HIV Vulnerability amongst South Asian Immigrant Women in Toronto

by

Roula Kteily-Hawa

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

Graduate Department of Leadership, Higher and Adult Education

Ontario Institute for Studies in Education

University of Toronto

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Abstract

This thesis focuses on the structural and behavioural factors that placed South Asian immigrant women living with HIV/AIDS in the Greater Toronto Area at risk. Informed by Connell's social theory of gender (1987), this study examined the role of hegemonic masculinity in legitimizing male power and contributing to the HIV risk of these women.

By conducting one-on-one interviews with 12 HIV-positive immigrant women, meaningful constructions of the women's narratives and accounts of their experiences relative to HIV were created. This study examined the intersection of power ideologies such as gender, race and class in specific contexts as they generated particular experiences that affected women's risk for HIV.

Following a community-based research approach, a collaborative relationship was established with the Alliance for South Asian AIDS Prevention where qualitative methods of analysis and an inductive approach with an iterative process were followed.
Factors such as isolation, economic dependence on their husbands, discrimination, racism, investment in psychologically and emotionally abusive relationships, combined with the absence of support from their family of origin exacerbated the women's risk of HIV infection. The strong ties exhibited by most of the women to their religious/ethnic communities helped sustain a gender-based social hierarchy.

To facilitate dialogue and social change for South Asian women, gender and culture need to be situated in social and historical contexts. As such, programs should be understood within a larger critical understanding of the social power relations and history of Canadian immigration patterns. Using anti-racist frameworks, initiatives should address violence against women, while tackling interrelated issues (i.e., housing, poverty, etc.).

This work draws attention to oppressions through the experiences of a community of women who are rarely given a voice within the context of research on HIV/AIDS. It will be also helpful for Ontario’s HIV prevention strategy and the field of women's sexual health.
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I leave you all with this, "to understand the heart and mind of a person, look not at what he has already achieved, but at what he aspires to" (Gibran, 1923). Peace to all!

Roula
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Chapter 1
Why Study HIV Risk in South Asian Immigrant Women?

1.1 Introduction

This thesis focuses on HIV-positive South Asian\textsuperscript{1} immigrant women\textsuperscript{2} in the Greater Toronto Area (GTA) in order to improve our understanding of the factors that increase women's vulnerability to HIV infection. My main objective in conducting this study is to explore how male power in South Asian communities, legitimized by hegemonic masculinity contributes to South Asian women's risk of being infected with HIV. Through gendered practices, resulting from shared gendered beliefs fashioned to benefit the dominant group, hegemonic masculinity is the said response to the issue of the legitimacy of patriarchy. Hegemonic masculinity works to legitimize the dominance of men over women.

In this study, I examined the role of hegemonic masculinity in legitimizing male power and contributing to the HIV risk of South Asian immigrant women to the Greater Toronto Area. My work was informed by R.W. Connell's (1987; 2009) social theory of gender which helped me to understand the factors involved in South Asian women's increased risk of HIV infection. Through the use of one-on-one interviews, I created meaningful constructions of the women's narratives and accounts of their experiences and how they "made sense" of their life situations as immigrants in relation to HIV. The women's lived

\textsuperscript{1} The term "South Asian" refers to an extremely diverse group of people whose origins can be traced to the region of South Asia, which includes the principal countries of Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal, Pakistan, and Sri Lanka (Statistics Canada, 2006). It also refers to people who identify themselves as South Asian although their country of last permanent residence is not in South Asia. This includes South Asians from places such as Africa (especially East and South Africa), Caribbean (Guyana, Trinidad, and Jamaica), South America, and Pacific (Fiji) and European countries who trace their origin to the Indian subcontinent and continue to describe themselves as South Asians (CASSA, 2000).

\textsuperscript{2} All the participants in the study were first generation South Asian, with the exception of one who was a second generation South Asian. The reason this participant was included in this sample is because she self-identified as a South Asian immigrant due to the fact that she moved from Canada to India on her own as an adolescent and resided there for several years.
experiences and the multiplicity of voice, class and location (exemplified by different countries of origin), became very important as they contested male power.

It is important to discuss the context within which the women's narratives are embedded. This study reflects the perspective of a particular group of South Asian immigrant women in the Greater Toronto Area who became infected with HIV in heterosexual relationships which changed their views on men, patriarchy and community. With most of the women reporting psychological and emotional abuse at some point in their lives as well as severe stigma resulting from being HIV positive, their feelings and attitudes towards their partners and their own communities become coloured by their life experiences. The women's lives as racialized immigrants is central in this thesis. Yasmin Jiwani (2011) discusses the racialization of others as:

Maintained and communicated through a focus on the inferiorization, deviantization and naturalization of difference. While overt and explicit forms of racism are no longer condoned by the liberal state, colour-blind racism permeates institutional rhetoric and through the mediation of inferential referencing, cordial tonality and culturalized modality, focuses on difference as the site of the abject and contemptible. (p.15)

In their paper Erased Realities: the Violence of Racism in the Lives of Immigrant and Refugee Girls of Colour, Jiwani, Janovicek & Cameron (2001) contrast the progressive expression of Canada's commitments with the lived realities and impact of domestic policies on the lives of racialized immigrant and refugee girls. They argue that "women's marginalization in the social, cultural, political and economic spheres of society contributes to their sense of 'otherness' and lack of belonging" (p. 3).

One cannot make generalizations about South Asian women, but should rather consciously speak from the standpoint of women's voices alone. The stories told by the women are unique, specific and connected to their settlement history and are not necessarily representative of the narratives of South Asian immigrant women. Accounts of "culture" such as collectivism, upholding an ideal of female purity and tolerance towards male promiscuity that emerged as themes in this study are characterizations that these particular women made and do not represent South Asian
women's understanding of "culture"; the fact that the women have been infected with HIV influences how they see and interpret these "cultural" traits and as such the results of this study cannot be generalized to South Asian men, South Asian women or South Asian culture.

The structural aspects of power that were examined in this study are grounded in Connell's (1987) social theory of gender. The notion of structure espoused by R.W. Connell makes this theory a social theory of gender which seeks to be transformative. According to Connell, social structure is:

More than another term for "pattern" and refers to the intractability of the social world ... It reflects the experience of being up against something, of limits on freedom. ... The concept of social structure expresses the constraints that lie in a given form of social organisation ... these constraints on social practice operate through a complex interplay of powers and through an array of social institutions. Accordingly, attempts to decode a social structure generally begin by analysing institutions. (1987, p. 92)

Three of the four emerging themes in the study are social structures identified by Connell's (1987, 2009) social theory of gender: power relations, cathexis or emotional attachment, and division of labour; the gender-based injustices and discrepancies that derive from each of these structures have generated different constraints that influence women's daily lives and consequently their risk for HIV. It was important for me to examine the interaction between structural relations of power and the South Asian women's individual beliefs in male superiority. Furthermore, based on Connell's social theory of gender, hegemonic masculinity tends to define legitimate discourse by imposing the reality of those in power on those who lack power through the establishment of shared beliefs at the collective level. Beliefs shared at the collective level become normative since most people perceive them to be acceptable and appropriate.

The fourth theme that emerged in my study is social norms. For example, some of the women in my study believed that premarital sex was acceptable and engaged in it even though they perceived that most people in their community did not find this practice
acceptable. However, even though personal and social norms did not always align, I examined social norms as perceived by the women in the study because that helped me understand how each participant made sense of these norms in her own life. Thus, I examined the interactions of all three social structures (power relations, cathexis or emotional relations, and gendered division of labour) and the social norms that the women acknowledged with individual factors in the women's lives. Finally, I looked at immigration as an occurrence of crisis tendency that affects the interdependency of the structural, individual, and normative factors.

With Connell's (1987) social theory of gender recognizing race, class and gender as structures that contribute to women's oppression, it was important to examine the vulnerability of the women to HIV using an anti-racist lens that posits the women as non-white, immigrants currently living in an imperialist nation that purports a love of difference on the one hand and exploits aspects of that difference to its own end, on the other. Examining the "dialectical interaction of multiple relations of domination and subordination based on age, race, ethnicity, and nationality with class and gender relations" (Beneria & Roldan, 1987, p. 10) reflect the "multiple axes on which power in society inevitably turns" (Cocks,1989, p.50). In this sense, the current study further developed the details involving the interactions between individual, structural, and normative factors without essentializing culture.

This study has two main aims. First, this thesis has investigated the macrostructural assertions of Connell's (1987, 2009) social theory of gender, which is primarily concerned with demonstrating the relational and hierarchical nature of gender. Moreover, with Connell's theory having a global emphasis, I have attempted to examine the theory using a local lens by focusing on the daily interactions of South Asian women. Therefore, this study has focused on gender relations in a local social context, the HIV-positive South Asian immigrant woman context, to examine how hegemonic masculinity is enacted.
Second, this thesis has focused on detailed interdependencies between structural, individual, and normative influences in the lives of HIV-positive South Asian immigrant women. Connell's (1987, 2009) theory lacks detail about the interactions between individual, structural, and normative factors and the theory is rather limited in its ability to explain how these factors affect one another. Therefore, my investigation examined Connell's theory in order to explain how social norms interact with both personal beliefs and social structures (power relations, cathexis, and gendered division of labour) to generate different constraints that influence South Asian immigrant women's risk for HIV. This has helped further investigate the interdependencies of social structures, individual-level factors, and social norms of behaviour. Through the use of detailed interviews with a particular group of women, in a particular time and place, that is, a particular context, this study addressed both limitations in Connell's theory.

1.2 Gendered Shift in HIV/AIDS

Today, women are at the centre of the HIV/AIDS epidemic. Recent statistics show that of the estimated 33.4 million people living with HIV/AIDS worldwide, an estimated 15.7 million, or almost 50%, are women (UNAIDS, 2009). This was not the case in 1985 when many HIV-prevention strategies were developed. At that time, for every infected woman, there were 10 or more infected men. At the time, there was little concern about women being infected with HIV and, consequently, the possibility was often ignored altogether. This negligence may be one of the factors that has led to the rates of infection among women skyrocketing. In an unforeseen reversal of the early trend, women have become a growing proportion of those infected.

In Canada, when compared to other types of transmission, such as through intravenous drug use, the transmission of HIV through sexual contact has increased over the past decade (Public Health Agency of Canada [PHAC], 2008). While for men, it is most common to become infected with HIV by having sexual relations with other men (PHAC, 2008), the number of HIV-positive test reports per year for women due to heterosexual
transmission has increased over the past 5 years and this has become the most common route of infection for women (PHAC, 2008).

An estimated 65% of all people infected with HIV in Ontario live in Toronto (Remis, Swantee, & Liu, 2010) and in 2008 over 44% of Canada's estimated 58,000 HIV-positive people lived in Ontario (PHAC, 2008). Overall, 26,630 HIV-positive persons were living in Ontario as of 2008, representing an increase of 4.8% compared to 2007 (Remis et al., 2010). Among females there was a 13.8% increase compared to a 2.1% increase among males. It is evident from these statistics that while the number of HIV diagnoses is increasing in Ontario, the percentage of these diagnoses being made for women is increasing at an alarming rate. While this harsh observation emerges clearly from the latest epidemiological literature documenting the unabated spread of HIV in women around the world, there is a dearth of critical and engaged literature that elucidates not only the increasing vulnerability of women but also the inability of the existing HIV-prevention strategies to address it.

1.3 Significance of Research

While there have been several studies focusing on HIV and women of different ethnic groups in the GTA, South Asian immigrant women have not received much attention. There is a shortage of research focusing on HIV in the South Asian community in North America. Similarly, there is a scarcity of HIV/AIDS-related published research on South Asian women in Canada in general, and in the Greater Toronto Area in particular. The few studies that were conducted in North America agreed that there is a stigma attached to HIV/AIDS in the South Asian community, which resulted in an overall denial of HIV/AIDS as a disease affecting community members (Abraham, Chakkappan, & Park, 2005; Alliance for South Asian AIDS Prevention [ASAAP], 1999; Gagnon, Merry, Bocking, Rosenberg, & Oxman-Martinez, 2010; Leonard, Medd, McWilliam, Rowe, Sudhibhasilp & Layman-Pleet, 2007; Raj & Tuller, 2003; Singer, Willms, Adrien, Baxter, Brabazon, Leaune, . . . Cappon, 1996; Vlassoff & Ali, 2011).
Moreover, while many of these studies identified factors such as male power, immigration, poverty, and discrimination as structural factors affecting South Asian women's risk for HIV, none of them explained how these structural factors affected women's behaviour. The effects of these structural factors need to be studied by exploring the unique individual experiences of South Asian immigrant women in Canada.

An in-depth study of how structural factors interact with individual behaviour is needed. Moreover, there is a need to use theoretical approaches that focus on structural power to better understand structural factors such as immigration and gender inequalities in a particular point in history as they relate to South Asian women's risk for HIV. There is a need for a particular theory which discards the ahistorical, deterministic characteristics of essentialist, ethnocentric feminist theories of the 70s and 80s and would be "explicitly historical, attuned to the cultural specificity of different societies and periods, and to that of different groups within societies and periods" (Fraser & Nicholson, 1990, p. 34). Connell’s social theory of gender (1987) which informed this study does exactly that.

To understand the factors affecting South Asian women's vulnerability to HIV infection, I decided to focus on the experiences of South Asian women who are already HIV-positive in order to explore how they as individuals became infected and what factors in their lives led to this result. Through the use of qualitative methods of analysis I describe the women's perceptions of the cultural, linguistic, and social factors affecting their risk at the time they were infected and the current conditions of their lives as HIV-positive South Asian women. Because many women who are infected with HIV are living longer and continue to lead sexually active lives, this investigation into the lives of HIV-positive women will provide useful information on which to base the development of strategies to prevent further transmission of the virus. As well, the results of this study will be useful for the development of prevention efforts directed at those who are not HIV-positive.
1.4 South Asian Immigrant Women and HIV/AIDS

All countries of the South Asian region have a fairly low prevalence of HIV. Results of a national household survey conducted in 2005–2006 indicated that around 2.3 million people in India live with HIV. Of these, an estimated 39% are female (National AIDS Control Organization [NACO], 2007). "The main factors which have contributed to India's HIV-infected population are high rates of labour migration and low literacy levels in certain rural areas which resulted in lack of awareness and gender inequality" (NACO, 2007). Based on the United Nations 2011 AIDS report, India has witnessed a 50% drop in the number of new HIV infections in the past decade, which has been attributed to India's aggressive HIV prevention campaign. These rates are not localized though, and become quite threatening to the world when population mobility is considered (UNAIDS, 2011).

In North America, and particularly in Canada, recent immigration patterns have resulted in a growth in the South Asian population (Statistics Canada, 2006). Based on the 2006 census data, South Asian communities in the GTA are rapidly increasing to the extent that more than 684,070 people in the GTA are South Asian. This represents 13.5% of the entire GTA population and marks a substantial increase from the numbers reported in 1999 (Statistics Canada, 2006).

When considering immigrants to Canada, changes in Citizenship and Immigration Canada (CIC) policies have led to more reporting of positive HIV tests after 2001:

On January 15, 2002, CIC added routine HIV screening for all applicants who require an Immigration Medical Examination and are 15 years of age or older, as well as for those children who have received blood or blood products, have or had a known HIV positive mother or are potential adoptees. In 2004, CIC discontinued the routine HIV testing of potential adoptees. (PHAC, 2010, p. 5)

From the 9,461 HIV cases in Toronto reported between 1984–2004, 117 cases (99 males and 18 females) were South Asian, constituting 2.1% of all the reported HIV cases in Toronto during that time period. South Asian females represented 2.5% of all the female
HIV cases reported in Toronto between 1984 and 2004. A total of 75% of all the reported South Asian HIV female cases in Toronto have been infected via heterosexual exposure. The proportion of reported HIV South Asian female cases in Toronto increased from 2.3% in 1985 to 3.7% in 2004 (Liu & Remis, 2007).

What is really disconcerting here is that a total of 42% of all the reported HIV cases in Toronto from 1984–2004 have unknown ethnicities. Despite the fact that data on race/ethnicity are routinely collected for AIDS cases since AIDS became reportable in August 1983, a total of 30% of the reported AIDS cases from 1984–2004 have unknown ethnicities (Liu & Remis, 2007). The large number of annual HIV cases in Ontario together with this missing information contributes to the large proportion of cases at the national level with unknown race/ethnicity. HIV diagnostic test data provide important insights into trends in HIV infection. However, missing information on laboratory requisitions often hinder interpretation of trends. In addition, laboratory requisitions do not collect information on race/ethnicity (Sullivan, Swantee, Rank, Liu, Palmer, Fisher, . . . Remis, 2011; Tomas, Remis, Gheorghe, Sullivan, Liu, Swantee, . . . Archibald, 2012). For these reasons, Ontario's Laboratory Enhancement Program (LEP) was developed to "collect additional epidemiologic information from people diagnosed with HIV, including race/ethnicity (since January 2009) and risk factor information". LEP looked at "patterns of HIV diagnosis in Ontario using supplementary data from an enhanced surveillance program and found that racial/ethnic communities are being seriously affected by the HIV epidemic in Ontario" (Tomas, et al., 2012, p. 1).

The LEP provides critical supplementary data on an ongoing basis to help monitor trends in HIV infection in Ontario. Data are adjusted in the provincial surveillance report to make up for the high percentage of cases where race/ethnicity and exposure category are listed as unknown (Sullivan et al., 2011; Tomas et al., 2012). For instance, the relative impact of HIV on racial/ethnic communities in Toronto has significantly increased since 2004. Adjusted data show that from January 1, 2009 to June 30, 2011, South Asians constituted 3.5% of the new HIV diagnoses in Ontario. Not surprisingly, the majority of South Asian cases (84%) were reported from Toronto (42%) and Central
East/Other Region, the area surrounding Toronto (42%). Trends in race/ethnicity were relatively stable over the 2.5 year study period for the South Asian group. (Sullivan et al., 2011, p. 1)

The combination of the above statistics and the increased immigration of South Asians to the Greater Toronto Area results in an increased risk of South Asian immigrants contracting the virus (PHAC, 2008). Consequently, culturally sensitive prevention programs need to be targeted and tailored to racial/ethnic communities and most affected by the HIV/AIDS epidemic.

1.5 Relevant Literature

There is lack of published HIV/AIDS research involving South Asians in Canada and the U.S. Among the few studies that have been done is Phase II of the Ethnocultural Communities Facing AIDS Study, conducted in 1996, which investigated the sociocultural factors that contribute to risk behaviours associated with HIV/AIDS in six ethnocultural communities in Canada and in three urban sites (Singer, et. al., 1996). One recommendation of the study was that HIV/AIDS awareness and prevention initiatives must address sociocultural differences as well as sex role differences between men and women which tend to have an impact on the ability of partners to negotiate for safer sexual practices.

Similar research was done in 1999, when the Toronto-based ASAAP took on a study which was funded by Health Canada to examine the types and effect of discrimination and the subsequent legal, ethical, and human rights concerns voiced by HIV-positive South Asian people in the Greater Toronto Area. In-depth interviews with 21 South Asian men and women who are infected with HIV indicated that there was a belief widely held in the community that HIV/AIDS was a disease that did not affect everyone. Widespread ideas were identified by the study as denying that HIV could affect the South Asian community, including the belief that sexual activity in the South Asian community is used strictly for "procreation, South Asians are monogamous, and married people do not
get HIV”. This was taken to confirm the presence of a strong collective culture (ASAAP, 1999, p. 10).

In 2003, an unpublished study by Raj and Tuller was conducted to measure knowledge, perceptions of risk and risk behaviours relating to HIV among a sample of South Asian women in one of the communities in the greater Boston area in the U.S. The researchers established that the women believed that the risk of HIV infection was low, indicating a fundamental lack of awareness in South Asian communities, and the possibility that this lack of understanding stemmed from existing social taboos that hinder education on the topic.

Another exploratory study conducted in New York City in 2004 focused on issues relating to HIV/AIDS among South Asian immigrant women (Abraham, Chakkappan & Park, 2005). The study, which was under-funded and very limited in scope, found that patriarchal norms affect the use of condoms. The study concluded that stigma associated with being HIV positive resulted in a mistrust of health agencies. This prevented HIV-positive members of the community from accessing health agencies' services, and the acknowledgement of HIV/AIDS as public health issue for the community, which in turn hindered attempts to control the spread of the disease (Abraham et al., 2005). The study also concluded that theoretical approaches that focus on risk perception and familial power structures are needed and that factors such as poverty, immigration, and gender inequalities affecting South Asian immigrant women also needed to be studied further.

The 2005 Ontario Women's Study (as cited in Leonard et al., 2007), a two-phase project, looked at the risk of acquiring HIV in 15 groups of Ontario women, including South Asian women. In the first phase, in order to identify groups of women at greater risk, the researchers reviewed the findings from a series of community discussions with diverse groups of women to explore the vulnerability of women as a group to HIV (Leonard et al., 2007). The researchers identified fifteen groups of women as having unique, group-specific HIV-related risks, including women from cultural backgrounds that value female virginity and/or accept polygamous relationships. The study concluded that although
women in Ontario may be equally at risk of acquiring HIV across cultures, their living conditions and ethnic backgrounds need to be considered when developing prevention programs (Leonard et al., 2007).

The second phase of the 2005 Ontario Women's Study (as cited in Leonard et al., 2007) was similar to the study conducted in the Boston area in that it documented women's understanding of how HIV is transmitted as well as the social, structural, racial, gender-based, and economic factors that affect risk behaviours relating to HIV among different populations of women in Ontario.

In 2011, Vlassoff and Ali published the results of their study involving four focus groups with a total of 35 participants from the South Asian community in Toronto to look at HIV-related stigma, how it affects HIV-positive people, and the role it plays in shaping their access to HIV services. The researchers concluded that although HIV-related knowledge has increased in the South Asian community since ASAAP's 1999 study, experiences of stigma and myths surrounding HIV/AIDS have increased as well (Vlassoff & Ali, 2011).

Similarly, an empirical study, conducted on a sample of 122 men and women of South Asian origin in Montreal, Canada, found that although knowledge about HIV had increased, there was still a significant gap in the South Asians' knowledge about sexual health: 50% of the sample had never heard of sexually transmitted infections and just under half had no knowledge of HIV/AIDS (Gagnon, Merry, Bocking, Rosenberg, & Oxman-Martinez, 2010). Moreover, stigma related to HIV was alive and well: half of the respondents considered HIV to be a punishment for "bad behaviour" and women were found to be more likely to hold stigmatizing attitudes toward HIV than men. The researchers concluded that there is a need for education to increase knowledge about sexual health in general and about HIV in particular to dispel myths and minimize the stigma associated with HIV infection and AIDS (Gagnon et al., 2010).
1.5.1 Summary

HIV-positive South Asian immigrant women in the Greater Toronto Area is an important group to study. The reality of having high HIV rates among Canadian immigrants along with the high immigration rate of South Asians to Canada, particularly to the GTA, makes this group at increased risk for HIV. Based on scholarly and community-based research in the South Asian community in North America, it is clear that there is a stigma attached to HIV/AIDS resulting in the South Asian community's denial that HIV/AIDS affects their community and in many of the HIV-positive women in that community not getting adequate support. Finally, there is scarcity of published work relating to HIV/AIDS and South Asian women in Canada, particularly those in the Greater Toronto Area.

While a few of the studies described above identified structural factors contributing to and/or affecting the HIV risk of South Asian women, they fail to explain how structural factors influence individual behaviour, particularly sexual behaviour. The effects of these structural factors will not be understood without an exploration of the unique individual experiences of South Asian women themselves. To fill that gap is the goal of this thesis.

1.6 Theoretical Underpinnings

Individualist approaches to studying gender relations (Eagly, 1995; Hollander & Howard, 2000; Maccoby & Jacklin, 1974) are limited since they tend to focus on individuals' traits and attributes in isolation. Institutional approaches (Acker, 1992; Hall, 2002; Jepperson, 1991) focus on the ways in which the form that gender relations take are embedded within social structures as part of the "taken-for-granted" reality in contemporary society. Interactionist approaches (Garfinkel, 1967; Goffman, 1959; Kessler & McKenna, 1978; West & Zimmerman, 1987) emphasize the ways that social interaction and social context influence the expression and discernment of gender. For most interactionist theorists, gender emerges and is sustained within social interactions. While all approaches have explained gender relations to some extent, none of them appears to be sufficient. Gender
should be seen, instead, as a multilayered system that functions at multiple stages (Ridgeway & Smith-Lovin, 1999; Risman, 1998). It is obvious that understanding gender relations at this level of complexity is no small task and theoretical approaches that focus on structural power are needed to better understand underlying factors such as immigration and gender inequalities. Connell's (1987, 2009) theoretical synthesis of these approaches captures this; thus, in order to achieve this kind of understanding of the gender relations in which the study participants live, this study examined the structural aspects of power using Connell's social theory of gender using in-depth interviews.

