no community supports often force women to place their health and needs at the bottom of their priority list. This is consistent with the tendency among women in general, and Aboriginal women in particular, to put the needs of others ahead of themselves. (CAAN, 2004, p. 8)

By delaying or avoiding their possible HIV-diagnosis in order to remain primary caregivers for their children, Aboriginal women often decide the not knowing (about their status) is the better alternative for themselves and their families. Lather and Smithies (1997) formed a support group for minority women living with HIV and recorded some of their experiences. Rita (who moved from a different state where she was "out" as a positive woman) had this to say about keeping her family safe from stigma:

Being out brings you more peace of mind, but it's still hard. I worry about the stigma on my son, especially. I was like a freak when I was out as HIV+. That's part of the reason I moved. I choose very carefully who I tell. You might be able to handle it, but what about your family? You can't really think about you wanting to tell the world. You have to stop and think how this will affect your family. (p.9)

For many Aboriginal women, facing an HIV-diagnosis means additional burdens that the greater community is often not aware of. As Rita explains, many have to consider the well-being of their families. This, in turn, jeopardizes the women's willingness to be tested in the first place, and then their ability to receive necessary healthcare and treatment options available to them. Not only are the experiences of living with HIV multicontextual, but so are the very decisions to be tested, and to acknowledge an HIV- positive status.

Goffman (1963) discusses the notion of passing: persons not appearing to be ill or different from persons considered normal and healthy. He illuminates that the control of identity information has a bearing on relationships. We interpret this ability for passing, and the sense of blindness and lack of family discourses, as stigmatizing discourse, including both what is said, and that which is actually not said, or intentionally avoided. To avoid social stigma, Peg sought to respect Kate's determination to pass as healthy as an act of seeking normalcy in each of their lives and of avoiding those possibilities for her illness that would be more discriminatory, such as an HIV-diagnosis. The notion of normalcy is especially problematic as we perceive our identities. Dominant belief or discourse purports that if someone is normal, then they are (or must be) healthy, and visa versa (Goffman, 1963). This belief—the dismissal of symptoms and ignoring possible illness—seem to be one of the causes that resulted in the delay of Kate's diagnosis, thus causing more serious illness, progression of the disease, and risk of spreading the infection.

The invisible and deeply internalized feelings of stigma have been categorized as "courtesy" stigma, in relation to accepting guilt and shame on behalf of family and friends (Byrne, 2000, Goffman, 1963). Sandelowskie, Lambe, & Barroso (2004) report their integrated findings from studying stigma in 93 reports of qualitative studies conducted between 1991 and 2002 with a total of 1,780 women, mostly from minority groups: "A factor likely accounting for the frequent blurring of perceived and actual stigma was the women's internalization of negative cultural views of HIV-infection that contributed to their feeling dirty, deadly, and deficient" (p. 124). In response to the health implications of historical labels for Aboriginal women such as "drunken squaw, dirty

Indian, easy and lazy” (Anderson, 2000, p. 99), Kurtz, Nyberg, Van Den Tillaart, Mills, & Okanagan Urban Aboriginal Health Research Collective (in press) comment: “This negative portrayal of Aboriginal women, along with racism and discrimination, contributes to their silencing, thus pushing them into an oppressed position in society and leading to their poor health today.” While Sandelowskie et al. (2004) highlight the negative impacts of social discrimination on the women’s identities, the distinction between “perceived and actual stigma” (p.124) has not been established. However, the realities of stigma continue to exist for Aboriginal women regardless of them being defined as perceived or actual.