Gendered experiences and behaviours can be best understood by examining the intersection of various ideologies of power, including gender, race, class and ethnicity. Connell's (1987) social theory of gender recognizes not only class but also race, gender, age, religion, etc., as social features structuring women's oppression. Unlike Marxist feminism, which seeks to understand women's position in society from a class-based perspective, socialist feminism sees not only class but also race and gender (and other structural features of society) as conditioning women's experience. Moreover, race, class and gender are seen as autonomous, though intertwined, structural features through which power relations are generated to shape the subordinate status of women. In this sense, unlike the other feminisms of the 1970s, socialist feminists were not involved in disagreements about what to pinpoint as 'the crucial source' of women's oppression" (Maharaj, 1995, p. 55).

Carrigan, Connell, & Lee (1985) and Connell (1987, 2005, 2009) explicitly describe how power operates between genders by providing a clear picture of gender as a structure of social practice. They emphasize the power relations between men and women while asserting that gender is organized in a relational and hierarchical manner, and comprises of multiple masculine and feminine defined roles. According to Connell (1995, 2005), gender is affected by both the impersonal power of institutions and the more intimate and interpersonal connections between people.

Central to Connell's social theory of gender is the concept of hegemonic masculinity which "embodies the currently accepted answer to the problem of the legitimacy of patriarchy [and] guarantees... the dominant position of men and the subordination of
women" (1995, p. 77). The legitimization of male power in patriarchal society can be seen as a contributing factor to the vulnerability of women to HIV infection.

Connell uses the term *hegemony* to signal that cultural representations of genders are portrayed as normal as an attempt to rationalize relations in which men have power over women. The prevailing conviction in the naturalness of this social order sustains and enables existing gender relations. Violence in relationships and, what Connell refers to as, the "ideology of supremacy" of men over women contribute to the dominance of males in society (1995, p. 83). "A structure of inequality on this scale, involving a massive dispossesson of social resources, is hard to imagine without violence. It is, overwhelmingly, the dominant gender who hold and use the means of violence" (Connell, 1995, p. 83).

There have been a number of critiques of Connell's approach. Whitehead (2002) proposes that Connell's concept of hegemonic masculinity does not comprise resistance and the role that agency plays in the lives of individuals and hence is inadequate in explaining the "everyday social interaction" of people (p. 58). Hearn's (2004) critique mostly revolves around whether hegemonic masculinity as a concept encompasses "cultural representations, every day practices or institutional structures" (p. 58). Consequently, Connell, in conjunction with other researchers, has addressed these critiques by reworking the concept of hegemonic masculinity (Connell & Messerschmidt, 2005).

The aforementioned critiques of Connell's (1987, 2009) theory do not destabilize the main concepts of the theory, but, alternatively, provide opportunities for elaborating and expanding upon it. The theory remains robust and of great value. Nevertheless, some areas, particularly around the application of the theory in a localized context and the ability of the theory to explain daily gendered interactions need to be addressed. Accounting for some of these challenges is essential and I have endeavoured to address them in a specific social context: that of South Asian immigrant woman.
1.7 Thesis Structure

In Chapter 2, the mutual dependencies of structural, individual, and normative factors in Connell's (1987, 2009) social theory of gender are discussed in detail. An adaptation of the theory to the area of HIV risk and prevention is examined. In addition, immigration's tendency to crisis and the context it provides that can draw together interdependencies between structural, individual, and normative factors are explored. A significant part of this chapter is dedicated to examining specific local contexts as a necessary step to bridging the split between macrostructures and micropolitical relations. The HIV-positive South Asian immigrant woman is presented as a lens for exploring the applicability of Connell's theory to local contexts. The South Asian family is offered as a site of gender formation and contestation. Crucially, issues of power between the women in this study and their male husbands and partners are explored, as well as the connection between them.

Chapter 3 provides an overview of the research design and methods utilized in the exploration of HIV in the South Asian community context. In this chapter I discuss the research approach, methodology, data collection, and analysis used in the study. This chapter also outlines how I ensured the quality of my research findings and addresses the limitations of the research design and the study findings. Finally, brief profiles of the women who participated in the study are provided to help put the analysis into context.

Chapters 4–7 present results and analysis of the women's narratives. These chapters provide a descriptive summary of the most prominent themes and subthemes that emerged from this research as a result of the combined influence of the interview guide, the interview experience, and the interpretation of both my own and the women's experiences around HIV risk.

Chapter 8 reports study conclusions and recommendations. Here I discuss the implications of this research for HIV-positive South Asian immigrant women, Connell's (1987, 2009) theory, and a number of issues the findings have raised. I conclude with a
summary of the research, the specific contributions of this thesis, and areas for future research.
Chapter 2
Social Theory of Gender in the Context of HIV-Positive South Asian Immigrant Women

This chapter focuses on Connell's (1987, 2009) social theory of gender. Gendered relations, structures of gendered relations, and an adaptation of the theory to the area of HIV risk and prevention are presented. HIV risk displayed by the women is construed by examining individual factors, normative influences in their lives, and social structures such as sexual division of power (power imbalance), sexual division of labour (economic imbalance), and cathexis (emotional attachments). The interdependence of individual, normative, and structural factors in Connell's theory as well as limitations of the theory are discussed. Next, the South Asian immigrant woman and the South Asian immigrant experience in Canada are discussed in detail. The last section in this chapter focuses on immigration as a "crisis tendency" and the role it plays in bringing in the interdependency between and among Connell's individual, structural, and normative factors.

2.1 Connell's Social Theory of Gender

For Connell (1987, 2002a, 2005, 2009), social structures, cultural or normative factors, and individual traits and characteristics help explicate the concept of gender. Connell suggests that fundamentally gender is constituted by relations of power, not a set of psychological traits of an individual (Carrigan et al., 1985; Connell, 1987, 2002a, 2005, 2009; Connell & Messerschmidt, 2005). Further, the claim is made that these relations are set up in such a way that both condones and facilitates the subordination of women by men. Thus, gender is hierarchical.

In his social theory of gender, Connell uses the term 'gender regime' to refer to the enactment of gender in smaller institutions such as the home, school and the workplace. At the societal level, traits that define masculinity and femininity, as well as relational
power within a society are historically constructed social powers, referred to by Connell as 'gender order' (Connell, 1987; 2009).

2.1.1 Gendered Relations

According to Connell (2005), gender is not determined by a rigid set of natural determinants, but rather by a historical process which involves the body. Gender is inherently relational and hierarchical such that at a certain time and place in history men would dominate women. Connell suggests that to understand gender, "the key is to move from a focus on difference to a focus on relations...gender must be understood as a social structure" (Connell, 2002a, p. 9 [italics in original]), but not one that merely expresses bodily difference. "Gender concerns the way human society deals with human bodies, and the many consequences of that 'dealing' in our personal lives and our collective fate" (Connell, 2002a, p. 10).

Women's experiences of subjugation in any establishment, across societies and over time, are best understood by using a framework that analyzes the structures of labour, power and cathexis. As such, Connell's framework can be seen as a meta-theoretical framework in that it identifies the underlying cultural aspects of labour, power and cathexis and how they work together in order to form understandings of particular behaviours.

2.1.2 Structures of Gender Relations

Connell proposed that sex differences are natural and have a strong influence on women's power in our society. In an attempt to explain the structures of gender relations, Connell (1987) proposed a relationship among the division of labour, power imbalance, and cathexis as structures that influence behaviour. Further, the aforementioned structures can be examined in any sphere using an ideological or material lens. For example, women's lower pay in the work force becomes a factor in the ideology of women and work which strengthens and is strengthened by inequality on which capitalism is based.
Economic dependence is determined by a woman's income, her childcare responsibilities, and how her work is valued. Male dominance is seen through women's experiences of power inequalities in their relationships with men on a personal and societal level. Emotional attachment, also referred to as cathexis, comprises gender and traditional sexual roles, interest in pregnancy, and the desire for trust and faithfulness in relationships with partners. It is suggested that the multidimensional life experiences of economic dependence resulting from the division of labour, male dominance resulting from power imbalance, and cathexis or emotional attachment of women to their male partners determine the nature of sexual practices between men and women (Connell, 2009).

2.1.2.1 Division of Labour

According to Connell (1987, 2002a, 2009), the sexual division of labour was the first structure of gender to be recognized in social science, and remains at the centre of most discussions of gender in anthropology and economics. In many societies and in many situations, certain tasks are usually performed by men while others are usually performed by women. Even though gender divisions of labour are common, division of labour varies from culture to culture and through time. Hence, the same task may be "women's work" in one context, and "men's work" in another. According to Connell (2009), the gendered division of labour has three components. First, where work is segregated by gender, men's and women's work are separate but unequal, and women have a more difficult time obtaining work that is high paying and of high status. The second component of the division of labour is the unequal pay for women for equal work. Third, low social value is placed on work given to women. The division of labour is seen as the allocation of particular types of work to particular categories of people. The division of labour is considered to be a social structure because allocation by gender leads to labour market constraints that affect people's daily lives and potential earnings.
Allocation of work based on gender as described above results in the economic dependence of women on men. The social rules for men and women's work are evident in the areas of both domestic and industrial work. Women may have skills equal to those of men, but often their skills are undervalued, which makes the gendered division of labour a central system of social control. Connell (1987, 2002a, 2009) proposes that economic dependence stems from the lack of recognition of women's skills which results in men having higher earning potential. This has historically encouraged promotion of men in higher paying jobs and promoted low-wage or non-paid housework and childcare for women. In the workplace, hierarchies are in place that create barriers to women's entry into management and higher level jobs, and create segregation in the job market. According to the social theory of gender, labour market constraints, low wages, having an occupation of low social value, and being responsible for child care lead to women's economic dependence on men, which, in turn, explains women's behaviour, including their sexual practices.

2.1.2.2 Power Relations

Power imbalance is inequities in power between men and women specifically evidenced by a woman's lack of ability to act or produce an effect, an inability to influence, and a lack of control or authority over her spouse or partner (Connell, 1987, 2002a, 2009). In the social theory of gender, power imbalance describes male dominance as evidenced in patriarchal authority and in female submissiveness and powerlessness.

Women experience powerlessness as a result of social gender rules and cultural norms that prescribe relatively rigid gender role expectations. Men are physically stronger, and as a result of societal norms, are sexually assertive, hold political and decision-making power, and experience more autonomy and freedom. In these circumstances, men tend to have control over a female partner's behaviour and over decision-making for the couple. Men have traditionally been socialized to be more sexually aggressive, and more dominant, while women have difficulty being assertive and making their voices heard (Connell, 2009).
Longstanding inequities in gender-based power relations and strong gender and cultural norms give women little power to negotiate. In the social theory of gender, male dominance, women's perceived lack of control over their partner's behaviour, and male authority with regard to decision-making affect women's behaviour. A recent study looked at the impact of sexism on women's risk behaviours relating to sexuality (Choi, Bowleg, & Neilands, 2011). The authors found that sexism was indirectly associated with unprotected sex with a primary or a secondary sexual partner, through two mechanisms: psychological distress and difficult sexual situations... people with higher levels of psychological distress, because of their poorer mental health and often increased substance use, are often less motivated or able to engage in safer sex behaviors than their counterparts with less or no psychological distress...difficult situations for women, particularly coerced sex, are linked to increased reports of unprotected sex and this reflects the public health epidemic of sexual violence against women. (p. 410)

The researchers recommended that men and boys become involved in anti-sexism and gender equality interventions in order to reduce women's HIV risk.

2.1.2.3 Cathexis or Emotional Attachment

The importance of emotional attachment in human life was made clear 100 years ago in the work of Sigmund Freud. Borrowing ideas from neurology, but mainly using his work with his own patients, Freud showed that positive and negative expression of emotion are linked, in the unconscious mind, to images of other people. His work opened up a whole field relating to the social structuring of emotional relations, attachments, or commitments (Connell, 2009).

For Connell (1987, 2009), cathexis is defined as the gender norms that govern appropriate social and gender roles and behaviour for men and women. Gender is socially constructed through people's social interactions and relationships. As such, it presumes gender differences between men and women, upon which the basis for defining masculine and feminine traits are formed (Connell, 1987, 2009). Social and cultural rules
in South Asian societies encourage sexual restraint, sexual purity, and submissiveness for women, and encourage protectiveness and dominance and permit sexual promiscuity for men.

Cathexis incorporates the gender roles of women related to pregnancy and motherhood (Connell, 1987, 2009; Foucault, 1980). It is seen in women's interest in motherhood and children. It also values motherhood as a way to establish a connection to a male partner (Wingood & DiClemente, 1998).

Cathexis also refers to the emotional charge associated with a woman's emotional attachment to her male partner. Part of cathexis is women's desire to form meaningful attachments to men as an integral part of their development (Connell, 2002a, 2009). Trust and fidelity are important components of a relationship and are an integral part of the attachment associated with cathexis. Trust in one's partner and fidelity to the partnership are desired in the social relationships women have with their male partners. Women assume that their partnership is monogamous, and that they can trust their partner to remain faithful to them and care for them.

According to Connell's social theory of gender (1987, 2002a, 2005, 2009), cathexis consists of the traditional gender roles between men and women, the need for emotional attachment, and a desire for trust and fidelity in the relationship. Women's desire to conform to sexual monogamy, to maintain traditional roles, to achieve pregnancy, and to establish trust in the relationship contribute to their gender-specific behaviours.

2.1.3 Interdependence of Social Structures

Even though Connell (1987, 2005, 2009) described the above social structures of power relations, sexual division of labour, and cathexis or emotional attachment individually for analytical purposes, it is stressed that there is an interdependence between and among the structures. According to Connell, this is a result of certain historical conditions.
None of the three structures is independent of the others. Economic dependence is related to emotional attachment and to male dominance, and all three help to explain women's sexual behaviour. In other words economic dependence, that is, low income, unequal wages, and responsibility for child care, are directly related to cultural and sexual roles, and to male dominance. Emotional attachments are both influenced by male dominance and lead to unequal power: in other words, cultural and sexual roles both lead to male dominance and female powerlessness and are influenced by male dominance and female powerlessness. Male dominance explains behaviour, specifically sexual behaviour, as do economic dependence and emotional attachment. The interaction among these structures helps explain gender relations and the behaviour that results (Connell, 1987, 2002a, 2005, 2009).

2.1.4 Social Structures and Women's Risk of HIV

Wingood and DiClemente (2000) offer a concise overview of Connell's (1987) social theory of gender in relation to the risk of HIV infection among women. Their application of the theory illustrates the mechanisms that negatively affect women's health by making them vulnerable to sexually transmitted diseases, such as HIV, by increasing their risk of exposure.

Wingood and DiClemente's (2000) adaptation of Connell's (1987) theory provides a theoretical framework for understanding the risk factors for HIV among women using Connell's structures of gender: the sexual division of labour, the sexual division of power, and cathexis. According to Wingood and DiClemente (2000), the gender-based inequities and disparities in expectations between men and women that arise from each of the above structures generate different factors that influence the risk of HIV infection among women. These factors are inherent in the structures of gender and stem from the inequalities between men and women.

Economic dependence, male dominance, and emotional attachment interact with each other to create a situation that explains women's sexual behaviour. A woman who has
limited wage earning power and experiences labour market inequality is dependent on her male partner for money. As a result, her partner has more power in the relationship and takes control of sexual decision making.

A study involving a sample of 1,418 women, aged 20–44, from Moshi, Tanzania, looked at whether the many facets of gender inequality have an impact on women's risk for HIV (Sa & Larsen, 2008). The three contexts of HIV exposure that were studied reflected power disparity based on gender: economic context (difference in age between partners, and dependence on a partner's child care allowance), physical context, (intimate partner violence or coerced first sexual experience), and social context (difficulty having children). Behavioural risk factors encompassed the number of sexual partners in the previous three years, having a partner who was involved in multiple relationships, lack of condom use, and drinking at least once per week in the previous year. The findings of the study support the hypothesis that economic disadvantage and being a victim of sexual aggression increased women's risk for HIV. It also provided support for development of behavioural approaches to HIV prevention to include empowerment of women economically and by eliminating gender-based violence, and creating awareness to change behaviours and attitudes among men.

### 2.1.5 Cultural or Normative Influences

Connell (2002a, 2005, 2009) looks at culture or symbolic relations as another factor that influences behaviour. Culture involves particular social interests, and grows out of historically specific ways of life. According to Connell (2009), "society is unavoidably a world of meanings. At the same time, meanings bear the traces of the social processes by which there were made" (p. 83). The use of the term "culture" in my work encompasses Connell's notions of customs, traditions, norms, "ideas, and social behaviour of a particular group as they relate to how people interact in a particular local context", such as the family. As such, culture incorporates perceived norms or shared understanding of "acceptable actions and behaviours in a particular setting" (Connell, 2009, p. 83).
2.1.6 Interdependence of Structural, Normative, and Individual Factors

The interdependency of structural, normative, and individual factors in social relations can be seen as instinctively obvious, but detailing "how" this is so remains to be a challenge (Emirbayer & Goodwin, 1994). Examining the interdependencies described in Connell's (1987, 2009) theory provides valuable opportunities for expanding and building upon the main concepts of the theory.

Interdependency is defined as "the influence that cultural and societal formations have upon social actors and the transformative impact that social actors, for their own part, have upon cultural and societal structures" (Emirbayer & Goodwin, 1994, p. 1442). A central notion is that "social structure, culture and human agency presuppose one another" (Emirbayer & Goodwin, 1994, p. 1413). Interdependency implies that "individuals engage in acts of resistance, [recognizable] through the voices and practices of everyday life" by actively negotiating their gendered selves and redefining institutional and cultural norms (Thapan, 2009, p. 163). "Even though it is not always possible to indicate the extent to which agency attains desired results, its immediate gains for women are undeniable" (Thapan, 2009, p. 163). "An understanding of the complexities underlying the concept of resistance and the implications this has for women's agency in everyday life" becomes crucial as women "negotiate, strategise, manipulate, revolt and rebel against situations, events and persons" to construct their embodied selves (Thapan, 2009, p. 162).

2.1.6.1 Interdependence of Structural and Individual Factors

For Connell (1987, 2005, 2009), the primary goal of hegemonic masculinity is the legitimization of the control that men exercise over women. Connell gives examples of hegemonic masculinity in society where men control government and corporate positions and are paid, on average, more than what women earn (Connell, 2009). Hegemonic masculinity signals male dominance through the use of ideology and institutional policies
and operates within a deeply entrenched belief system which devalues females and sees them as second-rate when compared to males (Connell, 2005).

The ramification of Connell's (2009) theory is that there is an "interdependency between the structural relations of power on the one hand and the belief [of individuals] in the superiority of men over women on the other" (p. 25).

2.1.6.2 Interdependence of Cultural and Individual Factors

Men as a dominant group work through popular culture and institutional policies to push their own agendas by defining what is considered legitimate and creating a belief system that promotes and sustains their power (Connell, 2005; Hall, 2002). This may give the submissive group an opportunity to show acts of resistance, which can be seen as "two sides of the same coin" (Thapan, 2009, p. 164). "The quality and power of resistance… enables possibilities even as it forecloses them, [thus allowing] engagement with the operation of power and simultaneously preventing the containment of power" (Thapan, 2009, p. 164). The dominant group will have the benefit of being able to influence and control ideologies, thus defining the parameters of legitimate discourse. Because belief systems function at the collective and the individual level, this can have the effect of shaping the beliefs of individuals. Beliefs at the collective level are normative. But cultural or normative beliefs are not the summation of individual beliefs. For example, a South Asian woman might personally believe that men and women should have equal power in a marriage, but perceives that most other women in her community do not accept that. Indeed, personal and normative beliefs are interdependent, but they are not necessarily aligned or congruent. However, cultural or normative beliefs and influences can be measured at the level of the individual because social norms are what most people perceive to be the beliefs of most other people.
2.1.7 Limitations of the Theory

While Connell's (1987, 2009) theory is useful, it does have its limitations. The first limitation of Connell's theory is that the particular local context in which hegemonic masculinity is performed are not dealt with fully. With gender enacted at local, regional and global levels, the application of the theory to local contexts is not fully developed. Typically, changes in a local setting such as the institution of the family occur more rapidly than societal changes (Connell, 2002a). Theoretically, Connell stipulates the significance of context in a general fashion and through the work of qualitative investigations of masculinities. Even though Connell has examined context in a more recent work (2005, 2009), the explanation of local social context is not sufficient. Thus, there is still a need to delve in-depth into daily transactions of individuals to explain personal context. The women's narrative in this study does just that.

Considering the local in more details is quite imperative. Hierarchies are formulated in a particular local context; the South Asian women in the Greater Toronto Area were chosen as a suitable specific local context and a site of gender construction and contestation, where hegemonic masculinity can be enacted. The detailed interviews with the women allowed me to closely examine the gendered expressions of this particular group of women and the issues of power between the women and other members of their family starting with their childhood experiences and later in their adult lives.

Second, the details in the interactions between individual, structural, and normative factors are not fully developed; the theory does not allow for a precise account of how structural, individual, and normative factors are interdependent. Connell’s (1987, 2009) theory tends to operate at the macro level, so the interviews with the women provide a micro lens where these mutual dependencies and interactions are explained. Data in this study showed that there was an ability to integrate interactions between and among social structures, individual attributes of the women and social norms in their lives based on their unique histories, thereby taking into account the women as social actors within the
context of their South Asian families. The results of this study explained specifically how structural, individual and normative factors interacted to legitimize hegemonic masculinity, thus impacting the women's risk for HIV.

Both of the above theoretical concerns deter the use of the macrostructures inferred by the theory to examine the specifics of individual people's lives and to explain how individuals participate in the construction of gender. This study has attempted to address these two limitations.

2.1.8 Crisis Tendencies

Gender patterns may change. To specifically account for the possibility of change and to stress the historical nature of gender, Connell proposed that gender structures may develop *crisis tendencies*, that is, internal contradictions or tendencies that "undermine current patterns and force change in the structure itself" (Connell, 2002a, p. 71 [italics in original]). Connell claims that oftentimes an imminent or occurring crisis will lead to a change in the existing gender dynamic. A factor such as immigration or diseases such as HIV/AIDS can lead to the development of a "crisis tendency", thus affecting patterns of gender relations in a group. For example, a project that examined how people from East Africa and the Caribbean living in Toronto perceived and experienced HIV/AIDS stigma within their lives found that the separations and reunifications often associated with immigration puts additional stress on families (Calzavara, L., Tharao, E., Burchell, A., Remis, R., Myers, T., Swantee, C., et al., 2005; Lawson, E., Gardezi, F., Calzavara, L., Husbands, W., Myers, T., & Tharao, W. E., 2006). The pressures these events put on families made people feel that their relationships were fragile, which were further complicated by the stresses of dealing with HIV.
2.1.8.1 Interactions of Gender, Power, and Immigration

The interplay of gender, power, and immigration needs to be examined. A context such as immigration can influence the interdependencies of structural, individual and cultural factors. Connell (2002a) suggests that support for gendered power relations is likely to vary from one local setting to another. As previously indicated, individual beliefs supportive of male dominance are interdependent with structural power relations, both of which are mutually dependent on perceived social standards involving male dominance. The combination of all three, namely individual beliefs, social structures and social norms helps explain how people do gender. Because gender relations can vary, Connell (2002b) suggests that power imbalances may be greater or lesser and relations of power may operate in different configurations depending on the local setting.

Because gender is a multifaceted system, it may be particularly resistant to radical change or disruption as a result of a dramatic event, such as immigration, for instance. Drastic changes are not expected to take place in the gender system over a short period of time. Each level at which gender is produced, the individual, interactional, and institutional levels, may be somewhat differently affected by changes in the larger society (Connell, 2009).

Women are a significant part of the immigrant population, making up slightly over 50% of the total number of immigrants (Statistics Canada, 2007). In her article, *The Paradox of Diversity: the Construction of a Multicultural Canada and 'Women of Color'*, Himani Bannerji (2000) provides a comparison between U.S., Canada and Australia with use of the terms multiculturalism and woman of colour. Bannerji describes Canada as a "multi-ethnic, multi-national state, with its history of racialized class formation and political ideology" (p. 545). Multiculturalism provides a way of both concealing and preserving social power relations thus providing an acceptable political language for Canadian society. Bannerji (2000) argues that there has to be a consideration for the country's fluctuating history of multiculturalism such as the open-door policies of the 1960s and
the 1970s which brought many people of colour to fulfill labour needs not being met by Canadians of the time. In other words, Canada's immigration policies have changed based not on external forces or demands from potential immigrants' needs, but from its own labour and economic necessities which demanded inexpensive and compliant workers.

Immigrant experiences are shaped or structured by gender. Particularly if they are members of a visible minority, immigrant women are often described as having multiple disadvantages in mainstream Canadian society arising from racism, language barriers, class, and, on top of that, sexism. Lorber (2000) suggests that a hierarchy develops in heterogeneous societies whereby a baseline normal is established against which all people are measured. In North American society, Lorber (2000) argues that the normal baseline is white, middle-class, and male. Against this measure immigrant women of colour are triply disadvantaged. This disadvantage is manifest through several institutions. Employment is limited for immigrant women and returns on education, in terms of higher-paying employment, are well below those enjoyed by native-born, white women, because opportunities are frequently delineated not only along gendered lines, but racial as well (Beach & Worswick, 1993; Dyck, 1992).

2.1.8.2 Immigration and Behaviour

A Health Canada (1999) report on immigrants concluded that immigrant women experience immigration and settlement far differently than men do. One of the reasons the researchers at Health Canada found is the double discrimination that women experience because of their gender and ethnicity. The study further concludes that immigrant women also face difficulties in adopting the culture of their new country because they are often tasked with the maintenance of their original cultural and religious values in the home. Since immigrant women are also often responsible for the health and well-being of their families, they are, like most other women, simultaneously health care service providers and health care service seekers. Thus, at times, these expectations
propagated by tradition and culture can make immigrant women's lives more complex than those of immigrant men.

Understanding of the intricate relationship between HIV infection rates and population mobility is gradually increasing (UNESCO, 2004). Several factors increase immigrants’ vulnerability to HIV infection. These include the norms that guide their behaviour and separation from families and/or partners. Other factors affecting behaviour stemming from discrimination or the nature of their immigration and might include loneliness, alienation, and despair. Factors of a more social nature also affect immigrants’ vulnerability to HIV infection. These include poverty, powerlessness, economic exploitation and racism in Canada. Himani Bannerji (2000) postulates that construction of the terms “multiculturalism” and "women of colour" are an attempt by White Canadian society to both embrace cultural and racial difference and to reinforce existing power inequities (p. 537). All of these influences may drive people to engage in behaviours in which they would not otherwise. Several studies have discussed the fact that South Asian immigrant women are socially ostracized and suffer from depression and psychological distress (Kobayashi, Prus, & Lin, 2008; Samuel, 2009). Being a victim of sexual violence is also a risk factor affecting many immigrant and refugee women (UNESCO, 2004).

### 2.2 Context and Gendered Power Relations

Context is an important factor in clarifying the interdependencies between individual beliefs, social structures and social norms (Emirbayer and Goodwin, 1994). It is important to note that context varies from one individual to the next and even within the individuals themselves depending on their personal attributes and the way they interpret experiences they have in their daily lives. These specific contexts are also shaped by social relations between individuals and diverse, shared cultural behavioural expectations. It is for this reason that context requires further exploration.
Connell is aware of the need for an understanding of context to assist in determining what upholds gendered power relations, how they may be challenged, and how the system as a whole works (Connell & Messerschmidt, 2005). Local context allows for agency in everyday discourses and practices, the complexities of which affect the formation of gendered selves. Individual gender performance can be more easily identified in a local context as opposed to regional or global surroundings, even though local settings are also affected by the regional and global settings in which they are found.

2.2.1 Specific Contexts of this Research

It is possible to think of the local setting in this study as the South Asian immigrant woman. South Asian immigrant women in the Greater Toronto Area were chosen as a suitable local context for examining hegemonic masculinity because of the multiple opportunities for gender construction and contestation in the women's daily interactions. The study participants were 12 HIV-positive women, ranging in age from 28–50, of South Asian descent, who immigrated to Canada from South Asian and African countries, and reside in the GTA. In-depth interviews with the women in this study helped me examine the women's personal resistance to and reinforcement of gender relations, and their constructions of HIV risk in as the context of their own families, work, and their immediate communities.

By focusing on the experiences of HIV-positive South Asian immigrant women I was also able to explore the role of immigration in bringing about change in a number of local settings. This ultimately shed some light on changing gender roles and the structures of gender relations and their effect on the sexual behaviour of South Asian immigrant women.

2.2.1.1 Who are the South Asians?

The fact that South Asians tend to be studied as a group obscures the heterogeneity within the group South Asian and differences tend to be glossed over (Murphy, 2003).
According to the Council of Agencies Servicing South Asian (CASSA), there are fourteen major languages and more than 400 dialects in India alone. Although Hinduism is the dominant religion in India and Islam is the dominant religion in Pakistan and Bangladesh, all the world's major religious traditions are represented in the South Asian population (CASSA, 2000).

Because South Asians form such a large heterogeneous group, it is easy to overlook the variability in and complexities of gender relations and familial relations and female voices go unheard (Murphy, 2003). Despite the many differences among South Asian women, they originate in the same geographic region, and they share many cultural practices, traditions, values, and beliefs (Anwar, 1998; Cappon et al., 1996; Okazaki, 2002). According to Statistics Canada (2006), South Asians are considered to be one of the ethnocultural groups in Canada. Statistics Canada defines an ethnocultural group as one whose members share characteristics unique to that group, which comprise "cultural traditions, ancestry, language, national identity, and country of origin". A group's cultural identity can also be defined by a religious ideology. Moreover, people who self identify as South Asians are categorized by having a strong communal culture with prominent traditions and widespread social, family and community networks (ASAAP, 1999). After all, according to Karlsen (2004), "ethnicity may be defined as self-presentation and behaviour, membership in ethnicity-specific organizations, perceptions, and experiences of racism and a sense of cultural assimilation"(p.133). The term "South Asian" as used in this study refers to a single ethnocultural group of people of similar cultural and ethnic backgrounds.

2.2.1.2 Immigration of South Asians to Canada

Although there have been South Asians in Canada since the 1800s, the first wave of immigration was not until the 1900s, with the first immigrants arriving from India to the west coast in 1903 (Allahar, 1998; Das Gupta, 1994; Handa, 2003). Most of the early settlers were Punjabi Sikhs who worked in the sawmills and lumber yards or in railway construction, mining, fishing, or agriculture (Handa, 2003). Even though South Asians
were faced with discrimination and despite limitations on immigration from Asian
countries, Indian immigrants continued to settle mostly in the western provinces of
Canada in pursuit of a better life (Allahar, 1998; Buchignani, Indra, & Srivastiva, 1985;

The settlement of South Asians in Canada can be divided into three waves. During the
first wave (1905–1914), South Asians were perceived as morally and politically
undesirable in Canada (Indra, 1979). It was also during that time that immigration laws
had the effect of banning Indian women from entering Canada until the 1917–1919
Imperial War Conference Agreement legislated their entry (Cassidy et al., 2001). During
the second wave (1928–1937), controls on immigration reduced South Asian immigration
to Canada, thereby resulting in less attention being paid to the South Asian Community.
The third wave started in 1967 when the federal government instituted a point system for
immigrants that favoured those with professional qualifications. The result of that was
having more South Asian immigrants to the Atlantic region of Canada.

During the last century, Canadian immigration policies have been contradictory and
inconsistent with regard to the immigration of non-whites to Canada (Handa, 2003). The
immigration of South Asians to Canada during the first and second wave was a result of
the mingling influences of colonialism and capitalism. In India, in particular, the
harshness of life, stemming from both famine and poverty, made the idea of going abroad
in search of a better life quite attractive (Bolaria, 1988). But the majority of South Asians
have been in Canada since the 1960s, when the point system was introduced. In her
article, "Canadian Immigration Policy in the Twentieth Century: Its Impact on South
Asian Women," Helen Ralston (1999), provided a historical look at Canada's immigration
policy. In that article she described that attitude of the policy toward the South Asian
immigrant woman as strictly a bride and child bearer for immigrant men. Their gendered
role was defined by social reproduction, rather than economic production; even though
many South Asian women immigrants had higher qualifications than the principal
applicant (the man) and Canadian law allowed them to apply in the "independent"
category, they were still viewed as "dependents" on men in the Canadian immigration policy at the time.

The dependency of sponsored people on their sponsors as enforced by the government (which was typically women dependent on men) amplified the power imbalance that already existed between men and women. Upon re-examination of the policies governing family sponsorships, Citizenship and Immigration Canada introduced a new Immigration and Refugee Protection Regulations document designed to protect sponsored women from mistreatment (Gazette, 2002).

The largest South Asian community in the GTA—the Tamils from Sri Lanka—have only been here for the past 2 decades. While Sikh and other immigrant groups from South Asia for the most part arrived either as landed immigrants or under the family reunification category, a large number of Tamils are here as refugees. South Asian Canadians are typically characterized by four major religions which include Islam, Hinduism, Sikhism, and Christianity and five key languages, including Punjabi, Gujarati, Bengali, Urdu, and Hindi (CASSA, 2000).

The most recent published results to date from Statistics Canada's 2006 Census indicate that there are almost 1 million people living in Canada who self identify as South Asians, representing approximately 3% of the overall population. Of the 68% of Canadians of South Asian descent, 75% immigrated to Canada in the last 20 years. In 2001, most South Asians (62%) lived in Ontario, with over 500,000 living in Toronto. The next largest group (11%) resided in British Columbia. In recent years the number of people of South Asian descent has grown more quickly than the overall population in Canada. For example, the percentage of people who self-identified as South Asian from 1996-2001 grew by 33%, as compared to the general population which increased by just 4%. This makes the South Asians as the leading visible minority group in Canada (Statistics Canada, 2006).
2.2.1.3 South Asian Immigrant Experience in Canada

Following migration, immigrants experience fundamental social and economic changes as they engage in negotiating new identities. This process is referred to as acculturation (Berry, 2002; Talbani & Hasanali, 2000). Migration can cause tensions between the traditions that people would like to retain and the traditions in the new host culture, which may be very different (Abouguendia & Noels, 2001; Berry, 2002). The new settlement experience creates space for struggle and contradiction, compliance and resistance occurring simultaneously, where individuals and families learn to redefine and renegotiate their roles and identities within and outside their religious or cultural communities (Abouguendia & Noels, 2001; Berry, 2002; Talbani & Hasanali, 2000).

As a result of the acculturation process, immigrants have two frames of reference and make comparisons between them. Through acculturation, they learn the behaviours that have the right social fit with their new cultural milieu (Berry, 2002; Talbani & Hasanali, 2000). In the process, some "cultural shedding" may transpire and at times accompanied by "cultural conflicts," which, for some, may give rise to "acculturative stress" (Berry, 2002; Bhabha, 1994).

Research has been done into how South Asians have adapted or resisted and contested the Canadian way of life. For instance, Chekki’s (1988) research focused on the family structure in India and in Indian communities in North America. He explored and compared some of the old and new aspects of families in the native and host cultural contexts. Chekki analyzed the changing sex roles within the family and, in addition, puts into question the notions of the "melting pot" and the "cultural mosaic," two perspectives that have dominated the discussion of immigration in Canada. The notion of the "melting pot" implies that ethnic groups should make concerted efforts to blend into Canadian society because the unity of the country is compromised if Canadians of different ethnic and cultural backgrounds remain immersed in their own traditions and customs (Chekki, 1988). At the outset of the 21st Century, Canada has become progressively more and
more multi-ethnic and multicultural and as such cultural mosaic predominates public policy in Canada.

Canadians from South Asian descent have in the past encountered extreme prejudice and blatant forms of racism (Allahar, 1998). For instance, in his 1947 speech about immigration in Canada, Prime Minister Mackenzie King stated "the native of India is not a person suited to this country as [they possess] manners and customs so unlike those of our own people and [are unable] to readily adapt themselves to surroundings entirely different" (Allahar, 1998, p. 341). Buchignani (1980) found that, compared to other ethnic groups, social and ideological acceptance of South Asians has been slow to develop in Canada because of their visible cultural markers and physical differences such as clothing and skin colour.

Today South Asians are still faced with discrimination and racism (Aujla, 2000; Henry & Tator, 2006; Rajiva, 2006). South Asian women, in particular, are discriminated against based on both ethnicity and gender. They might hear themselves described as obedient, uneducated, and smelly (Bannerji, 1993; Rajiva, 2006; Samuel, 2009). Some South Asian women have resorted to strategies such as denial and distancing to deal with these experiences, attributing incidents of racism to cultural miscommunication (Bannerji, 1993; Handa, 2003; Malhi & Boon, 2007; Rajiva, 2006). In a discourse analytic study involving twelve white-collar professional Canadian women of South Asian descent who have been in Canada for more than 5 years, Malhi and Boon (2007) found that the women in their study employed "various rhetorical strategies and discursive devices to avoid attributing negative experiences to racism." (p. 127). The authors argued that denial of racism results in "racism becoming invisible both to the perpetrators and the targets, and systemic inequalities and injustices remain unchallenged" (Malhi & Boon, 2007, p. 127).

South Asian women have become the centre of several research studies examining the settlement experiences of South Asians in Canada. In a study conducted in 1988, Naidoo and Davis reviewed research on South Asian women in Canada that had examined the
characteristics of their life and their approach to new cultural and familial values encountered in the host society. The review concluded that the South Asian participants combined traditional values of India, with contemporary Canadian values to secure personal beliefs about what was important in life. Moreover, the review study found that women continued to hold familial values, such as the importance of being a wife and mother, as of paramount importance to them and the values of being employed and educated as equally significant. The above findings seem to uphold over time. More recently, a review of empirical studies about South Asian immigrant women in Canada, undertaken by Naidoo, found that the women identified "sources of change" resulting from a dualistic world view which encompassed both family traditions and customs and individual development values from the host country (Naidoo, 2003).

South Asians do report experiencing cultural conflicts and acculturative stress after migrating to Canada (Agarwal, 1991; Jensen, 1988; Talbani & Hasanali, 2000; Wakil, Siddique, & Wakil, 1981). One study reported on multiple mental health issues described by 24 Hindi-speaking South Asian immigrant women in Toronto (Ahmad et al., 2004). Mental health concerns such as loneliness, anxiety, and depression associated with immigration emerged as predominant themes. These vulnerabilities were overwhelmingly experienced by the women in spite of the coping strategies they reported using. The researchers called for Canadian health and social programs, including medical training, to increase cultural understanding and sensitize practitioners more thoroughly to mental health concerns reported by South Asian immigrant women in Canada (Ahmad et al., 2004.)

Khan and Watson (2005) interviewed seven women of Pakistani origin who had recently immigrated to the Greater Toronto Area to compare their pre-immigration expectations and post-immigration experiences. The study identified loss of economic prosperity and subsequent loss of identity stemming from attempts to find employment in a job market that did not recognize their professional qualifications. The study described the women as undergoing four stages: "seeking a better future; confronting reality; grieving and mourning; and gains, remains, and coping" (p. 313). It concluded that the process of
immigration is an important life transition that requires strong adjustments emotionally, socially and culturally. In addition, culturally sensitive, supportive employment counselling needs to be offered both prior to and at the time of immigration (Khan & Watson, 2005).

George and Chaze (2009) reported on findings from interviews with 50 South Asian immigrant women in Toronto. Specifically, the authors examined the women's post-immigration experiences and the role of social capital (primarily information about the host country) in addressing their needs. They identified the importance of social capital in settlement situations and found that most of the participants derived their social capital from both formal and informal peer support networks. Moreover, having access to social capital was vital in helping the South Asian immigrant women transition to a new home country (George & Chaze, 2009).

Researchers have also closely examined settlement experiences and subsequent needs of specific subgroups of female South Asian immigrants in Canada. For instance, Choudry (2001) examined the settlement experiences of elderly South Asian women emigrating from India. The purpose of this descriptive qualitative study, which involved 10 elderly women, was to explore whether the participants' beliefs, values, and culture mediate the stress resulting from immigration and resettlement. The study identified four major themes: "isolation and loneliness, family conflict, economic dependence, and settling in and coping" (p. 387). The author stated that the women reported a sense of loss as a result of experiencing different traditions and values and the absence of support networks from their own community. As part of her recommendations, the author was focused in her attempts to alert health care providers to the unique psychosocial context of this group of women (Choudry, 2001).

In addition, another subgroup of South Asian women, South Asian sponsored brides, was examined, particularly in terms of their vulnerability to abuse from family members living in Canada. Two pivotal research pieces that examined the experiences of women sponsored into Canada had very similar findings (Cote, Kerisit, & Cote, 2001; Husaini,
2001). Husaini's (2001) qualitative research in Alberta, Canada involved sponsored South Asian women who entered Canada as a result of an arranged marriage. The women reported problems such as not being allowed to enrol in English classes or seek employment by their husbands, being prevented from socializing with others outside of their social networks, or having financial support withheld from them. Some of the women also reported experiencing harsh physical and emotional abuse. Similar results were reported by Cote et al. (2001) who interviewed 16 sponsored brides into the provinces of Ontario and Quebec in Canada, including some who were South Asian. Listening to the women's stories, the researchers talked about the women paying a hefty price for their sponsorship, which included being asked to do certain duties around the house, relinquish income to the husband, and refrain from socializing with others external to their social networks. The women also described experiences of various forms of abuse in their lives.

More recently, in a study that also looked at South Asian sponsored brides, Merali (2009) compared two groups of women (one fluent in English and the other not) in terms of how well they could understand and access information about available resources and Canadian policies. This study showed that those who lacked English were more vulnerable to abuse and violence than those who did not. The author suggested that efforts be made to provide information to all South Asian brides so that they would be empowered with knowledge of the rights and protections available to them in their new country (Merali, 2009).

Structures of gender relations and their effect on behaviour of the South Asian immigrant woman deserve further analysis. In her article, Social Theory of Gender, Maharaj (1995) talks about the "holistic approach to the structures of women's subordination [which] sees women's specific experiences as generated by intersecting structures which may derive from any social realm, be it the realm of culture, economics, politics, religion or ideology. What the generating structures are and from which realms they derive depends on the specific experience under analysis" (p. 57). Moreover, she argues that "ideologies of gender, race, class, ethnicity and other relevant ideologies of superiority or systems of
social stratification intersect with each other in specific ways in specific contexts to generate specific gendered experiences" (p. 57). According to the author, "this holistic view of the structures of women's oppression stands in marked contrast to reductionist views which seek to identify oppressive structures in one specific realm, while, at the same time, ignoring others" (p. 58).

2.3 Structures of Gender Relations in South Asian Immigrant Women

To explain the risk factors for HIV infection among women, there is a need to examine the three main structures that characterize the gendered interactions between males and females: the sexual division of labour or economic dependence by women on their partners; the sexual division of power or masculine hegemony; and cathexis, the emotional attachments, the social and sexual relationship between women and their partners.

As previously indicated, even though the structures of gender relations are discussed separately, they are intertwined and interdependent. The interplay among the structures as applied to South Asian women demonstrates the associations among gender relations, economic, and domestic power and cultural traditions and relational attachments. Women desire a committed and trusting relationship with sexual partners at the same time as they experience economic dependence on them. Cultural expectations of sexual purity for women, reliance on men, and submissiveness to their authority influences women's behaviour, and decreases their ability to be assertive in their relationship with a male partner (Murphy, 2003).

2.3.1 Division of Labour

Division of labour is affected by gender norms established early in life. Societal expectations for male and female behaviour, attitudes, and traits and socially determined
roles echo the value of males and females in a particular culture or society. They also support the division of labour and responsibilities between males and females, upon which different sex rights are granted (Murphy, 2003). Gender norms generate disparity between men and women, usually disadvantaging women in areas that involve social influence and status, autonomy, and health and wellness (Murphy, 2003; Wingood & DiClemente, 2002).

In their article, "Why do women still do the lion's share of housework?" Lachance-Grezel and Bouchard (2010) reviewed a decade of research on gender theory and household labour in North America. They found that all studies conducted in the 21st century concur that women continue to perform the majority of household work reflecting a lack of financial control in their interactions with males. The authors concluded that researchers are no longer looking for one theory to explain gendered division of labour, but rather share an increasingly global view of this phenomenon, one that considers the many factors that converge with the result that the traditional distribution of household tasks is maintained. Moreover, they pointed to the need for multiple areas of study, such as sociology, political science, and feminism, to more adequately explain the individual and social forces that are at play in maintaining the gendered division of household labour globally. In response to Lachance-Grezel and Bouchard (2010), Coltrane (2010) echoed the call for multidisciplinary studies and specifically pointed to a need for highlighting ethnic, gay and lesbian, and immigrant groups in their similarities and differences to expand our understanding of the division of household labour.

In her paper, "Situating South Asian Immigrant Women in the Canadian Global Economy," Jamal (1998) examined South Asian women in the Canadian workforce and found that they continue to be responsible for the household despite their employment outside the home. The study highlighted loneliness, isolation, and women's subservience, which were often attributed to women's role in household, and also looked at the incidents of racism women of colour routinely experience. The author tried to shed some light on the situation of immigrant
South Asian women in Canada [as] a particular category of worker that is important for capital not solely as surplus labour or a reserve army that can bring down wages of the organized workforce but because their race and gender constitute them ideologically and politically as the lowest paid and most exploited worker. (Jamal, 1998, p. 4)

When it comes to income, South Asian women have lower earnings as compared to South Asian men in Canada. According to Bélanger & Malenfant (2005), South Asian women have a higher unemployment rate: 11% compared to 7.4% in the overall Canadian female population. Similar to the general societal trends on the whole, South Asian women have lower incomes as compared to South Asian men: the average income for females over age 15 being less than $20,000 a year. With about a $12,000 difference from South Asian men, who earned slightly over $31,000, this phenomenon is reflective of the overall gender earning gap between men and women: women earn 62% of what men earn. Examining this group of women further one finds a difference within the group: larger numbers of women of South Asian descent have low incomes (22.7%) compared to Canadian-born women of whom 17.7% have low incomes (Bélanger & Malenfant, 2005).

The relationship of South Asian women to the Canadian economy has been studied, particularly with respect to the dual demands of home and the workplace. Recently a study of a group of South Asian immigrant women from Toronto engaged in home-based entrepreneurial endeavours was conducted (Maitra, 2007). The paper, which was part of a report for the Centre of Excellence for Research on Immigration and Settlement (CERIS), found that the South Asian women were incapable of locating suitable employment and consequently were engaged in home-based work mainly due to the lack of recognition of their educational and work experiences in Canada. As well the women viewed their work as a way to be able to fulfill their role in the home while at the same time reaping the benefits of the skills and training acquired from their countries of origin. The most frequently reported type of work was tailoring; the women's tailoring skills were not recognized by Canadian employers but were valued in South Asian enclaves in Toronto (Maitra, 2007).
2.3.2 Sexual Division of Power

Sexual division of power is usually established during childhood; children are socialized into gender-defined behaviours and attitudes predominantly by parents and other caretakers who treat boys and girls differently (Murphy, 2003). Further gender inequalities are reproduced in the relationships formed as children reach adolescence and adulthood (Murphy, 2003; Talbani & Hasanali, 2000). Gender-based socialization plays a significant role in cultural control to support a patriarchal system where men dominate (Talbani & Hasanali, 2000).

The patriarchal structure of South Asian families is at the root of the power imbalance. A scholar at the National Law University of Delhi traced the roots and current support of patriarchy in India and determined that although some laws have recently changed to protect women, a stronger social influence, family social structures and practices that control women's sexuality, cut across caste, class, religious, ethnic, and geographical divides to maintain the subordination of women in India (Sarshar, 2010). Similarly, in her review of feminist scholarship on patriarchy in Bangladesh, Chowdhury (2009) examined the effect of patriarchy in Bangladesh in the following three areas: (a) non-recognition of unpaid work; (b) sexual harassment; and (c) accumulation of capital. The author concluded that patriarchy allows men to dominate, oppress, and exploit women in both private and public life. In the home women are considered to be "passive dependants and property of their husbands and private patriarchy is maintained in the family through the misinterpretation of religion and the non-recognition of unpaid work done by women at home" (Chowdhury, 2009, p. 599). In the public arena, women are excluded from economic and political power and patriarchy is maintained through sexual harassment. Even though historically, a dowry is the money, goods, or estate that a woman brings into the marriage and often provides an incentive to the husband not to harm his wife, increasingly men in Bangladesh are using the dowry system for capital accumulation and thus further exploiting women.
Researchers studying South Asian women highlight the significance of ethnicity and gender, and argue that South Asian women in Canada face double subordination of racism in society and of patriarchy in their households (Dua, 2007; Ralston, 1999). On the other hand, the family may be a source of support for women against racism. The researchers further maintain that, theoretically, it is difficult to prioritize race over gender or vice versa in the experiences of South Asian women in Canada.

Gagnon et al. (2010) recently reported on a first of its kind empirical study of 122 South Asian immigrants residing in Montreal, Canada that specifically examined the women's knowledge, attitudes, and practices relative to HIV and other STIs and the role of gendered power in this context. Noteworthy was that more men than women reported having greater power than their partner in decision making generally in their relationship, and more men reported that they had more power specifically regarding the sexual practices in the relationship. Not surprisingly, women reporting that they had more power in their relationships also reported greater knowledge about HIV and other STIs and were more likely to ask partners to wear a condom during sex (Gagnon et al., 2010).