Within current societal views, social processes and social relations are entrenched in dominant discourses of white middleclass norms. Subsequently, they are also embedded in the perceptions of normalcy that contributed as a negative discourse to Kate’s stigma. As Mill (2000) suggests, stigma may be related to the continued epidemic of HIV-infection for Aboriginal people by delayed testing. The minority women in Sandelowskie et al.’s study (2004) reveal family members refusing to accept the HIV-diagnosis of a loved one, discrimination from friends, family, and professionals, and receiving severely prejudice remarks about HIV-positive people. The authors conclude that “[b]oth perceived and [actual] stigmas were pervasive in the lives of the HIV-positive women. HIV-related stigma was intensified in women because they were women” (p. 122). This “pervasive” (p.122) social stigma that Sandelowskie et al. (2004) refer to does not specifically address the effects of stigmatic discrimination for Aboriginal women. However, they do successfully report the pervasiveness and felt stigma for women in general, as opposed to generalizing stigma for both genders. Such significant effects of stigmatizing discourse directed towards HIV-positive women include: living in fear and the hurtful effects of stigmatization; social rejection; discrimination; violence in relation the children, partners, friends, relatives, and acquaintances; and, feeling and reporting the effects of stigmatization even when none was directed towards them (Hill, 2003, Mill, 1997, Sandelowskie et al., 2004). Aboriginal women diagnosed with HIV, who are faced with specific health disparities compared to other Canadian women, such as shortened life span, higher incidence of chronic illness (diabetes, arthritis, heart disease), also bear the burden of ill-health, premature death, and marginalization that is unimaginable by most other Canadians (Dion-Stout, Kipling, & Stout, 2001).

The effects of an HIV-diagnosis with the burden of societal discrimination of stigma are demonstrated by Kate’s father. His narrative about Kate’s HIV-diagnosis is imbedded with stigmatizing responses based on dominant discourses. He divides his life in two parts: fun and normalcy before the knowing, and then afterwards, the traumatic process of dealing with Kate’s new diagnosis. When asked how Kate’s illness has affected him, Mike answers “with a confession about how he was ‘wrong’ about HIV before he knew his daughter has it” (Poindexter, 2004, p. 504).

STATISTICAL REPORTING

Just as social discrimination impacts the lives of those diagnosed by HIV/AIDS, the way in which research studies are reported can lead to naming, blaming, and marking populations. Studies often report quantitatively, rather than qualitatively, about the disparities in the health of Canadians that exists among Aboriginal women (CAAN, 2004, Health Canada, 2003). It is about both kinds of perpetuating stigmatizing discourses, that of lived experience as well as that of statistical marginalization, that prompts our discussion. Statistical analysis, for public health and epidemiology reporting, is often vital to the progression of effective research and policy change.

For marginalized people such as Aboriginal women, these numbers can lead to the women’s objectification and to further mobilization of social stigma, blame, and isolation (Byrne, 2000). The anticipation of questions about their assumed and statistically reported risk behaviors is a barrier for Aboriginal women accessing services. Some women are not familiar with the statistics about their “Aboriginal and gender risk” of HIV-infection and wonder about the necessity of the questioning during testing, thus resulting in the hesitancy to disclose the truth or to go for testing (Bucharski et al., 2006).

One term for this kind of pathologizing philosophy, where statistics categorize and further spotlight those already marginalized, is individualism. Individualism involves a form of finger pointing or blaming the individual for his or her social and personal problems, rather than taking a critical look at the social or societal context. This view point changes the source of the problem from society as a whole to the person, rather than being concerned with the social problems of the greater society in which we live. When left unchallenged, the ideology of individualism assumes behaviors that are inaccurate; promotes the rise of isolation and marginalization of individuals; convinces society to avoid social justice causes for the benefit of such individuals; and “in short, maintains and elaborates the oppression of all peoples by distracting our attention away from the ‘man behind the curtain’.” (Chrisjohn, Young & Maraun, 2006, p. 285).

Clarke’s (2005) study is an example of blaming the individual for their HIV-status: “Those with the disease were characterized [in the media] as outsiders, considered to be at fault and themselves blamed for their diagnosis of HIV/AIDS [homosexual activities or illegal drug use]” (p. 2170). In such instances, where statistical reporting further marginalize, categorize, and finger-point towards Aboriginal women, they are further isolated from their communities and burdened with feelings of guilt, shame, and blame (Byrne, 2000).