There is research suggesting that the gendered power imbalance in South Asian cultures has endured across generations. Recently, a study of 17 first generation and 23 second generation women in the Malayalee immigrant community from India, which has roots in the Syrian Christian religion, articulated the complexities South Asian immigrants deal with in construction of their diasporic identities, particularly second generation females (Samuel, 2009). Samuel's study demonstrated the importance of arranged marriage practices to first generation women as a way to instil and perpetuate Indian social traditions in their children and the complexities second generation women faced because of their desire, on the one hand, to appease family and maintain cultural traditions and, on the other, adopt Western practices when it comes to choosing a partner. Women in the study who challenged marriage cultural norms by choosing partners or divorcing partners were rejected by their Indian communities. The women's desire to avoid social exclusion by the group, particularly those who were first generation, may have driven them to adhere more adamantly to traditions from India. It may also be that Indians in the
Diaspora believe that maintaining their customs is necessary to maintaining their identity as Indians within a dominant Western culture (Samuel, 2009).

The work of Meenakshi Thapan (2009) on embodiment in her book, *Living the Body: Embodiment, Womanhood and Identity in Contemporary India*, is worth mentioning here. Focusing on two sets of adolescent and adult women, those who are educationally advantaged—in school or working, professional, career women and those who are educationally disadvantaged—located in slums and engaged primarily in unskilled labour or domestic work, the author talks about gender and class as essential components of identity and how women contest power. She notes that, "the professional and educated women are articulate and conscious of their dilemmas and rights and view the world from their position in particular sections of society" and as an ethnographer, she would seek to "understand their lived experience from their location, listening to their construction of their everyday world, as an experienced and contested social reality" (p. xvi). On the other hand, poverty is central to women's experience in the slum and as a researcher, she would "consciously take their subjective experience of poverty as central to their recognition of themselves as gendered subjects and assert that subjective experience is crucial to [the] understanding of the complexities characteristic of everyday life" (p. xvi).

### 2.3.3 Cathexis (Emotional Attachment)

Cathexis is defined as the norms that govern the social and gender roles and behaviour of males and females. Components of cathexis which are discussed below are roles of men and women and fidelity in sexual relationships that result in women's emotional attachment to male partners.

#### 2.3.3.1 Roles of Men and Women

In ancient Indian culture, sexuality was freely discussed in religious and spiritual texts, such as the *Kama Sutra*—an ancient Indian text on the art of love and sexuality—and was
openly expressed in art work, sculptures, and erotic poetry of the 7th and 8th centuries (Okazaki, 2002; Wolpert, 1993). In contemporary Indian culture, however, sexuality is a taboo subject and is not openly discussed (Fisher, Bowman, & Thomas, 2002; Weston, 2003). How this change came about is not fully understood. Some suggest that the control of sexual pleasures was initiated by ancient philosophers who perceived the expression of sexuality to be a threat to the South Asian culture and family values (Meston, Trapnell, & Gorzalka, 1996); others suggest that open expressions of sensuality were suppressed by Muslim invaders in the 10th century who spread Islamic propriety and law in India (Wolpert, 1993).

South Asians adhere to strict moral and social codes in their daily life: modesty and restrained sexuality are highly valued, particularly among women (Bhopal, 1997; Ghuman, 2000; Okazaki, 2002). Discussion of issues surrounding sexual feelings and behaviours is considered taboo and shameful and, thus, rarely takes place (Bradby & Williams, 1999; Fisher et al., 2002; Weston, 2003). Discussion of sexual health becomes acceptable only "when the time comes," that is, after marriage (Fisher et al., 2002). These findings were based on women who live in rural areas and belong to lower caste or social class and as such may not necessarily apply to women in different contexts.

There is a distinct difference in the norms governing boys and men with respect to dating, socialization and premarital sex in South Asian society than those governing girls and women (Anwar, 1998; Hunjan & Towson, 2007; Talbani & Hasanali, 2000; Wakil et al., 1981). Culturally held notions of honour and shame are significant in the control of women's sexuality in South Asian culture. Men can experience disgrace and indignity if they are unsuccessful in exercising power over women in their own (Lindisfarne, 1998). South Asian cultures use the term izzat to describe family honour. A women's project in Derby, Britain involving different age groups of South Asian women examined the significance of "izzat, shame, subordination, and entrapment" and how they impact the women's lives, mental health and access to services (Gilbert et al., 2004, p. 110). The South Asian women who took part in this research described izzat "as a learnt, complex set of rules an Asian individual follows in order to protect the family honour and keep
his/her position in the community" (Gilbert et al., 2004, p. 111). The authors concluded that

shame–honour systems of one gender can impact on another. This is related to notions of control in that failure to control that which one is seen to own or be responsible for (one's children or wives) can result in stigma. Hence, shame and honour are not only socially defined but attention should be given to those who have the power to define them. (p. 111)

In patriarchal and collective cultures such as the South Asian culture, males typically have this power.

Honour, or izzat, is the value of a person in his or her own eyes and in the eyes of his or her society (Goddard, 1987). However, it is believed that as long as taboo or forbidden behaviours are hidden from public view they will not bring shame upon the individual or his or her family and can be tolerated (Weston, 2003). This encourages the masking of shameful behaviour with a public facade of acceptance (Wakil et al., 1981; Weston, 2003).

Honourable behaviour for men and women differs. A man is expected to take an active role in the defence of his family's honour. This gives men a duty to exercise control over other members of the family, particularly women (Goddard, 1987). Women, on the other hand, must preserve their purity, but are expected to take a passive role in relationships, which can also justify men seeing women as a burden (Goddard, 1987, Weston, 2003). Women's honour is an entity, a possession, and a resource, which is controlled and manipulated by men (Goddard, 1987; Weston, 2003). Therefore, women's sexuality, and the potential that they might engage in behaviours such as premarital sex, is seen as shameful and in need of tight control.

Thapan's work indicates that men's roles in South Asian societies can be negotiated and contested (2009). Examining women's voices from middle and upper class, marriage is seen as crucial to these women much as they seek to break away from normative expectations as respectable married women. Women, do "articulate and express their dissatisfaction with what they are expected to be" (p. xxi). The perspectives and
experiences of women in the slum point to the significance of work and marriage in the context of grinding poverty. Despite the fact that their experiences are situated "within a largely utilitarian perspective for the crucial role of childbearing, work and inevitable sexual relations, woman recognizes her ability to negotiate, strategise and intervene, as she wants to, and in the very recognition and articulation of both her position and her desires" (p. xxi).

2.3.3.2 Women's Emotional Attachment

In the South Asian family, in order to maintain or enhance the family's izzat, women must remain pure and marry into families with equal or higher status (Wakil et al., 1981; Weston, 2003). The main reasons for marriage in South Asian culture is to establish a family, have children, and enhance the family's economic and social status (Wakil et al., 1981; Weston, 2003). As a result, arranged marriages, which often take the form of contracts between families, are encouraged, while marriages founded on love are often frowned upon (Talbani & Hasanali, 2000; Wakil et al., 1981). Romantic love is regarded as destructive to the extended family since it usually involves intense emotions between two people rather than a beneficial arrangement between groups, that is, families (Hunjan & Towson, 2007; Wakil et al., 1981).

The arranged marriage is very often linked with the payment of a dowry and a bride-price which make separation or divorce very difficult. Control by the family group in the arrangement of the marriage implies similar control over its termination (Hussain, 2005). For immigrant South Asian women, the significance of izzat and the magnitude of upholding family honour as well as perceptions of individual dishonor and fear of loss of izzat were reasons why some of the women stayed in relationships where they felt they were trapped. Moreover, with the absence of support of their own families, many of these women became emotionally dependent on their husbands (Hussain, 2005). The South Asian immigrant women's strong emotional dependence on their husbands support hegemonic masculinity. In her review of studies about Canadian South Asian immigrant
women, Naidoo (2003) pointed out that a common area of intergenerational conflict comes about from the parents' desire for arranged marriages for their daughters rather than marriages based on romance (Naidoo, 2003). Thus an important source of cultural conflict for South Asians living in Canada is dating, sexuality, and choice of life partner. This is particularly the case between first generation immigrants and their Canadian-born offspring (Talbani & Hasanali, 2000; Wakil et al., 1981).

Samuel's (2010) study indicates that arranged marriage is still the norm for many immigrant women from India and the practice is encouraged even among second generation Indian women. Women who reject the practice often find themselves excluded from their community. Thus, social disapproval and even rejection is used to discourage romantic love in order to maintain family and kinship networks (Hunjan & Towson, 2007; Samuel, 2010). These practices are also reinforced by South Asians' strong beliefs about destiny or karma, including the idea that their mate as well as their fate is inevitable. Acceptance of fate or submission to the forces of the universe results in a woman's desiring to remain emotionally attached and faithful in a marital relationship (Hunjan & Towson, 2007; Wolpert, 1993).

2.4 Normative Influences in the lives of South Asian Immigrant Women

The following literature focusing on normative influences in the lives of South Asian women has to be situated within the broader Canadian society context. The role of factors such as immigration, racism and violence against women of colour have to be examined when looking at normative influences in the lives of South Asian women.

According to Yasmine Jiwani (2005), historically, Canada is known for being a peaceful country and for embracing the claimed multiculturalism and for its acceptance and tolerance of diverse people and moderate viewpoints. As such, Canada is often considered as a nation of peace-keepers. However, examining the role of the media post
9-11, she discovers a constructed view of Canada as a benevolent nation, one which embraces women's rights and democracy and one that knows better for those who are so 'unfortunate' to have been born elsewhere. As Sherene Razack (2004) states that this climate is reliant upon beliefs concerning race:

This national mythology has always depended on race. It is informed by the notion that 'we' know about democracy and 'they' do not; 'we' have values of integrity, honesty, and compassion that 'they' do not; that 'we' are a law-abiding, orderly, and modest people, while 'they' are not. (p.13)

Although South Asians are a diverse group of people of different geographic locations, languages, religious beliefs, and cultural practices, South Asian cultures share many characteristics. This should not come as a surprise given that, prior to independence from the British Empire in 1947, India, Bangladesh, and Pakistan were one nation known simply as India (Wolpert, 1993). After their division many of the cultural norms and beliefs remained consistent across the newly formed borders. Some of these common cultural characteristics include collectivism and a strong family orientation (Okazaki, 2002).

Collectivism (a conviction in shared dependence and the significance of preserving family and group unity) is one of the main cultural characteristics shared by many South Asians. This is in contrast to the individualism of Western society. South Asian collectivism is reflected in the notion of family honour in South Asian culture: the interests of the family, in this case in maintaining its honour, take precedence over the interests of individual family members (Kapoor, Comadena, & Blue, 1996; Weston, 2003).

Being part of a collectivist culture, South Asians value the family and have utmost respect for structured family roles and conformity to social norms (Agarwal, 1991; Ghuman, 2000; Jensen, 1988). Because family for South Asians takes precedence over the individual, the interests of the individual must be harmonized with those of the family (Agarwal, 1991; Ghuman, 2000; Jensen, 1988; Wakil et al., 1981). In their report, *South Asians in Canada: Unity Through Diversity*, Statistics Canada (2005) shows that family,
religion, customs, and values play important roles in the lives of South Asian immigrants. In 2002, most South Asians (69%) reported having a strong or very strong attachment to social networks and family and a large majority (88%) felt a strong or very strong attachment to Canada (Statistics Canada, 2005).

South Asians value family and aspire to get married to achieve the status gained thereby. According to Bélanger and Malenfant (2005), South Asian Canadians have a higher marital rate as compared to Canadians in the general population. In 2001, approximately 61% of people of South Asian descent who are over the age of 15 were married, in contrast with almost 50% of all Canadians 15 years and over. While the majority (60%) of the Canadian unions were women either living with a husband or in a common-law marriage, a lower percentage of Canadians of South Asian descent were living in a common-law marriage, with only 2% in contrast to 10% of all Canadian adults (Statistics Canada, 2005).

In addition, South Asians typically consider members of their extended family, such as grandparents, aunts, uncles, and cousins, to be part of their family. As such, since the welfare of the family is seen as paramount, individuals are expected to sacrifice their personal desires to ensure the well-being of their entire extended family (Almeida, 1996; Ibrahim, Ohnishi, & Sandhu, 1997; Segal, 1999). The emphasis on collectivism fosters familial interdependence throughout the individual’s life to the extent that children are encouraged to stay emotionally dependent on their parents well into adulthood (Almeida, 1996; Segal, 1999). As a result, parents and grandparents are influential in all aspects and throughout all the different stages of an individual’s life (Ibrahim et al., 1997; Segal, 1999).

A study that examined the negotiation of diaspora of 49 young (ages 16–18) South Asian immigrant Muslim women living in Britain points to a complex and fluid process of identity formation that is heavily influenced by traditional cultural norms and values (Dwyer, 2000). Women play the role of the keepers of cultural practices, a role that takes on greater significance in the diaspora. Many participants reported a gendered parental
expectation that as future mothers, they would replicate the cultural traditions of their family of origin. The study suggests that family and class are still significant factors in the determination of gender identities in the diaspora. Further, it suggests that social relations that result in gender disadvantaging may actually be strengthened by immigration rather than diminished, in which case new diasporic identifications may actually reinforce existing patriarchal relations (Dwyer, 2000).

In an article published in the journal Violence Against Women, Merali (2009) wrote about the experiences of South Asian brides who entered Canada following adjustments in regulation governing sponsorship for families. In the article she looked at the role that collectivism plays in the women's tolerance of abuse. According to Merali, factors such as collectivism and socialization centring around women's tolerance for affliction "posed barriers to women's attempts to actively respond to human rights violations, [depending] on their levels of acculturation into the host society, as well as the level of relative risk to themselves and their children" (p. 336).

As previously indicated, the aforementioned literature on normative influences has to be examined using an anti-racist lens so as not to essentialize culture. Using cultural norms such as collectivism to justify violence against women of colour and offering acculturation as a way to "rescue" these women from violence is problematic. In their paper Erased Realities: the Violence of Racism in the Lives of Immigrant and Refugee Girls of Colour, Jiwani and others (2001) argue that immigrant women of colour are marginalized in the realm of society. Moreover, their

retreat into their cultural communities exacts a price for [those] who experience violence. When the community becomes the only site for a sense of belonging and self-esteem, jeopardizing one's reputation incurs social costs which could amount to stigmatization and exclusion. In this sense, the plight of immigrant women who experience violence parallels that of rural women whose only choice in leaving a violent relationship becomes one of leaving their community. (p. 3)

This has resulted in a distinct 'othering' that occurs relegating non-White people in Canada to a lower status, one which separates 'us' from 'them'.
2.5 Conclusion

An understanding of context is necessary to an understanding of how gendered power relations are sustained. Context varies from one individual to the next and even over the life of an individual depending on their personal attributes and the way they interpret experiences. The context for this study is the HIV-positive South Asian immigrant woman, her experiences and her interactions within the family, school, and the workplace establishments.

"South Asian" was defined and the immigration experience of South Asians to Canada, South Asian women in particular, was discussed in order to lay the groundwork for the study's investigation into the experiences of the South Asian immigrant women infected with HIV who participated in the current study. Using Connell's social theory of gender (1987, 2009), the structures of gender relation in the lives of South Asian immigrant women were explored. Risk factors for HIV among South Asian women were examined by looking at the three major structures that characterize the gendered relationships between men and women: the sexual division of labour, sexual division of power, and cathexis. Using an anti-racist lens, cultural and normative influences in the lives of South Asian women were also examined.
Chapter 3
Methodology and Study Participants

In this chapter, I include a discussion of the methodology used in this research as well as brief profiles of the HIV-positive South Asian immigrant women who participated in the study. Adopting a qualitative methodology, and conducting in-depth interviews with the study participants enabled me to create meaningful constructions of what the women said they experienced and how they "made sense" of their life situations related to HIV.

The methodology used in this study is discussed in detail in this chapter. The following are discussed: (a) research approach; (b) qualitative methods; (c) site and sample selection; (d) data collection techniques; (e) managing and recording data; (f) data analysis strategies; (g) ethical considerations; (h) dissemination strategy; (i) study strengths, limitations, and suggestions for improvement; and (j) participant profiles.

3.1 Paradigmatic Approach

According to Creswell (2003), the following questions are essential for research design:

1. What are the assumptions brought by the researcher to the study?
2. Which approaches of inquiry will inform the study procedures? and
3. Which particular methods will be used for collecting data and analysis?

As a researcher I began my project with definite theoretical and ideological assumptions concerning how and what I would be learning during my investigation. These took the form of paradigms, philosophical assumptions, epistemological assumptions or ontological assumptions, and can be viewed as a set of basic beliefs or as a worldview (Creswell, 2003; Guba & Lincoln, 1994).

An interpretive paradigm (Creswell, 2003; Henderson, 1991), also referred to as the naturalistic paradigm by Guba and Lincoln (1994), was used to frame this study and
guide the research design. Following an interpretive paradigm in my work, I was able to make sense of social phenomena from the participants' perspective and see their behaviour as a product of how they perceive their world (Creswell, 2003; Henderson, 1991). The work is grounded in Connell's social theory of gender (1987, 2009), and I followed an inductive reasoning approach using an iterative process characterized by a cycling back and forth between data collection, analysis, and problem reformulation (Creswell, 2003; Henderson, 1991).

The ontology, the assumptions about the nature of reality, is consistent with that of the interpretive paradigm: "An interpretive approach recognizes that reality is constructed by the individuals who are involved in the research, and that multiple realities exist in any given situation" (Guba & Lincoln, 1994, p. 20). Epistemology in an interpretive approach implies that knowledge is created through the interaction of the researcher and participants. This was accomplished through the in-depth interviews I conducted with the participants.

Based on the recommendations of my thesis committee that I establish collaborative relationships with community-based organizations serving South Asians in the Greater Toronto Area (i.e., Toronto and surrounding regions and suburbs (GTA), I initiated contact with the Alliance for South Asian AIDS Prevention (ASAAP), a community-based organization serving HIV-positive South Asians in the GTA. Their programs offer culturally appropriate health promotion as well as support for South Asian people who are affected by and/or infected with HIV. The organization acknowledges the many social determinants affecting health and offers understanding and intervention to address these issues as well (ASAAP, 2011).

I followed the principles of community-based research (CBR) in my work by developing a collaborative relationship with ASAAP in the early stages of the study. My main aim was to follow a research approach that emphasized the significance of collaboration, participation, and social justice, where the focus was not only on individual South Asian women, but on the South Asian community as a whole. CBR is increasingly becoming
known for being a useful device for handling multifaceted ecological, health, and societal problems (Minkler, 2005; Minkler & Wallerstein, 2008). CBR "aims not merely to advance understanding, but also to ensure that knowledge [created] contributes to making a concrete difference in the world" (Flicker, Guta, & Travers, 2008, p. 1). Applying the principles of CBR in my work resulted in research that is more easily understood, receptive, and relevant. For instance, the involvement of People Living with HIV and AIDS (PHAs) in recruiting additional participants for the study helped in building capacity. Moreover, ASAAP's direct involvement in the study through recruitment, information dissemination, and direct support to the participants has facilitated capacity building for staff and volunteers involved in the study. I met several times with ASAAP's PHA Support Coordinator, which resulted in a strong working relationship with the organization.

Feminist research methods also informed the manner in which this study was conducted. They stress the importance of creating research atmospheres that foster an egalitarian relationship between the researcher and the participant (Hamberg & Johansson, 1999; Kirby & McKenna, 1989). Moreover, having a female researcher conduct interviews for research involving female participants on issues relating to health and/or sexuality is highly recommended in feminist research (Hamberg & Johansson, 1999). This avoids the potential that a gender-related power imbalance between the two parties will affect the data and allows more sensitive and accurate information to be collected (Papadopoulos & Lees, 2002). During the interviews, I was surprised by the ease with which the women talked to me. Even those who were initially reserved became comfortable as we moved into the interview. Many women said that they felt good talking to a woman because she would be more likely to understand their issues.

### 3.2 Qualitative Methods

This study was based on the narratives of HIV-positive South Asian immigrant women residing in the GTA. Qualitative methods were used as they are best suited to developing
an understanding of the personal experiences, feelings, perceptions, and values that underline and influence behaviour (Patton, 2002). Data collection through in-depth interviews was especially useful for gathering the personal narratives, experiences and histories of the study participants (Creswell, 2003; Marshall & Rossman, 1995). Due to the highly personal nature of the subject matter and the likelihood that many of the participants may have experienced some form of HIV-related stigma, the use of confidential, one-on-one interviews was especially appropriate. Interviews offer privacy and allow the participants to use their own words to describe their experiences (Guba & Lincoln, 1994; Rubin & Rubin, 1995). According to Punch (2000), interviews are "a good way of accessing people's perceptions, meanings, definitions of situations, and construction of reality. [They are] also the most powerful way we have of understanding of each other" (p. 175).

As well I used the context of the interview to establish equality, trust and rapport between myself and the participants to lessen the influence of my position as an academic researcher.

The qualitative approach has allowed me to explore the participants' own words and contexts to reveal their realities (Guba & Lincoln, 1994), and probe to reach beyond initial responses to questions (Creswell, 2003; Rubin & Rubin, 1995). The use of in-depth interviews with HIV-positive women who met set criteria provided me with rich data, and qualitative methods of analysis allowed me to thoroughly describe the women's perceptions and experiences related to HIV risk. Using a semi-structured interview schedule with open-ended questions, I encouraged the participants to tell me their stories unconstrained by the set of questions I asked.

3.2.1 Role of the Researcher

I acknowledge that my professional and personal background, including my perceptions and values, shaped my interactions with the women, how they perceived me as a
researcher, and my interpretation of their experiences. Sharing my academic background and expertise in the area of HIV/AIDS prevention with the women helped establish in them a sense of trust in my ability as a researcher. For four years, working as a graduate research assistant at the University of Alberta I conducted interviews with women and youth groups and did some work in the area of sexuality and HIV/AIDS prevention. Moreover, letting the women know that my thesis committee members have extensive knowledge in areas such as South Asian immigrant women, HIV/AIDS prevention, CBR in marginalized populations, ethnic minority communities, and diverse women's groups helped to establish my credibility as a junior researcher. The women felt more at ease sharing their stories with me knowing that I was under the supervision of this outstanding group of academics and researchers.

My ethnic identity and personal history also contributed to the women's comfort level and to building trust. As an immigrant woman myself, I shared some personal experiences, particularly around immigration and settlement, that are similar to those of the participants in this study. Just like the women in this study, I left my family of origin and came to Canada looking for greater opportunities and a better life. My husband and I first settled in Halifax, then moved to Edmonton, and finally came to Toronto in pursuit of education and employment. For the first few years, I held lower-paying jobs which included snow removal, parking attendant, restaurant server and paper delivery in order to pay tuition fees and make ends meet.

My background as an Arab of Lebanese and Palestinian descent shapes my identity and makes me who I am. Born and raised in Lebanon, a war-torn country, my childhood was filled with loss and turmoil. My parents who are Palestinian refugees, the largest refugee population in the world, had a similar childhood--one that is characterized by tragic loss, suffering, displacement and extensive human rights violation for the past six decades.

As a newcomer to Canada with no family support, I felt uprooted and experienced a sense of loss for several years. Being an immigrant, I felt marginalized and isolated for much of my education and life in Canada despite my academic achievements. Even after 20 years
in Canada, this sense of loss of identity has not gone away. I am still in pursuit of this never ending journey of finding who I am and where I belong. My experience in Canada has always been characterized by being "out of place"—much like the experiences of Edward Said in *Out of Place* (2000), a memoir portraying the birth of a noteworthy modern thinker.

It is important for me to highlight all the confusion of identity that I have experienced throughout my life in Canada as I came to terms with the dissonance of being a Canadian citizen, a Christian and a Lebanese of Palestinian descent, and, in due course, an outsider. My journey of finding my place and my unique history coupled with the absence of my narrative in Canadian society have shaped my sense of separateness that laid the grounds for my communal identity.

My journey, both personal and professional, had an impact on my relationship with the women and ultimately my role as a researcher. Some of the participants said that they felt more comfortable talking to me because of our shared experiences. Many participants believed that because I am an immigrant myself, even though I am not South Asian, I would be able to understand their point of view and they would not have to explain or defend themselves or their culture as they might to someone with whom they had less in common. Many also felt that because of my diverse life experiences, I would not judge or look down on them. One woman said that it is acceptable to her when an ethnic minority criticizes other minority groups, but when white people do so, she feels "bad" and "defensive."

Being a woman also helped me to get a positive response during the recruitment of the participants. Many participants stated that they would not be comfortable talking to men about intimate personal issues and relationships. For many South Asian women, sex is more important than ethnicity, in that they feel more comfortable talking to a woman who is not South Asian than to a South Asian man about intimate issues. These women would not, for example, invite men into their homes or talk to them for hours as they did when they invited me for the in-depth interviews required for this research.
3.3 Sampling Strategy

Qualitative samples are not always statistically representative or generalizable to the whole population. This does not imply that sampling in qualitative research ensues without any direction (Creswell, 2003; Henderson, 1991). For the purpose of this study, a non-probability, purposive sampling strategy was used. Originally, the study participants were to be limited to women who accessed the services of the ASAAP. However, since many HIV-positive South Asian women do not access AIDS Service Organizations (ASOs) due to the stigma of the disease, I resorted to snowballing techniques to recruit additional HIV-positive South Asian women. I also relied on referrals from an infectious disease specialist for additional participants.

3.3.1 Sample

The study sample consisted of 11 HIV-positive South Asian immigrant women to Canada and 1 second-generation South Asian woman ranging in age from 28–50 years, residing in the GTA.

All the women in my study self-identified as being of South Asian descent, and all except one were immigrants to Canada. All of the women could speak clear English so there was no need for translation, although one of the women did ask for her husband to be present during the interview because she did not feel her English was good enough for her to be interviewed on her own.

3.3.2 Sample Size

Unlike quantitative research, it is difficult in qualitative analysis to determine when an adequate sample size has been attained. I continued to recruit participants after the first interview had begun and until saturation had been reached. I terminated my sampling when I sensed that it was large enough to support my analysis and when no new information was forthcoming from the interviews. Theoretical saturation occurs when
further interviews do not offer any new themes or categories (Guba & Lincoln, 1994; Lincoln & Guba, 1985). Moreover, I had to determine how much detail I needed to have in my study, balance it with my own resources, and decide whether additional sampling would have been necessary (Creswell, 2003). The sample size was ultimately determined by how many HIV-positive women I could reach with information about the study, how many of the women who were interested met the criteria for the study, how many could be interviewed within an appropriate time frame, and the point at which theoretical saturation was reached. Since data collection, coding, and preliminary analysis were done iteratively, I was able to make a decision on whether the data collected were rich enough and covered enough of the dimensions of interest determined by my research objectives. A sample size of 12 women, 8 of whom were recruited through ASAAP, 1 through an infectious disease physician, and the remaining 3 through snowballing, was deemed appropriate.

3.3.3 Recruitment Process

Pernice (1994) highlighted the importance of using outreach techniques involving members of cultural communities to access isolated or vulnerable immigrant groups. A combination of outreach efforts and snowballing and the availability and flexibility of the researcher proved to be helpful. In spite of the difficulty of finding HIV-positive women willing to participate, I made a concerted effort to solicit participation from women of different socioeconomic groups and immigration trajectories to ensure that the ensuing sample would reflect the multiplicity among HIV-positive South Asian immigrant women in the GTA.

In the fall of 2007, I approached the ASAAP in the Toronto area about the study. After I met with the PHA Support Coordinator several times over a period of 7 months, ASAAP agreed to be involved. An advisory committee comprising ASAAP’s PHA Support Coordinator, Executive Director and the Women’s Outreach and Education Coordinator was formed. The advisory committee provided input into the recruitment process and offered to provide support to the HIV-positive South Asian women involved in the study.
if needed. ASAAP's Women's Health and Support Coordinator also had input into the study recommendations and a commitment was made by ASAAP to participate in disseminating information about study results to the South Asian community.

With the help of the PHA Support Coordinator at ASAAP, ASAAP's database was used to screen for women who met the study criteria. The PHA Support Coordinator made the initial approach to women who met the criteria, and all the women approached agreed to participate. I then made a follow-up phone call to each woman to schedule an interview at a mutually acceptable place and time. Concerned about confidentiality, most women were more comfortable conducting the interview in their own homes in the evening.

The snowball technique was also used for recruiting participants. During the interviews I received referrals to other women who might be interested in participating in the study. In these cases the initial call was made by the participant, then if the woman consented, I contacted her by telephone and introduced the research and myself. If she agreed to participate, I schedule an interview with her. Three of the participants were recruited using the snowball technique. These three women did not have any previous involvement with ASAAP, but had used other ASOs in the GTA.

Another source of participants was an infectious disease physician in the GTA. Two of her patients who met the criteria agreed to participate. However, I was successful in interviewing only one of the women. This woman has not used the services of any ASOs in the GTA; her physician was her only source of support. After many phone calls and much negotiation with the other woman, she finally told me that there could be no interview as her husband would not allow it.

Perhaps due to the stigma associated with HIV and psychosocial struggles of South Asian immigrant women in Toronto, scheduling a time to interview the participants was a challenge. For many of the participants multiple phone calls were required before a mutually agreeable time and place to do the interview could be established. Some of the women were struggling with employment issues and had multiple jobs or long working
hours. Others had the added responsibilities of housework and care giving which made it extra hard for them to be available. Overall, the women were busy and had little time to spare. In addition, four of the participants were ill with HIV-related conditions, which led to cancellation and re-booking of interviews. Because of the scheduling difficulties these factors gave rise to, data collection took a full year, from March 2007–March 2008.

3.4 Data Collection

Data collection took place through one-on-one, face-to-face interviews with each study participant. To achieve a positive research environment during the interviews, I treated each participant with respect and showed genuine interest as the participants' recounted experiences. Then I worked diligently with the participants to integrate the information gathered into findings that were useful, realistic, and accurate.

Face-to-face interviews, an effective means of eliciting detail-rich, contextual data that is helpful in gaining an understanding about the complexities of the participants' social realities, require good listening skills (Henderson, 1991; Kirby & McKenna, 1989). Mason (1996) describes good listening in the context of in-depth interview: "Listening—really listening to what people are saying. Observing, picking up verbal and non-verbal cues about the social situation, and the mood of the interviewee(s), recognize when people are bored, tired, angry, upset or embarrassed" (p. 46).

A semi-structured interview schedule was developed based on the objectives of the research and using Connell's social theory (1987, 2009) of gender as a lens. Basic sociodemographic questions, such as date of birth, country of origin, year of immigration, date of diagnosis, and languages spoken, were asked at the beginning of the interview (see Appendix A). The interview guide was used to facilitate the flow of the interviews, which took a conversational format (see Appendix B). Using a semi-structured interview guide with open-ended questions and probes allowed for additional inquiry into participants' responses and outlined specific areas and topics to be explored during the
interviews. Using the guide provided a certain degree of consistency among all interviews.

Probing of specific responses (e.g., Can you tell me more about that? Can you tell me about another time that happened to you?) was done to elicit additional information and questions from the interview schedule were reworded or reordered when the flow of the conversation called for this. This flexibility allowed me to elicit rich, detailed accounts from the participants.

Data analysis was started as soon as the first interviews commenced, which created an iterative process for the interpretation of the study data. When results of analysis suggested that a modification of the questions was needed this was done (Strauss, 1987). Interviews were tape-recorded and I made notes as the respondents spoke.

I also wrote a summary after each interview that included descriptions of body language, my first impressions of the interview itself, the main concepts and issues discussed, and any pertinent contextual features of the interview. The summary also served as a form of preliminary analysis and included reflections on issues and concepts that emerged from the individual interviews. The summary, which was no more than one page in length, was usually written on the same day the interview took place and was also used to inform future interviews. For example, in some instances, the order of questions was changed to improve the interview format, and in other instances probes were fine tuned to ensure the topics of interest were covered.

3.4.1 Building Rapport

My thesis advisor and committee members guided me throughout the different stages of the study. The involvement of the Advisory Committee at ASAAP, particularly the PHA Support Coordinator, helped me to establish a relationship based on trust with the study participants. The process of building rapport began when I talked with each participant on the telephone for the first time. During the interviews I felt that I was able to increase
rapport with the women right from the beginning, which led to the women responding comfortably, accurately, and honestly. At the beginning of each interview I spent five to ten minutes chatting with each participant to help her feel more comfortable. Next, I provided an explanation of the study and a brief history of my involvement in the area of HIV/AIDS prevention, and a little about myself. Having this information reassured the women and increased our rapport.

As I became more proficient at interviewing, I learned to follow the woman's lead, and to pay closer attention to what she was saying. To me, the process felt very organic; the order of the questions became less important as I became more comfortable. As the women became more comfortable, they offered more information. They also seemed interested in my work and asked many questions about it and about me. From the questions they asked, I realized that the women wanted to know more about me as a person than about the study itself. I was, for example, asked where I was from originally, how long I had been in Canada, and where my family was. My status as an immigrant woman also helped in creating rapport with participants.

During the interviews, the women were encouraged to provide feedback on the questions asked and to give recommendations for future HIV education and prevention initiatives. In general, the women felt at ease answering my questions and the laid-back conversational nature of the interview allowed them to share their life experiences freely.

3.4.2 Study Participation and Location

Two of the interviews took place at ASAAP, another in my car in a plaza parking lot, while the remaining nine interviews took place in the comfort of the participants' homes. Interviews typically lasted between 1 1/2 and 2 hours. One interview took close to 3 hours, but some of that time was spent socializing with the woman while she prepared lunch for her family. All interviews were audio tape-recorded and later transcribed verbatim by myself. Before the interview began, participants were reminded that they
could refrain from answering any questions and that participation was voluntary. They were also informed of their right to pull out from the study at anytime without any consequences. Participants received a one-time $25 honorarium for participating in the study to compensate them for their time. During the interview a request for future contact was made in case additional clarification or information was needed during or after data analysis. All of the participants agreed. All the women were interviewed once; none of the participants were contacted following the interviews and no follow-up interviews were conducted for this study.

3.4.3 Informed Consent

Before the interview, I asked the participants to review and sign the study consent form (see Appendix C). The consent form outlined the issues of confidentiality, anonymity, recruitment, eligibility, and briefly described the data analysis procedures. Potential risks and benefits associated with participation in the study were also presented, including the honorarium that would be paid to each participant. The form also described the steps to be taken to preserve the anonymity of the participants.

Participants were encouraged to take their time reviewing the consent forms, and I went over every section of the consent form with each participant to ensure that she understood the study objectives, her role, and the safeguards in place. Any questions or concerns the participant had were also addressed at that time. The only concern the women in this study expressed was around anonymity. They wanted to be assured that no one would be able to identify them as a participant in this study. I reiterated that no one would have access to the tapes but myself, that pseudonyms would be used in all transcripts and reports, and identifying information would not be included in this thesis.
3.5 Analysis

3.5.1 Managing and Recording Data

All interviews with the study participants were conducted and audio tape-recorded by me. The tapes were transcribed by me, and transcripts had all identifying information removed. The transcripts were kept in a locked filing cabinet in my home office. All audio tapes were destroyed after data analysis was complete.

3.5.2 General Inductive Approach

The general inductive approach is a technique used to analyze qualitative data where the analysis is directed by both explicit research objectives and the data (Creswell, 2003). As previously indicated, I followed an iterative process the primary purpose of which was to allow research findings to materialize from the frequent, prevailing, or central themes built in the raw data (Thomas, 2003). The use of an inductive approach was intended to aid in understanding data through the formulation of summary themes and categories from the raw data.

Analysis involved continual reflection on the data, asking analytical questions, and writing memos throughout data collection and beyond (Creswell, 2003; Miles & Huberman, 1994). Preliminary analysis started when data collection did and continued throughout the interview process. Included in the data were the summaries I wrote following each interview in which I recorded notes on salient or interesting points that arose from the interview and points to consider for future interviews, such as changing the order of the questions. After each interview was completed and transcribed, I listened to the tapes and checked the transcripts for accuracy.
All interview transcripts were subjected to preliminary thematic analysis. Thematic analysis is the clustering or coding of research findings into groups of closely related themes so as to provide a more manageable view of the data (Strauss, 1987). The QSR*Nudist 4 computer software package was used to assist in the coding of the data (Qualitative Solutions and Research, 1997). An external peer researcher, recommended by one of my thesis committee members, examined the transcripts and compared her own perceptions of the emerging themes with mine. She then looked at my code book and selected sections of coded text. This check was done as an objective second review of the transcripts and their emergent codes and themes.

3.6 Ethical Considerations

This project was approved by the University of Toronto's Ethics Review Committee, and as such was deemed to have met their ethical standards (see Appendix D for University of Toronto ethics approval).

3.6.1 Potential Risks to the Study Participants

The potential risks for the participants in the study were minimized through the consent and confidentiality procedures. Every effort was made to protect the anonymity of the participants in the study as has already been described.

Due to the participants' involvement with ASAAP and/or other ASO or a health care provider, all women had access to health care services, social services, and social supports. In the event that a woman experienced emotional distress, or possibly some sadness during her interview, she was responded to with empathy, and asked if she would like to stop. Every effort was made to ensure that the interview process was comfortable and non-threatening. If a woman had required additional support because of some aspect of their interview, a referral to ASAAP's PHA Support Coordinator or other support would have been made. However, none of the participants needed the extra support.
3.6.2 Potential Benefits to the Participants

One of the benefits of participation in this study was having the opportunity it provided to express thoughts and feelings about the experiences of being HIV-positive and of South Asian descent. Also, all the participants were offered the opportunity to get a summary of the results of the study. ASAAP benefited from access to the results of the study in that these allowed them to better focus on issues specific to women with HIV. Moreover, I hope that with the new information made available by the study, all women with HIV in the community will benefit because gaps in services might be identified, which could provide grounds for more funding being dedicated to supporting women with HIV/AIDS.

3.7 Dissemination Strategy

Dissemination is critical for the success of this study. Since the intention of the study was to create a document that promotes action for improving care and support for women living with HIV in Ontario, it is important to ensure that stakeholders learn of the study and its findings. A second reason for a strong dissemination plan is to ensure that the women involved in the study see that their contribution created practical knowledge for change. CBR methods stress the importance of ensuring that research results are shared with affected populations and not restricted to academia (Leininger, 1992).

The main objective behind CBR is to share information with the boarder community, and, in this case, to build bridges by providing information from the study to the Ontario Women's Health Strategy. My thesis committee members, ASAAP, and myself will be involved in information dissemination in the form of presentations at conferences, small group presentations, community forums, posters, reports, and publications in peer-reviewed journals. The new data resulting from this study will be helpful for Ontario's HIV prevention strategy, South Asian women, women with HIV, and the field of women's sexual health in general.
3.8 Study Strengths: Quality

My involvement at every stage of the research, the planning, conducting the interviews, transcribing, and analyzing the data, helped me to understand the data more intimately and to know the strengths and weaknesses of the data collection process. Because I conducted the interviews myself I was able to observe both the verbal and the non-verbal behaviour of the participants, and use that information in the analysis of the data. The semi-structured interview schedule with open-ended questions allowed me to be flexible and to explore unanticipated issues as they arose. This flexibility might not have been possible had more structured questioning methods been used.

Interpretive research and qualitative methods must meet the tenets of methodological rigour. Trustworthiness in qualitative research is gained through credibility, dependability, confirmability, and transferability (Guba, 1981; Henderson, 1991; Patton, 2002). In qualitative research, credibility can be described as equivalent to internal validity in quantitative research. Dependability is comparable to reliability, confirmability is parallel to objectivity, and transferability is similar to external validity (Henderson, 1991). These four concepts are dealt with individually to demonstrate how this study ensured trustworthiness.

3.8.1 Credibility

Credibility refers to how truthful the study findings are and how accurately the researcher represents the participants' reality in the findings (Guba, 1981; Henderson, 1991; Patton, 2002). Credibility is enhanced by using member checks and peer debriefing, both of which help to establish a link between participants' constructed realities and those presented in the study findings (Guba, 1981; Maggs-Rapport, 2001).

Member checks involve going back to the participants to give them an opportunity to comment on the accuracy of the researcher's observations, interpretations, and conclusions. As mentioned above, each transcript was checked for accuracy against the
audiotapes by an external peer researcher and myself and some preliminary analysis was
done on the transcripts. Next, I consulted my thesis advisor, who, as a South Asian
immigrant woman herself, was able to give me valuable feedback on the emerging
themes in the study. I worked closely with my thesis advisor to polish my themes and her
role was instrumental in shaping the final analysis presented in this thesis.

Having faced many challenges in finding mutually agreeable time to interview the
participants, it was hard for me to get back to the women to discuss study results.
Moreover, members of the advisory committee have since moved on in pursuit of other
career options, so I met with the ASAAP's Women's Health and Support Coordinator
instead and gave her a draft copy of my thesis. She reviewed the study findings to see if
the evidence supported my conclusions. She also asked questions about the study to make
sure the needs of the women PHAs were met. Comments from the Coordinator were
incorporated into my recommendations chapter.

3.8.2 Dependability and Confirmability

Dependability and confirmability are contingent on the fit between what the researcher
records as data and what actually occurs in the setting (Creswell, 2003; Maggs-Rapport,
2001), and whether the data can be traced to the original sources (Guba & Lincoln, 1994).
It can be argued that in a well-designed and well-documented qualitative study, the data
will be reliable. But it can also be argued that replicating the study is impossible, since
the world is constantly changing, thus the study cannot be confirmed (Creswell, 2003;
Henderson, 1991). As a researcher, I was able to ensure the dependability of my results
by having a flexible but well-documented research plan (Henderson, 1991; Maggs-
Rapport, 2001). I documented the logic and process of the making of decisions to make
changes in the research design, methods, and analysis. This created an "audit trail" of the
research process, which included information about the challenges that were faced in the
course of the study.
Confirmability also refers to the objectivity of the findings. That is, it refers to how far the findings are reflective of the participants of the study and not a product of the researcher's biases and prejudices. The creation of an audit trail was one step taken to ensure confirmability. The audit trail took the form of a journal in which the coding techniques used to link findings to participants' actual words were described (Henderson, 1991; Maggs-Rapport, 2001). Another step taken was to enlist a peer researcher, described in the section "General Inductive Approach," to examine and code some part of the transcripts and then compare her results with mine.

### 3.8.3 Transferability

Transferability refers to whether or not the participants studied are representative of the population from which they come (Creswell, 2003; Guba & Lincoln, 1994). It also refers to how applicable or generalizable the research findings are to another setting or group. This is particularly important in this study given the goal that its results will be applicable to the development of programs for South Asian immigrant women with HIV, for members of other minority groups, and for support of women with HIV in general as well as HIV prevention programs.

In order to ensure the transferability of the results, I first did a thorough investigation of related literature and the particular setting of this research. I then took detailed notes about each participant's interview, the arrangement process, the physical setting, personal impressions of the participant, and comprehensive sociodemographic information to give the reader a clear picture of the psychosocial context of each interview. This allowed me to provide a rich, thick description of the research findings, sample, and analysis, which Guba and Lincoln (1994) suggest is the best technique for ensuring transferability. Using this contextual description, future researchers of HIV/AIDS service providers can determine the transferability of these findings to other HIV-positive women.

However, this study makes no claims to be transferable to South Asian women living with HIV in other contexts. The study was, by design, Greater Toronto Area specific. But
it is hoped that the findings may be useful to others, and to this end, detailed description of the research methods and sample were provided.

3.9 Challenges and Suggestions for Improvement

3.9.1 Sampling Strategy

One of the disadvantages of using a non-probability sampling strategy is that it is not random (Creswell, 2003). In the early stages of my study, I interviewed two South Asian immigrant women chosen at random at the South Asian Women's Centre in Toronto. Upon careful analysis of the data gathered from those interviews and given the research objectives of my study, I determined that the non-purposive sample from the South Asian population did not yield any useful information for my study. As a result, my thesis committee recommended that it was best to select a purposive sample composed of HIV-positive South Asian immigrant women. The recommendation that I recruit a purposive sample was a sound one, but it presented challenges in terms of access and recruitment. Even though the choice of a purposive sample created challenges, it was worthwhile since it led to the development of findings that make a significant contribution to the existing literature.

3.9.2 Sample and Recruitment

Because HIV is a highly stigmatized condition, I expected that immigrant HIV-positive South Asian women would be hesitant to come forward to be interviewed about their HIV-related experiences. This, indeed, did prove to make recruitment difficult. By coming forward to be interviewed a woman was disclosing her HIV-positive status and consequently sacrificing her anonymity. In order to overcome the challenges associated with recruiting HIV-positive women in the GTA, my thesis committee members helped in brainstorming the most effective and sensitive approaches to take in the recruitment phase of this study.
Despite my efforts at recruitment, the sample size was still limited (total of 8 women from ASAAP, 3 from snowballing, and 1 referral from a medical practitioner), since not many HIV-positive South Asian women sought help from ASOs—typical of a larger help-seeking pattern among South Asians in Toronto.

Despite the challenges that I faced in locating participants in the study I felt satisfied that I did manage to achieve saturation during data collection and I was happy with the degree of diversity among the women in my sample.

Another challenge was that two-thirds of the women interviewed were recruited through ASAAP, that is they were women who had already acknowledged their HIV status by reaching out for help. Women who had not taken this step might have had different stories to tell. An attempt was made to recruit women who did not use the services of ASAAP through snowballing and through an infectious disease physician. But, with the exception of the participant who was referred to me by an infectious disease physician, the other women I interviewed, who were recruited using the snowball technique, were connected with the participants who accessed ASAAP; these women had access to a plethora of community services and had already established support networks with other HIV-positive women and, thus, were not necessarily isolated or hard to reach.

### 3.9.3 Quality and Rigour

To prepare myself to conduct the interviews for the study, I conducted several mock interviews with peers and I conducted and tape-recorded two pilot interviews with immigrant South Asian women at the South Asian Women’s Centre in Toronto. This experience gave me an opportunity to become aware of my own communication style and make improvements as needed. The mock interviews as well as the pilot interviews also revealed some areas in need of improvement in the interview guide, which led to fine tuning of certain questions and the inclusion of additional probes.
In spite of the preparations I made before beginning the study, I still found that I became better at interviewing over the course of the study itself. As a result of this experience I would recommend that researchers who are planning to conduct in-depth interviews go through intensive qualitative interview training in addition to the course work in their doctoral program.

As the interviews progressed, I became more comfortable with the interview process and, for example, learned to wait out or tolerate silences of the participant. This gave the women more opportunities to expand on topics that they deemed important.

3.10 The Participants

As seen in Table 3, the diversity within the South Asian women's community in Toronto is reflected in the sample. In the sample were South Asians from India, some parts of Africa, the Caribbean, and South East Asia. All the participants in the study were South Asian immigrants, with the exception of Juhi who was a second generation South Asian.
Table 3
Diversity in Study Sample

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
<td>Hindu - 6</td>
</tr>
<tr>
<td></td>
<td>Muslim - 3</td>
</tr>
<tr>
<td></td>
<td>Sikh - 1</td>
</tr>
<tr>
<td></td>
<td>Mixed Christian/Hindu - 1</td>
</tr>
<tr>
<td></td>
<td>Mixed Muslim/Christian - 1</td>
</tr>
<tr>
<td>Country of Birth</td>
<td>India - 4</td>
</tr>
<tr>
<td></td>
<td>Tanzania - 3</td>
</tr>
<tr>
<td></td>
<td>Canada (Indian background) - 1</td>
</tr>
<tr>
<td></td>
<td>Kenya - 1</td>
</tr>
<tr>
<td></td>
<td>Zimbabwe - 1</td>
</tr>
<tr>
<td></td>
<td>Trinidad - 1</td>
</tr>
<tr>
<td></td>
<td>Malaysia - 1</td>
</tr>
<tr>
<td>Length of Stay in Canada</td>
<td>0-5 years - 1</td>
</tr>
<tr>
<td></td>
<td>6-10 years - 4</td>
</tr>
<tr>
<td></td>
<td>11-15 years - 1</td>
</tr>
<tr>
<td></td>
<td>16-20 years - 3</td>
</tr>
<tr>
<td></td>
<td>More than 20 years - 2</td>
</tr>
<tr>
<td>Age</td>
<td>20s - 2</td>
</tr>
<tr>
<td></td>
<td>30s - 4</td>
</tr>
<tr>
<td></td>
<td>40s - 5</td>
</tr>
<tr>
<td></td>
<td>50s - 1</td>
</tr>
<tr>
<td>Languages Spoken Aside from English (most participants spoke more than one language aside from English)</td>
<td>Gujarati - 7</td>
</tr>
<tr>
<td></td>
<td>Hindi - 6</td>
</tr>
<tr>
<td></td>
<td>Marathi - 2</td>
</tr>
<tr>
<td></td>
<td>Punjabi - 2</td>
</tr>
<tr>
<td></td>
<td>Swahili - 2</td>
</tr>
<tr>
<td></td>
<td>Tamil - 1</td>
</tr>
<tr>
<td></td>
<td>Malay - 1</td>
</tr>
<tr>
<td></td>
<td>Shona - 1</td>
</tr>
<tr>
<td></td>
<td>Njamda - 1</td>
</tr>
<tr>
<td></td>
<td>Kachi - 1</td>
</tr>
<tr>
<td></td>
<td>Baluchi - 1</td>
</tr>
</tbody>
</table>
### Table 3 Cont'd

*Diversity in Study Sample*

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Level of Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High School – 6</td>
</tr>
<tr>
<td></td>
<td>Community College - 4</td>
</tr>
<tr>
<td></td>
<td>University - 2</td>
</tr>
<tr>
<td>Number of Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>None – 3</td>
</tr>
<tr>
<td></td>
<td>1 Child - 4</td>
</tr>
<tr>
<td></td>
<td>2 Children - 3</td>
</tr>
<tr>
<td></td>
<td>3 Children - 2</td>
</tr>
<tr>
<td>Perceived Mode of Infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Husband/Partner – 8</td>
</tr>
<tr>
<td></td>
<td>Blood Transfusion - 2</td>
</tr>
<tr>
<td></td>
<td>Unknown - 2</td>
</tr>
<tr>
<td>Number of Years since Diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0-5 years - 4</td>
</tr>
<tr>
<td></td>
<td>6-10 years - 4</td>
</tr>
<tr>
<td></td>
<td>11-15 years - 2</td>
</tr>
<tr>
<td></td>
<td>16-20 years - 2</td>
</tr>
<tr>
<td>Marital Status at Time of Infection</td>
<td>Married: 10</td>
</tr>
<tr>
<td></td>
<td>Divorced: 2</td>
</tr>
<tr>
<td>Marital Status at Time of Interview</td>
<td>Divorced – 5</td>
</tr>
<tr>
<td></td>
<td>Married - 4</td>
</tr>
<tr>
<td></td>
<td>Remarried - 2</td>
</tr>
<tr>
<td></td>
<td>Widowed - 1</td>
</tr>
</tbody>
</table>
The participants spoke many languages, such as Gujarati, Hindi, Tamil, Punjabi, and Marathi, along with other local African or Caribbean dialects, and each spoke at least two languages, including English. They also represented a wide variety of religions: Islam, Hinduism, Sikhism, and Christianity. The participants ranged in age between 28 and 50, with an average age of 42 at the time of the interview. Six women had some community college or university education, and six had only attained a high school diploma.