In Kate’s situation, she may have been shielded from the social stigma of HIV initially as she did not fit the ‘profile’ based upon statistical reporting for HIV-infection. However, her HIV- illness signs and symptoms were ignored, delayed, and her parents and physician were blinded by her white middle-class position in society and by the statistical reporting, resulting in more serious health problems due to a late diagnosis. This in itself further marginalized her and contributed to her poor health by not receiving a timely diagnosis and treatment and by the perpetuation of stigma, statistically and socially.

In comparison to Kate’s delay in diagnosis and HIV-related stigma, some Aboriginal women who are pregnant are often told they have to get tested for HIV, or are automatically given a requisition for the blood test (or other tests) without explanation by the health care professional, or are threatened with having their children taken away by the government if a woman refuses to be tested (Bucharski et al 2006).

Ryan (1976) describes individualism in another way, as socially imposed alienation. This kind of stigma should be critically reviewed in relation to the way in which statistical data is reported, particularly with respect to Aboriginal women:

The new ideology attributes defect and inadequacy to the malignant nature of poverty, injustice, slum life and racial difficulties. The stigma that marks the victim and accounts for his victimization is an acquired stigma, a stigma of social, rather than genetic, origin. But the stigma, the defect, the fatal difference—though derived in the past from environmental forces—is still located within the victim, inside his skin. (p. 7)

Our argument is in agreement with Ryan, that stigma—in this case, statistical highlighting—significantly categorizes those living with HIV/AIDS. In Western society, where Aboriginal women already face social discrimination based of their ethnicity, the practice of further marginalizing them based on the kind of social illness they may have contracted needs to be seriously addressed.

In Poindexter’s study (2004), Mike speaks about Kate’s HIV-diagnosis as an ‘acquired’ stigma, thus framing the stigma socially. He blames Kate’s boyfriend who may have given her the virus, rather than considering that Kate may have been infected elsewhere:

106: If it isn’t going to bother you,
107: You have nothing to gain by learning about it,
108: Why bother?
109: If it isn’t interesting.
110: I mean, just look at *her*.

111: And think, I think that guy that brought it in, into Kate's *life*.
112: Is a guy that came into our *house*.
113: Had dinner at our *table*.
114: Dated Kate. (p. 504)

There does seem to be a shift (beginning to accept the diagnosis) in Mike's perceptions and stigmatic discourse, however, as he slowly comes to terms with both the virus and its impact on his family member's lives. He goes on to say:

115: It was just one of those *things*, you know, and it's *sad*.
116: Yeah, I look at that today, I thought it was *dirty*.
117: I thought, well, you weren't supposed to *get* it.
118: Well, she *did* get it.
119: And uh, then you find out *anybody* can get it
120: Doesn't matter where, what, *where* you are. (504)

Mike admits his previously held stereotypes about HIV and people living with the disease in the ways he uses the word "dirty," makes reference to "that guy" who sat at the family dinner table, and when he implies his daughter was not "that kind of girl." However, his narrative also voices a paradigm shift, as he moves through a place of confusion during the two years of not knowing about Kate's true illness, to a current place of more understanding and acceptance.

MEDICALIZED STIGMA

To synthesize Poindexter's position on HIV stigma within this family, "the parents were also experiencing stereotyping, profiling, and blindness. The parents shed their ignorance suddenly, just as the physicians did" (2004, p. 508). Some of the patterns explored throughout their narratives include their confusion of not knowing, their shock and trauma of finding out, and their profiling (just as the medical system did). Kate and her parents, along with their doctors, exemplified a parallel process of social discrimination, statistical assumptions, and stigmatizing medicalization. Even if Peg and Mike were correct to assert the medical profession's blindness to Kate's diagnosis based on typical gender, class, and lifestyle profiling, the doctors were not alone. They were assisted by Kate's parents' inability to also see and accept. Kate simply did not *appear* to be sick with the HIV virus. Subsequently, this double-edged sword of "othering," of incorrectly profiling, and thus, of further jeopardizing Kate's life with a delayed diagnosis, is an example of the absence of overt discrimination. But it is, in fact, still a negative part of the discourse of stigma that many Aboriginal women, especially those living with HIV/AIDS, endure.