The length of time the women had been in Canada ranged from 3 years to over 30 years. Given that foreign education and training are commonly unrecognized in Canada, it is not surprising that most participants worked in low-paying, unskilled jobs upon arrival, such as the restaurant business, factory work, retail, textile, house cleaning or self-employment in their own family business. Because the women were South Asian they were also subject to the well-documented discrimination against women who are immigrants and non-white in the labour force.

All participants were married by age 24 with the exception of one who was married in her early thirties. Four were married in their teen years. In terms of length of time since HIV diagnosis, there was a wide range reported: four women were diagnosed less than 5 years ago and two were diagnosed for over 15 years ago. There was a strong desire among the women to have children with some who were suspecting infidelity in their marital relationship taking risk in unprotected sexual relationships in order to conceive and strengthen trust in relationships. Nine of the women had children, and one participant had to deal with the added burden of an HIV-positive child.

Eight participants were infected with HIV by their husbands or sexual partners, two by unknown sources and two by transfusions. After being infected with HIV, only five of the women remained with their original marriage partners, including one who lost her husband to an AIDS-related illness. The husbands of the remaining seven women left them after they were diagnosed with the virus. This amounts to a 67% divorce rate, which is extremely high when compared to the rate among the Canadian population at large.
This can be attributed mainly to HIV-related stigma and discrimination, and is reflective of a power imbalance in the relationships. Although in most cases the husband was also infected with HIV, and likely infected the wife, it was the husbands who left the wives rather than the other way around. Two of the women remarried; one married an HIV-negative man and the other an HIV-positive man. Also, post-HIV infection, most women suffered economically as a result of losing employment due to illness. Seven were living on social assistance benefits or savings.

3.11 Participant Profiles

Deepa
My first interview was conducted with Deepa at the ASAAP office in downtown Toronto. She appeared to be confident and relaxed during the interview. There was a feeling of being quite "at home," probably because Deepa was a member of ASAAP and an active volunteer. The interview took place in a private room at ASAAP during which I sat at a table and Deepa in a chair facing me.

Deepa was a woman in her 30s who was born and brought up in India. She speaks Hindi and Gujarati as well as English and is an observant Hindu. Deepa described her family of origin as typical and loving. She stated that both of her parents worked and her entire family had graduated from high school. When Deepa was 6 years old, she moved with her family to the Caribbean where she continued her elementary schooling.

While living in the Caribbean she met the man who would be her husband. Her marriage was not arranged, but the families knew each other and approved of their union. When Deepa was 16 years old, she travelled to Canada and got married to the man she met in the Caribbean. He had gone on before her to prepare her paperwork and make sure her transition to Canada was a smooth one. She continued her schooling in Canada and held various low-paid jobs such as cashier and restaurant server. After being in Canada for 1 year, Deepa gave birth to her daughter at the age of 17.
Over time, Deepa returned to school and graduated from an accounting program at a community college. While she was attending school and working, her husband engaged in sex outside the marriage and became HIV-positive. Deepa believes that she became infected with HIV by her husband as they never used condoms in their relationship.

When Deepa confronted her husband about the possibility that he was HIV-positive, he refused to be tested himself and subsequently sought a divorce from her. In hindsight, Deepa speaks about her own responsibility for her husband's infidelity because she was away from home a lot going to school and working full time. She also mentioned that even if she had confirmed that her husband was HIV positive, she would not have been able to insist he use a condom as in her culture women do not tell men what to do.

Becoming a single parent to her daughter coupled with her ill health resulted in Deepa obtaining government disability assistance to support her family.

At present, Deepa is divorced and concerned about whether she will ever become involved with another man, primarily due to her being HIV-positive but also due to her fear of male infidelity.

**Sutra**
I waited for Sutra in the lobby of her apartment building until she arrived home from a community meeting at ASAAP. For religious reasons, Sutra wore a head cover which she took off when we entered her apartment. The interview was conducted in her living room as her small child played on the floor. The apartment was small, but clean and tidy, and there were many religious symbols on the walls as well as portraits of family members.

Sutra was a woman in her 30s born in a country in Africa who describes herself as of South Asian descent. She speaks English and Gujarati and is learning Arabic. She described her cultural background as mixed. Her mother's father was from India, and her mother's mother was Arab. She described her father as Arab and African. In terms of
traditions, she cooks all kinds of food, including Indian food. In addition, she recalls watching Indian movies on holidays and keeping South Asian traditions at some family marriage celebrations as a child. In her family of origin, her father provided financially for the family and her mother stayed home. Sutra reported that she was thankful that she was raised in a very religious Muslim household as her staunch beliefs have proven to be an invaluable source of strength. Sutra attended college and obtained an accounting diploma. She was employed in business for a couple of years in Africa before immigrating to Canada as a refugee with her husband and two children.

Sutra met her future husband in high school and, with parental approval, they married shortly after her graduation from college. They had two children in Africa before emigrating. They arrived in Canada by way of the United States in the middle of a snow storm. Sutra was overwhelmed by the weather, their isolation, and the lack of employment opportunities, which made this a very stressful time for her and her family.

She described her husband at the time as controlling and reported that he had been physically abusive on one occasion. In spite of this, she appreciated that he encouraged her to attend school in Canada in order to increase her employment opportunities.

Prior to the birth of her third child, after she had come to Canada she began to experience gynecological problems. Her doctor suggested an HIV test and it came back positive. Sutra was shocked and confused. She didn't know how she could have contracted the virus and was grateful for her religious faith as she said this was the only thing that kept her from killing herself. Her husband was extremely angry upon hearing of her HIV status and decided to return to their country of origin with their two older children immediately. The youngest son remained in Canada with her. She does not know her husband's HIV status, nor does she know how she contracted the virus herself.

Eventually Sutra met a man who is also HIV-positive. They are happily married and raising her son together.
Shreya

Shreya's interview took place at her comfortable house in the GTA. The atmosphere of her home was serene. There was a running water fountain and incense burning on a Hindu alter at the front entrance. The interview was conducted quietly in the living room as her teenage son, who was unaware of her HIV status, slept upstairs.

Shreya is a Hindu woman in her 30s, born in a country in Africa, who described herself as South Asian. Her extended family, including her parents, came from India. She grew up in a small city and was born into a big family in which she felt loved. Both her parents died from illnesses when she was a child in Africa. Shreya comes from a wealthy family that owns several businesses in Africa. She completed high school at 17 years old, and then worked in her family's businesses until she was married at age 18. Her marriage was both a "love marriage and an arranged marriage." After she became pregnant, her husband immigrated to Canada and with plans for her to follow him the next year.

The year she was separated from her new husband was a difficult one as she had a baby daughter and was living with her in-laws. Her baby became ill and died of pneumonia at six months old. Following this, she was involved in a serious car accident and required a blood transfusion. This is how she believes she became HIV-positive. After recovering from her accident, she travelled to Canada to join her husband who was employed and had a home here. She worked in retail when she arrived until she became pregnant with her second child. After 9 months of pregnancy, her doctors became concerned because she was overdue so they ran a battery of tests, including an HIV test. The test came back positive. Her husband was then tested and found to be positive as well. Her son is HIV-negative in spite of her having had a vaginal birth.

Shreya spoke about having HIV as part of her fate so she accepts it as part of her life. She said that she just thinks of it as having a virus. She has been ill periodically and is currently on HIV medication. Her son was an adolescent at the time of the study, but was still unaware that his parents are HIV-positive.
Shreya believes her husband is faithful, though she claimed that many South Asian men do have sexual contact outside their marriages. Currently her husband earns the household income and she does volunteer work with ASOs. Although Shreya does most of the cleaning, her husband and son share the cooking and other household duties with her. She stated that this arrangement is not typical of South Asian marriages because many believe the woman does all household work. Shreya also asserted that she and her husband make decisions about large purchases, such as furniture, together.

Shreya's religion is an important part of her life, which she observes with daily prayers and rituals and regular attendance at temple. Shreya has many social contacts through the temple, but also claimed to have friendships with people from a wide variety of backgrounds. In spite of this, she said most of her close friends are family and others who are South Asian from Africa.

**Haifa**

Haifa's interview was difficult to schedule. It took many phone calls and was arranged and cancelled many times as she was moving at the time. After travelling almost two hours, I met Haifa and her little girl in the parking lot of a plaza. A friend of hers looked after her daughter while the interview was conducted in my vehicle. Haifa was verbally expressive and emotional throughout the interview, not only about her diagnosis, but also about the multiple social stressors she was dealing with, such as poverty, health, immigration, and housing.

Haifa is a woman in her 30s who was born in Africa. Her mother tongue is Gujarati, and she also speaks two African dialects, Shona and Njamda, as well as English. Haifa has three siblings: two brothers and one sister. They were raised on a farm on which her father worked, while her mother worked in the home. Haifa's parents were mixed racially and religiously; her father was a white Christian and her mother was a South Asian Hindu. Haifa completed high school and began to study accounting in college, but did not complete her degree due to upheaval in her home country. She worked part time in her home country doing accounting work before coming to Canada.
Haifa's father was killed for political reasons in her country of origin, which prompted her hasty exit from the country to come to Canada. She thought the president at the time was against white or Indian landowners and many farms were burned.

Haifa immigrated to Canada at 21 years of age. She was assisted by several women who helped her obtain the proper papers in her country of origin, accompanied her here, and helped her get connected with suitable support social services through a church. She was also accompanied by several other young women also fleeing the country at the same time. Arriving in Canada, she did not know the whereabouts of her family. Eventually she discovered that her mother was still alive, one brother had fled to a neighbouring African country, and her other two siblings remained in her country of origin. Shortly after her arrival in Canada, she secured an apartment and a job in a factory working midnight shifts. Haifa stated that the decision to come to Canada was very difficult because she had to leave her family and did not know anyone here. Further she has felt unwelcome in Toronto and has encountered people who don't believe her account of the circumstances that precipitated her leaving her country of origin.

Haifa reported that her family upbringing and culture dictated that she accept an arranged marriage. In spite of this, she engaged in a clandestine 4-year sexual relationship with a boy in her country of origin. She described this union as a love relationship. The boy's father was, in fact, instrumental in helping her leave the country, which marked the end of the relationship.

Haifa met and married her husband in Canada a year after she arrived. They had met through workmates of hers. After dating for six months, they were married, partly due to the denial of her refugee claim and his willingness to sponsor her application for permanent status in Canada.

Prompted by her immigration lawyer, Haifa obtained an HIV test and discovered she was HIV-positive. Haifa had only had sex with two men during her lifetime: her boyfriend
and her Canadian husband. She believes her husband is the one who infected her. One reason for this belief is that she had an HIV test when she first arrived and it was negative. After she told her husband that she was HIV-positive, he ended their relationship. She arrived home from work one day and found that her husband had left her and taken all of their possessions. Haifa said she came very close to ending her life then by jumping from her balcony. Soon after, Haifa began to get ill and had to miss work frequently. Her employer caused her further stress by changing her duties leading Haifa to believe they wanted her to quit, so she did.

Eventually Haifa met another man, who was South Asian and HIV-negative, and she had a daughter with him. Their child was born HIV-negative. She lived with this man, who was from a different cultural group than her own, which proved to be a problem for his family. When Haifa gave birth to their daughter, her boyfriend's mother came to stay with them to assist her. While the mother lived with the couple she treated Haifa badly. This resulted in a great deal of fighting between Haifa and her boyfriend and they eventually broke up. She and their daughter continue to have regular contact with this man and he periodically brings them food and money.

Financially, Haifa primarily survives from government assistance and regularly receives support from ASOs. She is currently looking to move outside Toronto to increase her anonymity as an HIV-positive woman due to her fears of being stigmatized and facing the discrimination that she has seen others face in her community. She takes her daughter to Hindu temple in order to calm her mind and make social contacts. No one at the temple knows about her HIV status.

**Anandi**

After three months, during which there were many phone calls and scheduling and re-scheduling of the interview due to Anandi's poor health related to her infection with HIV, a meeting finally took place at Anandi's home. Anandi reported being financially secure and had a comfortable house. She appeared confident and was talkative throughout the
Anandi is in her 40s and was born in South East Asia into a family of seven daughters. She speaks Tamil, Malay, and English and was raised as a Hindu. She describes her upbringing as strict as she was not allowed to leave home to socialize on her own unless accompanied by house staff. Anandi graduated from high school and college in her country in South East Asia. She considers her attendance at college to be the beginning of her social independence, and it was there that she met her husband. Because her husband to be was from a different ethnic group and a lower caste, her family flatly rejected her relationship with him. Anandi continued to date him anyway, and also lost her virginity to him during that time. Eventually her parents agreed to the marriage despite the ethnic and caste differences. Anandi and her husband enjoyed a lengthy European honeymoon that culminated in them immigrating to Canada in the 1980s.

When Anandi and her husband first arrived in Canada, they lived in Montreal with his brother. Anandi stated that she started to see her husband differently following immigration because he was connected to many people from his cultural community in Canada while she was isolated. Her husband began drinking heavily and, she said, he became verbally abusive. Anandi believed that if she could just get pregnant, it would improve their relationship.

When Anandi and her husband decided to move to Toronto, she believed that it would help their relationship as her husband would no longer have the same social circle. During that time, a Ministry of Health employee informed Anandi that her husband had been treated for an STD and that he was having sex with other women, including sex trade workers, and recommended that she should get herself checked. When she confronted her husband about his behaviour, he said that he could do whatever he wanted because he is a man. Anandi eventually got pregnant and had a son followed by a daughter the next year. She accepted her husband's infidelity as her fate. When her daughter was 3 and her son 4 years old, Anandi realized that the regular fighting with her
husband was having a negative effect on her children and she decided to return home to her country in South East Asia.

Anandi did not inform her husband that she was ending her relationship with him; she simply moved with no intention of returning to Canada or the marriage. Soon after, her 4-year-old son had a series of illnesses and then, during a hospitalization, it was discovered that he was HIV-positive. As a result, Anandi and her children experienced discrimination from her son's school and her immediate family. Somehow at school, the families found out that her son was HIV-positive and the kids started calling him names such as "AIDS boy". When her own family found out, they did not want her son to mix with other kids in the family for fear of getting infected. Upon the advice of a doctor, Anandi returned to Canada with her children hoping to secure better education and health care for them here.

After arriving back in Canada, Anandi was compelled to take work cleaning houses as this gave her the flexibility she needed to care for her children. Due to her son's illness, Anandi had many encounters with professionals, some of which were positive and others quite difficult. While attempting to obtain her landed immigrant status, Anandi had a required HIV test. At this time, she was informed that she was also HIV-positive. Shortly after that Anandi became ill with an opportunistic infection. At the time she was still without immigration status or health care benefits. Anandi ended up spending some years in Canada, dealing with periodic illness without health coverage and the stress that went with that. During her illnesses, Anandi accessed various social and health services to meet her children's and her own needs. She said that the separation from her husband caused her children stress. Her daughter gave birth to a child in her adolescence of whom Anandi has full custody today.

While Anandi was seeking employment online several years ago, she became acquainted with a man who lived in another Ontario city. They built a relationship and he has since relocated to Toronto where they currently live common-law. Anandi discussed some of her struggles with being in a relationship with a man who is from a different cultural
group than hers and who is HIV-negative. Anandi described herself as agnostic, though her son practices Hinduism.

At the time of the study Anandi was working full time as an HIV personal support worker and as such is articulate about the multiple psychosocial stressors related to being HIV-positive, an immigrant woman, and a single parent. Anandi was very dedicated to her work and could relate to most of the stressors and struggles of her clients and provide them with suggestions and recommendations about preventing the spread of HIV.

**Anjali**

The interview with Anjali was conducted after 2 months of phone calls and re-scheduling due to HIV-related illnesses and her travels. I met with Anjali in her apartment, which was in the basement of her parent's comfortable home. The atmosphere was informal with both of us sitting on her sofa bed. Anjali was confident, comfortable, and articulate throughout the interview process. Following the interview, her parents invited me to have lunch with the family.

Anjali is a woman in her 40s who was born in an African country into a Muslim family consisting of her brother, herself, and her two parents. Her mother tongue is Kachi and she also speaks Swahili, Hindi, Gujarati, and English. She considers herself to have grown up in Canada as she immigrated here as a young adolescent. While in school in Canada, she recalled having to cope with racism from white children and even being involved in physical fights as a result. When her family first arrived in Canada, her father's brothers were already here and rented them an apartment which they moved in to right away. Despite her hardships at school, Anjali reports that she enjoyed living here and that Canada was the world as it was a land of people from all over the world. Anjali described her upbringing as very traditional and her social contacts growing up were primarily with girls and boys she met at mosque. She was not allowed to date, yet her brother was free to date whomever he chose. Most of her childhood was spent in the house, helping her mother with cooking and cleaning chores. Currently all of her family lives in Canada, no relatives remain in Africa.
Anjali completed a university degree in Toronto and worked for two years here before travelling to a country in Africa to get married. Anjali met her husband, who was in Canada studying on a student visa, while at university. He was a South Asian living in a country in Africa. At 26 years of age, she moved to her future husband's place of residence to marry him. She said her husband was a "terrible, terrible person," and that he was emotionally abusive in that he was jealous and possessive. Anjali reported undergoing years of psychotherapy to cope with these experiences. He was wealthy and she did not work outside the home, nor did she have access to money herself. Her life in that African country was characterized by neglect from her husband and living under the dictates of her in-laws. Anjali eventually left her husband and moved back to Canada to live with her parents.

Soon after she returned to Canada, Anjali went on a trip to another Canadian city with a friend where she had unprotected sex with a man who was a casual acquaintance. She secured a stable job with the government upon her return to Toronto. Later, Anjali donated blood and it was through that experience that she discovered, from a phone call during her lunch break, that she was HIV-positive. At the time, treatment options were scarce and Anjali stopped working immediately and went on disability insurance through her work plan. She continues to live on disability as her health has slowly deteriorated and she experiences severe side effects from her HIV medications. Anjali believes she was infected with HIV by the casual sexual partner she met on the trip following the separation from her husband. She did not use condoms and was using an intrauterine device (IUD) at the time for birth control. Anjali was not aware at the time, nor was it widely known, that there was a risk of infection from heterosexual sex.

After Anjali determined she was HIV-positive, she moved out of her parents' home and lived independently for some time in the gay community. She described that period of her life as being rich with social contacts, primarily with gay men.
At the time of the study, Anjali lived at home with her parents and had embraced her Muslim religion once again as a major source of strength and guidance to help her cope with living with HIV. Volunteering with others who are HIV-positive is an important facet of her life. She was also, at the time of the interview, involved in a relationship with an HIV-negative man of a different ethnicity.

**Doyel**

The interview with Doyel was conducted on a Saturday evening in her busy kitchen with pets, teenage children, and their friends in other rooms getting ready to go out. Her home was in a government-subsidized residence in a working class neighbourhood. Doyel's friendly personality added a warm and relaxed atmosphere to the interview.

Doyel was a woman in her 40s who was born in the Caribbean and is of South Asian descent. Her mother tongue is Hindi and she also speaks English. She was raised in both the Muslim and Christian traditions, though her parents practiced Islam. She continues to attend church and also to recite her daily Muslim prayers. Her parents came from mixed religious backgrounds, which she stated is common in the Caribbean. She comes from a family of eight children, two girls and six boys. While living at home, her father worked and her mother stayed home. Doyel completed high school in the Caribbean and was married when she was 18 years old. Hers was not an arranged marriage, but it was more of a convenience marriage since the families introduced them to each other and approved of their marriage.

The following year, Doyel immigrated to Canada with her husband and they eventually had three children. Her goal in marriage during that time was to make her husband the centre of her world. When Doyel first came to Toronto, she worked in low-paid jobs, such as a server, and also completed college part time. Eventually she completed training in office work and was able to secure employment in a bank.

Although Doyel was infected with HIV by her husband, who had been infected through unprotected sex outside his marriage, she said that the marriage had been good, that they
both earned money outside the home and shared household duties. Throughout their marriage, her husband had had multiple health problems, such as diabetes and colon cancer. To her knowledge, he died of complications related to these illnesses, not HIV, though he was diagnosed as positive at least one year before Doyel discovered that she was HIV-positive. He did not tell Doyel of his diagnosis. Following his death, Doyel disclosed that she was infected with HIV to her children and her husband's family who live in Canada. Her extended family continues to reside in the Caribbean and she has not disclosed to any of them. This is primarily due to her concern about the stigma of HIV and the effect it might have on her relatives back home.

At the time of the study Doyel was living with some of her children and receiving income from a government disability program.

**Noor**

Noor was referred for the interview by an infectious disease physician and was not connected with any ASOs at the time. Her home was in a subsidized apartment building in a working-class neighbourhood. She was pregnant with her second child at the time of the interview. Her young daughter was also present and played in sight while the interview was conducted. At the end of the interview, Noor refused to accept the study honorarium.

Noor was a South Asian woman in her 20s who was born in a small town in India. She described it as an area with a diverse population comprising Sikh, Muslim, Hindu, and Christian people who co-existed peacefully. Her mother tongue is Punjabi and she is of the Sikh religion. Noor has one brother. Her father supported the family by working abroad and her mother cared for the household and children. Noor completed high school in India, but did not work there.

At age 20, Noor was introduced to her husband by her family and the marriage was arranged. Her husband, who was 11 years older, had been living in Canada for 10 years and had returned to India to find a bride. Following their marriage in India, her husband
went back to Canada alone and stayed there for a couple of years to prepare for her arrival. During that time, he engaged in unprotected sex with other women.

Upon arriving in Canada Noor felt comfortable right away because so many of her husband's relatives (three other couples) were living in Canada already, and her sister-in-laws helped her adjust. They taught her about shopping and cooking here and introduced her to the gurdwara they attended. Both she and her husband bring money into the household; he works at a factory and she works as a part-time cashier at a fast food outlet. They make financial and parenting decisions together. Currently she attends the gurdwara once a week with her husband and daughter. There she meets with other family members and friends from the Sikh community. Noor stated that most women in her culture are homemakers, though some, especially those who live in Canada, also work outside the home. In addition, many Indian families comprise extended family, including in-laws such as mother- and father-in-laws. She explained that her in-laws did live with them in order to help look after her daughter when she was younger.

For the first two years of their marriage, Noor and her husband tried to have a baby and therefore had unprotected sex. Eventually she became pregnant and, at four months, she was tested for HIV and found to be positive. Her husband was also tested at that time and it was determined that he had infected her. They assume that he contracted the infection during their separation before she immigrated to Canada. Although Noor is periodically angry about how her husband became HIV-positive, she does not believe he knew he was positive prior to the test. Their daughter is HIV-negative.