Lather and Smithies (1997) share Diane's personal testimony: "Also it is hard when you are a woman, because with the diagnosis you are either promiscuous, or labeled as not normal." When asked what she meant by label, Diane's answer is, "Well, I mean, like people stereotype people who are infected with the virus. I mean, we are very stereotyped. We are gay. We are uneducated. We are, you know, sleeping around" (p. 4). Kurtz et al. (in press) confirm the difficulties many Aboriginal women and their families struggle with:

As the healthcare decision-spokesperson for the family, they attempt to negotiate healthcare services in environments where their 'Nativity' labels them as 'Other' and keeps them outside the dominant culture in which health care is delivered (Barrios & Egan, 2002). Many such issues result in Aboriginal women choosing to avoid or seek access to mainstream health care.

Stigma and discrimination, fuelled by a healthcare system that perpetuates racist attitudes such as these, have serious social and physical implications for Aboriginal women who must face these ongoing barriers that impact their health and well-being.

With social discourses about stigma inclusive of discrimination, quantitative statistical highlighting, and medicalization, HIV-positive Aboriginal women's marginalization and despair will only continue. The stigmatizing lens through which the women are viewed, directed by such statistics, only intensifies with the interlocking oppressions of classism, race, gender, and sexual orientation. Butler (1998) contends it is impossible to isolate gender when deconstructing oppressions just as Razack (1998) notes the equal impossibilities of unlocking race, place, and space from gender politics. These interlocking oppressions need to be slightly deconstructed.

Stigma related to position in society, sexual orientation, and the workforce surfaces from the medicalization of HIV/AIDS. If we consider class, those HIV-positive women best able to manage the worst effects of their stigmatization are white and middle-class (Poindexter, 2004, Sandelowskie et al., 2004). Earlier findings by Collins (1993) also defend this premise: "White feminists routinely point with confidence to their oppression as women but resist seeing how their white skin privileges them" (p. 25). Gender orientation and race are further areas of discrimination. These include relational intersections of oppression, heterosexism, and limited vision (Razack, 1998, 2002, Zinn & Dill, 1996). For example, some time ago, an Aboriginal woman disclosed to me (author, Donna Hill) that she was recently diagnosed with HIV (personal communication, 2006). Even though testing can be, or for many clients, is meant to be, anonymous, there still exists an information tracking system. In the unfortunate result of a positive viral test, identifiable markers such as initials and birthdates are used so the client can be traced and given the appropriate health information and counseling. This woman continued to share with me that, although she was informed of her positive status only a week prior, "they've [the medical staff at the clinic] known I was positive for two years." Considering the invisibility imposed upon her, we might ask, were health protocol and procedures not followed because this client is a woman? Is it because she is Aboriginal? Or, did her invisibility occur because she perhaps transgresses the social norms by being a sex worker or a drug addict? The complexities from which these questions stem embody the medicalization of stigmatizing discourse.

Poindexter (2004) addresses the intersections of medicalization, social expectations and discriminations, and the realities of being faced with an HIV-diagnosis. Ultimately, the parents in the explored case study do not blame the doctors, nurses, or the medical system for their lack of early diagnosis of their daughter's illness. Nevertheless, this does not negate an emphatic example of the medicalization of stigma attached to the discourse of HIV/AIDS for women. It is an example that creates stigmatizing responses towards women. In this situation, the doctors may not have had all the "right answers" but in their search for a correct diagnosis, their hegemonic power prevailed over everyone, including themselves, in the consideration of HIV as a source of illness. We argue that the family's societal status, ethnicity, and employment advantages privileged them over other minority women such as the Aboriginal woman mentioned above. This Aboriginal woman is someone who experienced, either implicitly or explicitly, multifaceted layers of oppression, limited vision, and marginalization from various mainstream healthcare professionals. We believe her situation is an example of the medicalization of stigma.