**Minu**

Minu's interview was conducted in her comfortable house in an upper-middle-class neighbourhood in the suburbs of Toronto. Her husband was present throughout apparently to act as an interpreter. Minu was talkative throughout the process and didn't seem to have any difficulty comprehending questions or responding on her own, although she did not answer any questions independently. Her husband offered responses to the
interview questions and was informal and friendly. He offered me a drink at the end of the interview.

Although Minu asked for her husband to be present because her English was inadequate, it was clear that she both understood and could communicate in English. The power her husband had in their marriage was evidenced not only by the fact that he attended the interview, but also by the fact that he responded to questions that Minu was attempting to answer herself throughout.

Minu is a married woman in her 50s who was born in India and speaks Gujarati, Marathi, Hindi, and English. She recalled that her father worked in an insurance company and that her mother worked in the home. Minu completed high school in India and took painting classes there after high school. Minu did not work in India. She is Hindu and has two children with her husband, who is also HIV-positive.

Minu and her husband married for love when she was 21 years old. The union was controversial because they were of different Hindu sects. As a result, they eloped. But their families are comfortable with the arrangement today and they have two children.

Minu described herself as excited when she first came to Canada. Her eldest child was already living in Canada after having studied for two years in the United States. They immigrated with a business visa and she and her husband bought a franchise business and a home upon arrival. Both had friends from India already living here and Minu had some family living in the U.S. At first, Minu attended Language Instruction for Newcomers to Canada (LINC) classes to learn English while her husband worked at the business. Approximately two years after they had arrived in Canada, her husband became ill and required surgery, which he had in India. At the prompting of her husband's doctor at the time, Minu got an HIV test, which turned out to be positive. She believes that she had contracted HIV several years before in India from a blood transfusion, and that she had passed it on to her husband. Because her husband was present throughout the whole
interview, it is possible that Minu actually believed that she contracted HIV from her husband, but wouldn't say so in his presence.

Minu and her family had used ASOs extensively and had had positive experiences with them in Canada. Minu contrasted this with the likelihood that they would have had negative experiences in India due to HIV discrimination. At the time of the interview, they were living on savings and have since sold their business because of ill health.

**Nandita**

Nandita's interview was conducted at an AIDS hospice in which she was living at the time. The environment was institutional in spite of efforts that had clearly been made to create a homey atmosphere for residents. Although the interview was conducted in a private room, there was a feeling of a lack of privacy because of the many AIDS patients in residence. There was also an air of secrecy about my purpose there as evidenced by the request I received from Nandita's worker to enter by a back door. Due to her suffering from AIDS-related dementia and difficulty with English, Nandita's AIDS worker attended the interview to assist with responses that Nandita was unable to provide.

Nandita was divorced at the time of the interview, and in her 40s. She was born in India and raised as a Hindu. She speaks English and her mother tongues are Hindi and Gujarati. She completed Grade 12 in India and also attended sewing classes after high school. Nandita helped her mother in the home and did not work in India. She comes from a family of five sisters and two brothers. She stated that it was expected that she and her siblings would get married, not date, though she says it was easier for the boys to date if they chose to. Nandita's father was a farmer and her mother helped him on the farm. Nandita described her father as the boss in the family. Nandita married her husband in India at when she was in her 30s. The marriage was arranged by her parents.

Nandita had one brother and four sisters living in Canada at the time of the interview. One of her sisters was the first to arrive and she sponsored Nandita to come in when she was in her 30s. She, in turn, sponsored her husband. Nandita described herself as
unhappy when she first arrived in Canada, in part because of the cold and snowy winters here. At first, Nandita worked with her husband doing manual labour in a factory. Although she said she found work quickly, she described the job as difficult. Nandita and her husband pooled their earnings in a joint bank account.

Throughout her marriage Nandita attempted to have a child. She had multiple miscarriages and because of this her husband separated from her. Nandita's understanding was that he ended the relationship because she could not have children and this was acceptable to her because childbearing is a social imperative for married couples. Her husband has since remarried and has a baby with another woman. He brought the baby to visit Nandita periodically.

In 2006, Nandita became very ill and was hospitalized for some months. The doctors did not know what was wrong with her until they performed an HIV test and it came back positive. They do not know how Nandita contracted HIV. Her husband, to her knowledge, was never tested. But she did engage in almost ten years of unprotected sex with him while they attempted to have children. She mentioned that she was vaccinated in India before she came to Canada and wonders if that was how she became HIV-positive.

Nandita is Hindu, prays every day, and goes to temple once a week. Her religion and affiliation with the temple is important to her. When Nandita was married, she cooked Indian food for herself and her husband and associated with other South Asian people from the temple. Currently she does not socialize, but receives some visitors, such as her ex-husband and his baby and her sisters.

**Chandra**

Chandra's interview was conducted in a government-subsidized apartment building in one of Toronto's inner-city neighbourhoods. Her home was tiny and cluttered, but her warm personality made the interview experience very comfortable. Chandra was cooking when I arrived. She offered me food during the interview and gave me some samosas.
before I left to share with my own family. Chandra presented herself as comfortable and confident with the subject matter.

Chandra was a woman in her 40s who was born in Africa. She described herself as Baluchi and of South Asian ancestry. She spoke Swahili and English. Her parents spoke Baluchi, which is their mother tongue. Her family of origin is Muslim, and her mother was very religious. Chandra comes from a big family.

Chandra was strictly raised not to have contact with boys, although as an adolescent she had a clandestine relationship with an Arab boy. Her parents disapproved and wouldn't allow them to marry due to their cultural differences. They then presented her with another man who was from her community in Africa for marriage although he had a reputation as a womanizer and was not her father's first choice. In hindsight, Chandra believes she chose him to spite her father because he wouldn't allow her to be with the man she loved. After completing high school, she took a secretarial college course and was employed as an administrative assistant at an automobile company. She was married at 24 years old and not long after came to Canada for the first time with her new husband and 9-month-old daughter.

Chandra and her husband came to Canada as refugees and, as such, they were not allowed to work and were forced to live on government assistance. Chandra stated that this was a big departure from how she had lived back home and the move was very challenging emotionally because she missed her family a lot. In addition, they did not know anyone but each other and her husband began to stay out late and drink alcohol. Later on when, she was eligible for work, she had difficulty securing employment and was repeatedly told that the reason was that she didn't have Canadian experience. She worked through temporary agencies and eventually got a permanent position doing computer work and administration. The money she and her husband earned was shared and they made decisions together, but they were "just surviving." Because of the difficulties in the marriage, Chandra decided to return home to Africa with her child.
During the separation, she realized that her husband was a good father and she wanted her daughter to grow up knowing her father. In addition, she was raised to believe that the husband should be central to a wife's world, so after about a year, she returned to him in Canada.

When she got back to Canada, they decided to have another child and to apply for private health insurance. During the required testing process, she and her husband learned that they were HIV-positive. This precipitated a crisis in which because of her isolation and lack of HIV knowledge Chandra phoned friends and family back home to ask them to raise her daughter. She also recalled considering poisoning herself and her family due to her perception that their situation was hopeless.

After this initial phase, Chandra went to great lengths to learn a lot about HIV and also used ASOs as needed. Chandra said that she thinks her husband became HIV-positive while they were separated by having unprotected sex with women in Canada. She also said that this is her fate and that her faith has helped her maintain her marriage to this man.

Chandra spoke about the challenges of living in Canada and trying to promote Islamic values, such as no premarital sex, to her children, particularly to her daughter. She also said that her son will probably be allowed to bring girls around as he grows older, but her daughter will not be, as she wants to preserve the tradition she grew up with.

**Juhi**

Juhi struck me as being a very articulate and well educated and confident young woman. Juhi appeared to be healthy and fit and responded eloquently to the interview questions and appeared to be at ease during the process, most likely due to her experience working with an ASO. Juhi’s interview was conducted, for the most part, in an office at ASAAP, which provided a more formal setting. Just before the end of the interview, Juhi indicated that she had an appointment and had to leave. So, I offered her a ride in my car, during which I was able to complete and tape record the last 15 minutes of the interview.
Juhi is an English-speaking woman in her 20s. As she was born and raised in Toronto, I was surprised by her strong adherence to South Asian traditions. Her parents emigrated from India before her birth, and Juhi speaks and understands only a little Gujarati. Juhi described her upbringing as "traditional" and described her family growing up as a typical South Asian family. For example, she spoke of her father as dominant and stern and her mother as withdrawn and subservient. Juhi was raised with Hindu religious beliefs. Her grandparents also lived with them as well as her only sibling, a brother. Growing up, in spite of being born in Canada, Juhi and her brother did not mix with members of other cultural communities but stayed within their own South Asian circle of friends and family.

Due to continuous conflicts with her parents over dating and relationships, Juhi left home upon graduation from high school and travelled to India and lived there for several years. There she met and married her first husband at age 19. Just before they were to be married, her fiancé became ill and his doctor suggested an HIV test. He told Juhi that the result was negative and, because she was still a virgin, she expected that he was too, therefore she believed him. In hindsight, Juhi believes that he tested positive and chose not to tell her. They engaged in unprotected sex for the duration of their marriage. She stated that the relationship was abusive and that she felt trapped and forced to marry him at the time. After two years, she left him and returned to Canada.

Juhi was diagnosed as being HIV-positive when she was in her 20s. At the time, she was involved in a relationship with the man who would eventually be her second husband. He does not share her ethnicity and is HIV-negative. Although they both work and money is pooled in one bank account, Juhi is responsible for all household chores. Juhi is currently employed at an ASO where she has met other people who are HIV-positive.
3.12 Summary

To summarize, in this chapter I described the methodology used in this research to explore HIV risk including an overview of the rationale for the method used, details about the study population, data collection, management and analysis, and the steps taken to warrant the quality of the work. I also described some challenges faced and suggestions for overcoming these challenges. Finally, a brief profile of each participant was provided to help put the analysis into context.
Chapter 4
Theme 1 – Power Relations

Chapters 4–7 provide a presentation of the study findings in the context of discussion of the emerging themes. Although the themes are interdependent, they are discussed separately for analytical purposes. The participant quotes included in the discussion of each theme and its respective subthemes illustrate the interactions between and among the themes. In these chapters, the results of my in-depth interviews designed to investigate the experiences and interactions of the participants within their families and their immediate community are described. Women's narratives added to the information provided by the review of the literature earlier and led to a greater understanding of gender relations in the South Asian immigrant community in the GTA. Through the interviews I was able to examine in some detail the women's personal resistance and their perceptions of gender relations and how these affected their risk of HIV infection in the particular context of the South Asian community in the GTA.

I analyzed the respondents’ experiences according to four primary themes related to HIV risk in women: power relations, emotional relations, gendered division of labour, and social norms. As previously indicated, my main objective in conducting this study is to explain what legitimizes male power so that I can have a better understanding of the factors in the lives of these immigrant South Asian women that contributed to them becoming infected with HIV. In this chapter I look at power relations, which are at the root of the four interdependent themes.

Men benefit from their power over women. Central to Connell's treatment of the imbalanced power relations between males and females is the concept of patriarchal dividend, which he defines as:

The advantage to men as a group from maintaining an unequal gender order. The patriarchal dividend is reduced as overall gender equality grows. Monetary benefits are not the only kind of benefit. Others are authority, respect, service, safety, housing, access to institutional power, and control over one's own life. It is important to note that the patriarchal
dividend is the benefit to men as a group. Individual men may get more of it than others, or less, or none, depending on their location in the social order. (Connell, 2002a, p. 142)

The women's stories reveal power relations during their childhood and in their adult lives, characterized by power imbalance and male dominance as evidenced in patriarchal authority. The women were expected to be less assertive and more submissive than males in their families. All the participants described their fathers as "head of the household," and talked about the power exerted by their fathers, brothers, and husbands as an accepted reality of their world. Examining social power as understood by the women allowed me to see its complexity. Force is only one component of establishing and maintaining dominance. Physical abuse was not often used as a way of exercising control over these women, however the majority of the women experienced ongoing emotional and psychological abuse, unequal access to household and workplace resources, and an inability to set the provisions under which actions are comprehended and matters examined, to define morality, and to formulate ideals in their own culture.

Reflecting on the women's childhood experiences, the following subthemes emerged: gendered roles and male figure authority in family of origin; from the stories that the women shared about their lives later on with their husbands and partners revealed the following subthemes: power imbalance in marriage, gendered roles in the home, normalized infidelity of men, and domestic abuse. Through the women's stories, I was able to see the way power generated identities and practices that conform to an ideal of masculine hegemony, and how that power was contested.

4.1 Power Relations During Childhood

Many of the women reported several forms of power imbalance, including gendered roles and male authority, in their families of origin. The power relations described by the women were most often centred around sexuality and relationships of young people. Many women spoke about the freedom that male siblings had when it came to spending
time with members of the opposite sex when they were growing up. Boys were allowed to date, or at least were not punished for it, while for girls it was completely unacceptable. As girls grew older, it was often the father's role to choose or approve their marriage partners. At meal time, the female members of the family served the males before sitting down to eat themselves. Being attended to in this way, having one's personal needs met, is one aspect of Connell's (2002a) masculine dividend enjoyed by men across the socioeconomic spectrum.

4.1.1 Gendered Roles

From the perspective that gender relations are relations of domination and that the construction of gender is of the two genders in relationship (i.e., there is no male without female and vice versa), the cultural definitions of masculinity and femininity should shed light on whether a dominant–subordinate relationship exists between men and women. For male dominance to be widespread, there must be a widely held belief that men should act in ways that women must not, in ways that demonstrate men's power in comparison to women, and in ways that demonstrate that women are inferior to men. Therefore, an examination of perceptions of gender norms and ideals will permit us to see if there is indeed a dominant–subordinate relationship between the defined genders. This conclusion provides a perfect lens for examining the interdependence of gendered roles and social norms.

All participants reported gender-based roles in their families of origin. Gendered roles were most obviously in organization of the household: females, including girl children, performed household tasks such as cooking, cleaning, and childcare while males worked outside the home. These gender roles reflect and help exacerbate the power differential between men and women; women occupy the domestic sphere in which the resources are controlled by men, whereas men operate in the public sphere outside the home, where the resources are also controlled by men, although what control individual men have depends on their socioeconomic position, as Connell (2002a) indicates by pointing out that men differ in how much of the "patriarchal dividend" they enjoy (p. 142). Nevertheless, these
prescribed roles manifest generally in the husband having more power than the wife over, for example, the family's resources.

In Anjali's family of origin, gendered roles were clearly defined. Anjali described her family as a "traditional South Asian family," in which her life was very different than her brother's. She was not allowed to go out with friends after school and often felt isolated, whereas her brother was allowed to go out and also to attend school trips. Anjali reported that as a female, she was expected to assist her mother with household duties: "In terms of the household, you would be helping your mom with everything. You know whether it's cooking cleaning, house chores, you would be helping your mom out. The boys don't, the girls do."

Haifa's experience was quite similar. On the farm where she was raised, her father attended to the running of the farm while her mother worked in the home. According to Haifa, these roles reflected the social norms of her community: "Yeah she (mother) stayed at home. Most of the time, yes. Most women used to stay home, they never used to go to work."

Minu and Sutra also talked about gender roles in the families they grew up in. Born and raised in India, Minu described her family as typical in that her father was the income earner and "boss" while her mother worked in the home. As she remarked, "My dad he's in the insurance company and my mom was a homemaker. Okay, back then you didn't know about the money. It was more like your husband looks after the money." Sutra, a thirty-nine-year-old woman of South Asian descent born in Africa, also grew up in a home where her father provided financially for the family and her mother did not earn money. Sutra described her mother as "just a housewife." She stated:

Yeah, I grew up seeing my dad, like he's the one who's responsible for bringing the food in the house and taking care of us. My mother never worked in her life, never. Until today she's not working. She tried to do some business and it didn't work and then she stopped. So all her life, she's
just a housewife. You know she's not working, she's not earning anything.
All the time it was my dad who was working

When Doyel was asked about her parents' roles in the family, she described a situation of male superiority. Although she spoke about her mother working periodically with her father on the family farm, it was clear her father held a position of authority over her mother. Even though her mother was working in the field alongside her father, she was viewed as an assistant to him, not as an equal contributor in her own right. Doyel remarked: "The man, he's superior…this is how I see it when I was growing up. Of course a man is not as equal to a woman. He would do more of the job. She's just there to help him."

The women's narratives provide support for the interdependency of individual beliefs and attitudes and widely held social norms. The gendered roles experienced by the women first hand reflect wider socially accepted beliefs about the roles of women. All of the women in the study commented that the gendered roles in the families they grew up in reflected the roles that men and women played in the larger society. In the case of Noor, her father supported the family by working abroad and her mother cared for the household and children. Noor commented on the roles of women in her home town in India: "Yeah some of them work and some stay at home, yeah. Mostly they do housewife, like that, yeah. Well mostly men earn, earn money. And women stay at home." Similarly, Minu described men's power in the home as reflective of their power at the societal level: "he's the boss in India. Okay the man is the boss." Men working outside the home, providing the family's only source of income, ultimately allowed them to maintain power over women. Anjali expressed this by saying, "Men have the last say, men work and make the decisions, and the woman take care of the children and house…like because they work, then they have more say."
4.1.2 Male Authority in the Family of Origin

The women reported various ways in which males demonstrated their superiority within the family. The most common was the influence of the father over the upbringing of the children in the home. The participants often described their fathers as "bossy" or "scary" and fathers were seen as figures of such lofty superiority. The father was in charge of discipline, which for females was the social imperative they stay home and not go out socially except to religious functions. Boys were allowed to participate in school and community activities, whereas girls were not. The women frequently described how male authority played out interpersonally within the family. For example, it was stated the men in the households were always right and could not be questioned. As daughters grew up, fathers determined that they could not date independently or choose their own marriage partners. Most of the women reported that their families were key in determining who they should marry.

Anandi in describing her strict upbringing offered this example of the discipline she and her siblings received:

I never had a chance to sit with him because my father was fierce, very, fierce. If one person got beating, every, all seven of us got it. And we would never sit in front of my father and watch TV or anything. We just went to our rooms and that's all we were.

To further convey the extent to which meeting the men's needs in her family was paramount, Anandi described how the privileged male position in the family played out at meal times:

Even when you have food, you fill the [male] mouths instead of female. Yeah, the dad …and if I had a brother; brother and father will have something to eat. … It's always my mom used to serve my brother-in-law and then they sit and eat. They don't sit together and eat. It's just the respect they have for the son-in-law and the males, that's how it is.
Haifa described the relations between the sexes in her country of origin as an imbalanced power dynamic that favoured males. She expressed it as such: "Men are supreme back home. Whatever they do, they are right. No women, if they do, they tell you to shut up, you shut up. That's how it is back home. Men have more power than women"

Many of the participants spoke about their families' involvement in the choosing of their marriage partner. Some described both parents participated in the choosing process. At age 20, Noor was introduced to her future husband by her family and the marriage was arranged. Her husband had been living in Canada for 10 years and he returned to India to find a bride. He was over 30 years old so there was an 11-year difference in their ages. Similarly, Doyel described her marriage as "kind of arranged" because her family did introduce them to each other and the families met while her husband was visiting her country of origin. Doyel later came to Canada to marry him here. According to Doyel, the imperative for women to marry was quite clear: "I got married, I came, [to Canada] well, with the intention…Yeah, 18 years old. You want to get married."

Others spoke only about the father's role in this process. For example, as a teen, Chandra had a clandestine relationship with an Arab boy, but her father disapproved of their marriage due to their cultural differences. Chandra said: "So I stayed for a couple of years and then he, my current husband, came for me and he comes from the community and all. He came, my father refused at first, because my father knew he's really a rough guy."

Chandra's father then agreed to the marriage despite the boy's reputation for being a womanizer simply because he was from their community.

Male authority was also exercised in relation to dating during adolescent years. Haifa described the expectations for females growing up simply as: "No, we were not allowed to date." Responding to the question as to whether it was more acceptable for males in her family to date, Haifa responded, "No, none of those are acceptable." Noor's experience in regards to dating was very similar to Haifa's. Neither girls nor boys were allowed to date before they were married, it was "same like boy and girl."
In Nandita's family the rules about dating were similar, but enforcement was stricter for girls. She stated that the sexual norm for both herself and her siblings was to get married, no dating, though she said it was easier for the boys to date if they chose to.

In other households, double standards for dating were openly exercised and enforced. Several of the women spoke about males in the household, usually brothers, being allowed to date, whereas they, as female children, were explicitly told that dating was not an option for them. Sutra shared her experience of double standard in her family: "but my dad wouldn't talk to his son, saying that, 'You can't do this.' But he would talk to me. You know, even if he knew my brother had girlfriends."

Legitimization and contestation of hegemonic masculinity can occur simultaneously; despite the fact that most of the participants described conforming to the strict rules around females having associations with males outside marriages, either by dating, having sex, or choosing their marriage partners, some reported acts of resistance in this area. Resistance to hegemonic masculinity can take many forms. It can be seen in women's expressions of strong feelings about a norm. Some may set forth different dogmas, others may try to beat the system and contest through subterfuge. But fundamentally, the power relations of hegemonic masculinity are only found to be illegitimate where the inherent values are rejected by all or most women. Both Anjali and Haifa felt strongly about the value of sexual experimentation before marriage. Consequently, both contested male power, but chose to do it in a rather secretive way by having clandestine sexual relationships with boys. Others, such as Juhi, Anandi, and Minu, contested male power more directly. Juhi rebelled against her parents and left home to go to India in pursuit of a new life away from her family. As she described it:

Canadian-born Indian children grow up with Indian families, obviously the ideals don't match anymore and I was having trouble getting along with my family. So I left home and I went to India and I stayed there for a few years.
Anandi grew up in a "very strict environment," and was never allowed to go out of the house for any social activities. But she achieved freedom by going to college. As a result she met her future husband, with whom she had a love relationship, who was not of her ethnicity or socioeconomic status. Her parents, particularly her father, were adamantly opposed to the marriage because of the economic and ethnic differences, but eventually agreed to it. For Anandi, it was important to marry the person she loved even though that meant going against her parents' wishes:

I met my husband and we dated. My parents were against it because he was a Sri Lankan. And so they said no, sorry, and all that. So I went against them. I am an Indian, a South Indian Tamil. So my parents were against it. And because, it's not only the caste or anything like that, it's the, you know, Sri Lankans, how they are, the Malaysians, I mean we Tamil are totally different. And it's not like oh my parents were in the caste. My father was very staunch Indian. … We should only get married to our people.

Minu married for love when she was 21 years old. The union was controversial because she and her husband were of different Hindu sects and Minu's family was "orthodox." As a result, they eloped. But their families became comfortable with the arrangement afterwards. Minu lived happily with her husband and they had two children.

In summary, both gendered roles and male authority in the families of origin have had profound impacts on the women in this study, manifesting primarily in the intimate relationships established later on in their lives. Women reported growing up with weighty messages about their limited power in the world in households where their brothers, fathers, and uncles were superior. In addition, they were not permitted to venture into the dating world, as their brothers sometimes were. These social norms were reinforced during the most developmentally significant time in their lives, while they were determining who they would be in and what their lives would be like in the future. Strict gendered roles in the household requiring women to perform household duties, such as cooking, cleaning and childcare, and men to work outside the home to provide food and a
home for their families, were reported by all of the women in the sample. This was clearly what the participants expected for themselves. Fathers were often described as being authoritative and distant from their daughters. As a result, the women were afraid of their fathers and the repercussions of defying their dictates. In addition, fathers were key in the determination and implementation of rules regarding girls dating and their future marriage partners. Males, husbands and partners, in most of the women's lives continued to dominate, and the women expressed a desire to transfer these same rules, based on gender inequality, to their children, particularly their girls.

4.2 Power Relations in the Current Family

The participants in the study spoke extensively about power relationships in their current familial relationships. Specifically, they mentioned power imbalanced marriage relationships, strict gender roles in their households, normalized male infidelity, and psychological and emotional abuse in their marriages. Women's perceptions of inequality in their marital relationships were aggravated by feelings of isolation as newcomers to the country. Women reported experiencing less power resulting from the strict gendered roles in their households as most of them carried out a subservient home-based role that required them not to venture out into the world. Many participants reported different fidelity conventions for women and men, with men having either tacit or explicit permission to have sex outside the marriage while women being strictly forbidden to do this. Most of these women viewed the man going outside the marriage for sex as the primary reason for HIV risk among South Asian women. Finally, many of the women suffered from psychological and emotional abuse, and for a few, physical abuse that marred their marriages culminating in feelings of inadequacy, resentment and at times resistance.

Current power relations in families as described by the women in the study create a picture of imbalance rooted in gender as manifested in the marital relationship, by strict gendered roles, normalized male infidelity, and domestic abuse. Closely examining these familial dynamics through religious dictates and communities reveals a psychosocial
context of tremendous HIV vulnerability on the part of immigrant women in the study. This is evidenced most powerfully by the fact that most of the women in the sample were infected with HIV by their husbands.