Medicalization is the dominant medical power over a subjugated group (Byrne, 2000, Poindexter, 2004). It is the dominant belief in our society that doctors have the right to tell their patients what to do, and that doctors have all the answers. Medicalization is an assumption that Western medical hegemony is the best health care for everyone concerned. The medicalization of stigma is the more insidious process that reproduces the *status quo* of women and HIV. This is evident in both academic and popular literature that theorizes women's vulnerability toward HIV/AIDS. For example, as J. Weeks contends;

AIDS has become the symbolic bearer of a host of meanings about our contemporary culture: about its social composition, its racial boundaries, its attitudes and social marginality; and above all, its moral configurations and its sexual mores. A number of different histories intersect in and are condensed by AIDS discourse. (Cited in Shefer, 2004, p. 3)

Relating to Weeks' concerns about the varying intersections of AIDS and histories, we acknowledge the historical and postcolonial contexts of these challenges, such as racial boundaries; colonialization and the lasting effects

of residential schooling; multigenerational abuse; drug and alcohol addictions; economic, social and physical power imbalances; and, subordination in education, employment and social and legal status (Campbell, 2002, Chrisjohn et al, 2006, Ship & Norton, 2001, Wuest, 2003). Although such encompassing issues cannot be covered within the scope of this paper, we concede they are crucial to understanding Aboriginal people and the historical and the societal contexts in which they live that affects who they are as people today.

ANTI-STIGMA STRATEGIES

So far, we have briefly surveyed three cornerstone examples of discourse around HIV-related stigma: social discrimination, statistical reporting (stigma resulting from quantitative statistics) and medicalization. We have also touched upon socially interlocking oppressions for HIV-positive women, particularly, Aboriginal women, such as categorization, isolation, poverty, race, gender, and sexual orientation. We will now look at a few interdependent anti-stigma strategies.

Briefly, a blueprint for anti-stigma strategies includes self-advocacy, specific target groups based on prior discriminatory attitudes, lack of public backlash, flexible education packages, intervention over time, and continuing contact to maintain momentum (Byrne, 2000, Smith, 2002). We, along with Byrne and Smith, advocate for a shift away from stigmatizing discourse, if not a complete disbanding of such discourse. However, researchers such as Guttman and Salmon (2004) place more focus on the strategies themselves, and remind us of the ethical considerations in public health communication interventions. Since the focus of anti-stigma strategies is already about ethical considerations for improving the lives of marginalized people, we agree, only to a point, with Guttman and Salmon. If ethical deconstructions of stigma interventions were to land too far to the conservative right along the continuum of helping those most negatively affected by stigma, then we would argue for more caution about their concerns. Instead, what is needed is a greater sense of concern about more marginal assumptions, rather than the *status quo*. There needs to begin a greater valuing of inclusion and diversity, rather than remaining persuasively situated within the hegemonic discourses of “othering” and marginalizing people in our society.

CONCLUSION

Our intent in this paper has been to critically challenge the three dominant discourses around stigma and their effects on Aboriginal women living with HIV using current literature and one woman’s personal experience. Both suggest it is time to disband all forms of stigmatizing discourse, particularly that which surrounds HIV positive women. We encourage working together to put an end to the women’s experiences of discrimination, social rejection, and marginalization. Society needs to assist the women in the reconstruction of healthier social and personal identities for themselves. After all, “[h]uman development is an ongoing effort to affect a balance between these needs and these fears [about stigma]” (Josselson, 1989, p. 104). We concur with Josselson that the ability to affect change influences the identity of human development. This identity is one that is shifting, altering, and fluidly affecting, and being affected by, our society. Within this cultural embeddedness, we believe that our social constructs of identity do, and are able to, change over time. The social contexts surrounding the discourse of stigma can, and must, transform for the benefit of women living with HIV/AIDS and their healthy identities. As Clarke et al (2005) concedes, “Stigmatization is still a significant component of the experience of Aboriginal people with HIV/AIDS, it needs to be addressed” (p. 2178). This needs to be addressed with Aboriginal women living with HIV/AIDS, leading the way with the support of their families, communities, and society.

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