4.2.1 Power Imbalances in Marriage

While recounting their stories, many women mentioned that they felt that their immigration experiences had exacerbated existing inequalities in their marriages. Women reported being isolated from their social support systems and insulated by associating exclusively with people from their own cultural communities. In other words, the existing subordinate positions of women were reinforced. In hindsight, when recalling the social context of their HIV infections, the women identified many factors associated with their perceived social inequality in their intimate relationships that rendered them susceptible to HIV infection.

Despite her frequent confusion due to AIDS dementia, Nandita provided a clear example of the perpetuation of male power in her relationships. Nandita was divorced by her husband, allegedly for her inability to produce a child. She agreed that this was the right thing for him to do. When Nandita was questioned about the men in her family and asked who was in charge, she clearly stated that it was her "dad and husband" who had the power.

Chandra identified the isolation that came from being new to Canada and the subservient home-based role that required her not to venture out into the world as the sources of her lack of power in her marriage. She was alone, and she believed her only option was to wait for her husband to arrive to keep her company. In addition, she had to endure the lies he told to explain why he was away from his family until all hours in the morning:

Yeah he was, he had the power, you know and I was new in the country, you know, and he leaves me at home and I go to work. He has the car, he goes out. You know, he can come home and lie to me. He comes four in the morning. "Oh the car broke." You know, just lying.
The isolation and lack of family support that Chandra experienced as an immigrant made it so difficult for her to live here that in spite of being pregnant at the time, she packed her belongings and went back home to stay with her parents. She stated, "I was already five months pregnant when I came with my daughter, and you know we were newly married, a new country with the ups and downs and I decided to go back home." Chandra believed that with her husband going out and partying and staying out late, she was the only one striving to make the marriage work. Further, when she confronted her husband regarding his behaviour, their arguments became abusive, "We had arguments, we were both young and it's like I was trying to fight for a nice marriage … and he was being a little bit abusive. That's when I packed and left." Chandra explained her reasoning:

I really didn't argue about it. I said this is my fate; this is what I have to do. So I couldn't put up and eventually I couldn't eat. Because it's difficult to go against the man, with the South Asian.

Anandi also described a marriage based on a power imbalance. She recalled an incident in which she received a call from the Ministry of Health informing her that her husband had a sexually transmitted disease. As per protocol, she was informed that he was infected, but she was not entitled to any explanation beyond that. Anandi decided to confront her husband in an attempt to find out what he did and what exactly she was exposed to. Her recollection of the conversation is that her husband's said: "I'm a man, I can do anything I want."

A couple of the participants reported that their marriages ended upon the discovery that they were HIV positive. When husbands were confronted, not only did they refuse HIV testing, they also ended the marriage against the will of their wives. These women now believe that they were infected by their husbands, but can't confirm this because of their husband's refusal to an HIV test done. Haifa described the scene after her disclosure:

When I told my husband, my husband packed his stuff without telling me and left. When I came back from work, he was gone….the first time I found out I wanted to kill myself, especially when my husband left me and
I spoke to my husband and he just left me without telling me he's going. I just had to walk into our house inside and your whole house is empty.

Moreover, when asked whether she would go to her family to tell them that her husband was cheating on her, Haifa reflected on her short-lived marital experience and responded:

There's no women's rights … No, you cannot go to your parents and tell your parents, oh my husband is cheating on me! You can't go to your parents and tell them that. It's your business. You mind your own business … whatever the husband wants to do, he does.

4.2.2 Gendered Roles in the Household

The gendered household role mentioned most frequently was the social norm that the woman remain at home in charge of cooking, cleaning, and childcare. When the women remained in the home, their power was restricted to that realm. The man was allowed social independence and because he earned the money for the family he was valued more highly and more powerfully. These norms were more pronounced for the women upon their arrival to Canada as immigrants because of their social isolation. One woman spoke about a married woman's role of being an object of beauty for a man to own and of being required to submit to their mother-in-laws and husbands with respect to the activities of everyday life. Chandra spoke about the gendered household roles in her own family when they first arrived in Canada. While both she and her husband worked, she was expected to remain at home when not at work while her husband was able to socialize.

This is how Anjali described the gendered roles in her household in Kenya and her marriage:

Yeah, I stayed home, yeah….Because he was very well off and we lived in a very nice house and we had servants and gardeners and drivers back home. It was different. So I didn't have to do anything. I just tagged along with my mother-in-law everywhere … I was not consulted in anything. I
was just there as a trophy wife. … I knew nothing. All I knew is there was
this house and there was mother-in-law, and there were servants, and I was
there and I was newlywed into this household. … With all the luxuries, but
I didn't have a husband.

Juhi was asked about the allocation of responsibilities such as cooking and cleaning in
her household. Although her second and current husband is not South Asian, she carried
out the prescribed women's role of cleaning the house and cooking for the family. She
replied: "I do it". Later on she confirmed this by repeating, "It's just me, yeah".

Doyel's experience with gendered roles in her household was slightly different. She
described herself as working inside the home while her husband worked outside. She
stated that her husband was unusual in the South Asian community because he assisted
her with what are considered typically female duties of cooking, cleaning, and childcare.
She said: "No, no, no, we both share that … he helped and I didn't feel a burden … So he
helped cook … He helped look after the kids … Back then he worked twelve-hour shifts
where you get so many days off, four or five days off."

4.2.3 Normalized Infidelity

Based on the women's accounts, men engaging in sexual relations outside of their
marriages is considered normal. The interdependency of social norms and male power
that is enacted in the normalization of male infidelity is clearly seen in the women's
stories. The women in the study agreed that it is commonplace for their men to stray
outside their marriages. They reported that the social acceptance of this behaviour is
rooted in cultural and religious dictates that enforce the notion that the man is superior
and his behaviour is not subject to criticism. The participants internalized these beliefs
and when they were combined with fear of possible severe repercussions they were silent
in the face of their husband's infidelity. The community reinforced the notion of marital
privacy and the stigma attached to divorce by not discussing the issue openly. Further, the
women reported being at increased risk for HIV infection by their husbands because they were unable to request condom use by their husband even if they knew he was unfaithful.

Shreya talked about women's idea that when a woman is married, she requires nothing else in life but her husband. Even if she briefly thinks about sex, she will only think about it in relation to her husband. She remarked of sex:

Well you do that with your husband. Yeah, that's really with their husband, and we don't think about anything else. If sex comes to your mind, definitely you're gonna think about this with your husband. You're not gonna think about other men. There are so many guys out there, but if I look at them, they don't mean anything to me, they are just guys. Because I have mine. Yeah.

Shreya added that women will not go outside the marriage because they know what is in their best interest. In other words, if a woman does engage in this behaviour, her life could be destroyed.

It's not something … It's not that she's not allowed to, but it's not something an Indian woman would do … oh yeah, to us the men can go and sleep with fifty women. Nobody will say anything. But the woman goes and sleeps with just one man, that's it. Yeah, that's the end. I mean her entire life is ruined.

Juhi had a slightly different take on the imperative that women be faithful to their husbands. She pointed out that she was sure that sometimes women engage in sexual relationships outside the marriage, but that it was so socially stigmatized and taboo that no one in the community would know about it. On the other hand, if it were a man doing it, people would talk because it is more commonplace. She said:

I'm sure it happens, you know I'm quite certain it does happen. You just won't hear about it. It's more common to hear about a man straying outside of marriage. Because it's more acceptable, right, but not so for a woman.
When questioned directly about whether women are unfaithful to their husbands, Deepa responded that women were raised with cultural dictates about marital obligations from a young age. Women are taught from one generation to the next to behave submissively in their marital relationship. Asked about infidelity among women, she responded:

Well none that I know of [are unfaithful]. I don't think [they] cheat. That's not, that's not women. That's not, that's not how we are brought up, that's not how our culture works, that's not how it happens. Our culture, you reach a certain age and you got married, fifteen, sixteen, fourteen, even twelve, but that's it … So it's not, it isn't something that we're taught to do because that is not how we were brought up in society, or whatever, or how we were taught from generations, generation up. So, I don't think so.

According to Deepa, for a woman's own self-preservation, she will choose not to have sex outside the marriage and she will accept that men sometimes do and women's role is to acquiesce. She also talked about women's fears of being sent to prison or being tortured if they were to engage in these behaviours, therefore they do not. This is how she expressed it:

I think, yeah. I think that's men. Like I said before, men is men and they choose to do that. That's how they see themselves as men. You know like I'm not judging anybody, but I know for a fact it happens in the culture and they're just men and they're gonna remain men, right? A woman can't do that. If we do that then we will be shamed, be disgraced, maybe we might get killed, we might get stoned to death. They will chop off our hand, you know all these bad things. They might send us to prison and bad things will happen to us. But men, it's like that's something they do.

Deepa also talked about her belief that it is natural for men to go outside the marriage but not for women. There is an understanding that men are unruly at times, that they may drink alcohol and forget their wives. There is an understanding amongst women that men
just do this and that there's nothing to be done about it. Deepa also said that when men drink, they do not have control over their actions, thus a woman must understand this context as an explanation for a man's infidelity.

So men take risks … It's a different factor too because, for instance, if they go out for a night out with their friends or their buddy, and having a few drinks or whatever they will do. You know sometimes they are intoxicated or they are drunk or they're just having fun, and they don't even know. Like they're not focused and things happen.

Later on Deepa talked about the socially dictated sexual norms within the marriage that give a man permission to have sex outside the marriage. It was almost as if she viewed men as being unable to be accountable for their actions because they are men. They may go out and drink alcohol and make sexually risky choices, but it is merely something they do, not something they are truly responsible for. Further, Deepa connected these social norms to HIV risk in that she claimed that even though a woman may be aware of her husband's infidelity, she will not ask her husband to use condoms while having sex with her, thus she is at risk of HIV infection from her husband. As Deepa put it:

You know they go out having fun, they have sex with people, and they become infected because they're not conscious at that point in time what can happen … But, like I said, our culture is if you are married to a man, you don't do that. Right? You don't use a condom or you don't use birth control or you don't use prevention or whatever. That's your husband, that's who you're supposed to be having sex with.

Anjali had similar thoughts around the issue of normalized male infidelity. She illustrated this by saying:

Because husbands have the prerogative to have multiple partners, yet the wife doesn't, so that puts the wife more at risk. Yeah, yeah, okay. And the wife, I don't think, has a say even if she says can you wear the condom or
such things. There is no, pop, pop, you know, you get a couple of slaps and shut up.

Anandi not only reiterated that males claim explicitly that they have power over women, but further stated that women are slaves to men, and that this is the function of the wedding dowry. She also reported that women will not put their children at risk of community scorn due to the stigma of divorce. Because Anandi left her husband and returned to Canada, she was acutely aware of the social stigma attached to divorce. She acknowledged just how unusual it is for women to leave their partners because they are unfaithful. This is what she said:

Like what my husband said "I'm a man. I am in power. You are like a slave to me I bought you because of the dowry thing. So I paid for you and you are mine. You are my slave. That is the way it is." And the men, he will have a wife and he will go out and have sex and it doesn't bother him. And how many South Asian women are willing to go out and live, the way I lived. They are so afraid. Either they go back to anywhere they came from. But are willing to, you know, sacrifice their lives, just because of the kids, you know.

There is an underlying sense of self-blame in some of the women's stories. They blame themselves for their inability to satisfy their husbands, and see this as a justification for the men's infidelity. Some blamed women in general for failing to keep husbands from straying into extramarital relationships. This can be seen as legitimizing hegemonic masculinity. Deepa spoke about her responsibility for her husband's infidelity because she was away from home a lot going to school and working full-time. Chandra commented on the fact that she was approached regularly by men who are strangers and she wondered why they did that and pondered whether it was because they weren't having their sexual needs satisfied at home.

I walk during my lunch on the street. I'm being approached by different people. You wouldn't believe. And I'm thinking, what's wrong, like, am I
looking so cheap? Or am I that attractive that somebody's coming after me, you know? It's men. That's what I said, they're … you know? … It's, its maybe they didn't get the satisfaction at their homes.

Chandra, who is a Muslim herself, thought that irrespective of culture, men would cheat if they are not satisfied in their relationships. Even though religious precepts, such as the Muslim belief that a man can have four wives, or the Hindu women who strongly value their husbands do play a role, Chandra believes that men in general can behave in any way they please and are not accountable to their wives or anyone else for their behaviour. This is what she had to say:

I don't know it's not the culture only. It's every man here, I'd say. So a man who goes out with other women… I don't know, but it can be anybody because when I walk on the street, it can be any other man.

When her husband was in Canada and she wasn't, her friends believed it was a foregone conclusion that he would engage in sexual relationships outside the marriage until she returned to him. She believes her husband became HIV positive during this time, infecting her when she returned to Canada to be with him.

Once again, religious conventions are mentioned as a possible explanation of why women do not discuss issues of infidelity or raise it with their husbands. Sutra mentioned that women who are Hindu elevate their husbands and as a result will not cheat on them. She expressed it like this: "Like women, they are very, very, dedicated to their husbands, you know. They, majority, especially Hindu, I don't think they will go outside their marriage".

4.2.4 Abuse in Marriage

The threat of physical, psychological, or sexual abuse can decrease the victimized partner's sense of control in the relationship. The fear of abuse may lead to the sexual passivity of or lack of resistance in the victimized partner (Beadnell et al., 2000; Biglan et
al., 1995; El-Bassel et al., 2000; Rhodes & Cusick, 2002), thus decreasing the probability that safer-sex practices will be adopted (Langen, 2005). Conversely, females who are not afraid of negotiating condom use with their partner are more likely to reject uninvited sex (Sionean et al., 2002). Psychological abuse may also be used by a partner to gain power in the relationship, again decreasing the other partner's control over whether safer-sex practices are adopted (Davila, 2002). For example, Davila (2002) reported that a participant felt it was easier to engage in unprotected sex with her high AIDS-risk husband than to go through the verbal abuse that would result from her refusal and negatively affect her self-confidence.

Connell points out that men tend to use aggression to "sustain their dominance" over women. Aggression is not seen as a "privilege," but frequently as a way of "claiming or defending privilege, asserting superiority or taking an advantage" (Connell, 2002b, p. 95).

The women reported enduring various types of abuse during their marriages. Only one woman spoke about physical abuse while others mentioned ongoing emotional and psychological abuse which was worse when they were new brides. Sutra said that although her husband was controlling and they had had at least one incident of physical abuse, she claimed that he was supportive because he encouraged her and paid for her to attend college. She reported that he was controlling when they first arrived in Canada, which rendered her vulnerable to the eventual physical abuse. Sutra described the incident of physical abuse:

It was really hard that time in particular just for controlling things. You know we went to the wedding and he wanted to leave early and … And then he left me and he went home. … Now when we got home, he started arguing with me and then we got into fight. Yeah, that's the only time when we got into a physical fight. Yeah, and after that he realized what he did and he said, "Sorry" Yeah, that's it. Yeah, but it's the only time I remember that we got into a real fight. Yeah, but usually it's verbal, verbal fight in the house.
Most of the women were separated from their immediate families at the beginning of their marriage due to immigration either to Canada or another country. They, therefore, did not have their family's support to help them through life transitions such as marriage, childbearing, and immigration. Chandra returned with her daughter to her home country and stayed there for two-and-a-half years when she was still a new immigrant. She spoke about the isolation she felt as a new immigrant and how acutely she missed her family, especially because she needed them to help her adjust to the new marriage and motherhood.

Women in the study contested male power whenever possible. Three of the participants in the study who reported abuse in their marriages left the relationships. Given the prominence of the belief among the women in the study that divorce under any circumstances is forbidden, it took a lot of courage to do that. Both Juhi and Anjali were married abroad and lived in their husband's country of origin without their own families or support systems. Juhi said of her first marriage, "It was not an arranged marriage … But, I can't say, I can't say even if it was a love relationship, because it was an abusive relationship and I was just trapped and stuck." Anjali did not report physical abuse but spoke about difficulties surrounding emotional abuse in her marriage. She spoke about the abuse in her marriage when she was living with her husband and his family in Kenya.

You know this is almost twenty years ago and I've done lots of therapy to get him out of my system. So his family was very kind, but he was not kind. We had a lovely affair and romance, but after marriage he was, he was just a terrible, terrible, terrible person. I felt like I was married just for a showpiece wife. And yeah, it was not a good relationship … It was emotional abuse … Yeah, he would come home, he would have hickeys on his neck, I'm just freshly a new bride and you're doing that … No he was insecure, he was jealous, he was possessive, he was abusive, and I was just left with his mother all the time.
The third woman, Anandi, came to Canada with her husband and was compelled to leave the marriage in order to protect her children from the ongoing stress and fear they experienced when she and her husband fought. She was aware that the verbal abuse from her husband was harming her children. Anandi left her marriage and returned home to Malaysia. Another factor that was influencing Anandi at the time was that she did not have her landed immigrant status in Canada, and she had been hoping her husband would support her application after they got married. Unfortunately, she was so disturbed by the negative effect their fighting was having on her children that she left without telling him that, in fact, their marriage was over. As she described the situation:

"He started drinking. Yeah and was verbally abusive and started, you know arguing and fights among us. So I thought maybe you know, eventually when we have children, things will change….But my son was three and my daughter was two and I never got my immigrant status yet. I decided it's too much for me to put up with him, the children are growing up. My son was watching me daily fight and he is scared … and I needed comfort and you know it was too much for me. I thought he would change but he eventually didn't even change."

Metanarratives have an imperative theoretical function in situating the particular and the specific in wider historical and relational perspectives: "to reject all notions of totality is to run the risk of being trapped in particularistic theories that cannot explain how the various diverse relations that constitute larger social, political and global systems interrelate or mutually determine and constrain one another" (Maharaj, 1995, p.50)

The abusive behaviours of most of the husbands and partners in this study cannot be seen in isolation. Many of their individual beliefs are reflective of an ideology that legitimizes male power. As Connell (1995) eloquently puts it:

"Most men do not attack or harass women; but those who do are unlikely to think themselves deviant. On the contrary they usually feel they are entirely justified, that they are exercising a right. They are authorised by an ideology of supremacy. (p. 83)"
The above findings warrant some explanations as they seem to perpetuate a viewpoint about the traditional, patriarchal, misogynist, South Asian culture which contrasts with a superior White culture. Sherene Razack (2007) talked about patriarchies as not just rooted/expressed in culture but rather as "systems interlocked with capitalism and white supremacy" (p.23). In Culture and Imperialism, Edward Said (1994) argues that "this position of superiority of the west is held against an Orientalist narrative which is based on binaries which are translated into extremes of systematic difference between the Orient, which is viewed as undeveloped, inferior and aberrant and the West, which is constructed as embracing science, as humanitarian, and thus, superior" (p.37-38).

Culturalization of violence—when stereotypical normative influences such as collectivism and family honour are used to explain violence against women from that culture—as well as racism seem to perpetuate violence against immigrant women of colour and contribute to their increased risk of violence. It is important not to "culturalize" the violence faced by the immigrant women in this study. With these negative stereotypes existing in the South Asian culture, many of the women resist talking about the violence they have experienced for fear of confirming stereotypes or further abuse. Moreover, "in a racist milieu where men of colour are increasingly criminalized, reporting violence can, in effect, be construed as race treason" (Jiwani, Janovicek & Cameron, 2001, p. 3). This has a direct impact on heterosexual immigrant women living with partner abuse for example, as their fears of deportation and criminalization may lead many to avoid authoritative institutions, especially ones perceived as possibly jeopardizing their legal status in a new country. In addition, the economic dependence of women on male sponsors prevents them from reporting aggression.

4.3 Summary

Power relations in marriages are determined by fundamental social beliefs and behaviours that dictate the inequality between men and women. These imbalances of power are, at times, replications or extensions of the family dynamics experienced while growing up. The women who contested male power and socially accepted norms by
engaging in premarital sex, did so in secrecy. The women who contested publicly by marrying men of their choice still ended up conforming to the norms of male power later on in their lives. The effect of socially accepted male dominance on the women's individual attitudes and behaviours can be seen in the women's acceptance and adherence to socially entrenched norms established in childhood and extended or replicated in their adult years.

The women internalized female gendered behaviours from early childhood and carried them into their intimate relationships with men. They described practices in their families of origin that resulted in them being, for the most part, passive in their acceptance of marital partners chosen for them subsequently remaining in relationships with them. The women illustrated the power imbalances in their marriages by speaking of men as superior and women as inferior and controlled by men. These dynamics are expressed clearly in the relationships between men and women described and through child-rearing beliefs and practices.

Understanding the realities of South Asian immigrant women using an anti-racist lens is offered as a way to prevent culturalization of violence and to reduce the sense of 'learned helplessness' resulting from victimizing the victim.
Chapter 5
Theme 2 – Emotional Attachment

In this chapter, I discuss the role of the social structure emotional relations in the lives of the women, and how it affects their risk of HIV infection. The legitimization of power relations is dependent upon a widespread endorsement of the ideology prescribing them, that is, of masculine hegemony. However, the question remains as to what leads to the endorsement of such an ideology by the subordinate group? Himani Bannerji (2005) seeks to address this query by encouraging use of various entry points when shedding some light on the social aspects of lives. She posits that social problems could be viewed in terms of 'political problematic' (p. 146). Using Marxian theory, she demonstrates the importance of understanding these problems as developed over time within a wider social context of both socioeconomics and cultural associations.

Certainly, as we have seen so far, the participants' individual beliefs in male superiority and widely accepted beliefs and norms supportive of male dominance are interdependent with power relations as a social structure, and that without that interdependence there is no basis for the hierarchical relations of power between the women and their partners. Moreover, the abuse of women in their marriages, as reported by some of the study participants, helps to sustain masculine hegemony. But, as previously indicated, while the presence of abuse suggests a failure of legitimacy, it is not valid to infer from that that its mere absence constitutes legitimacy. For this reason, I propose that in addition to power relations, emotional attachment plays a central role in validating male power, and in legitimizing it.

In this chapter I focus on the social structure of emotional attachment and its interaction with the structure of power relations to better understand the factors that put these immigrant women at increased risk for HIV. I argue that the interdependency of the social structural factors of power relations and emotional attachment, the women's personal values and beliefs, and social norms as illustrated by the women's shared
understandings of traditions and practices plays a role in how these women constructed male superiority in their lives and how hegemonic masculinity was legitimized. The role immigration plays is also examined where relevant. The in-depth interviews with the women in this study allowed me to investigate the social structuring of emotional relations, attachments, and commitments. Based on my interviews with the women, the following subthemes emerged: sexual and marital roles and relationships, emotional dependence and husband reverence, desire for trust and fidelity in relationships, and the childbearing imperative and the value of motherhood.

5.1 Sexual and Marital Roles and Relationships

As specified in Connell's latest book on gender relations, (2009) sexuality and sexual expression is a prominent arena of emotional attachment. This means that the corporeal aspect of sexuality does not exist prior to, nor is it detached from the social practices in which relations between people are initiated and carried out. Sexuality as a structure, views the body as "an artefact of specific configurations of power." In other words, according to Connell, sexuality is "enacted or conducted, it is not expressed." (Connell, 1987, p. 111)

A major arena of emotional attachment is sexuality. In the lives of the women who participated in the study, sexual norms varied by gender. As previously indicated, the interviews with the women revealed a double standard whereby promiscuous sexuality was permitted for men and forbidden for women, which is a direct result of the greater power of the men, and reinforces that power. Most of the husbands of the study participants were involved in extramarital relationships, but few of the women were aware of that before they were diagnosed as HIV positive, thus, without their knowledge, they were at increased risk for HIV. Moreover, the women reported being at increased risk for HIV infection by their husband because they were unable to request that their husband use condoms even if they knew he was unfaithful.
The interdependence of social norms and the social structures of power relations and emotional attachment in the arena of sexual roles and marital relationships is clearly illustrated in the women's stories. For the majority of the women, husbands or partners asserted their power by dictating the terms of their sexual relationships, including whether condoms were to be used. Social norms reinforced the submissive role of women in marital relationships, including their inability to make demands on their husbands, and legitimized male power in the lives of the women.

This unequal social dynamic is replicated for Canadian women as well as noted by Statistics Canada: *Homicides in Canada* report (2009). A few statistics illustrate the phenomena of gender inequality as expressed through violence in women's lives where "on average, every six days a woman in Canada is killed by her intimate partner and 67 women were murdered by a current or former spouse or boyfriend in 2009" (p. 14). Moreover, a statistical profile on violence in Canada showed that on "any given day in Canada, more than 3000 women, (along with their 2, 500 children) are living in emergency shelter to escape domestic violence" (2009, p. 12). This glance at statistics reveals the influence of patriarchy and gendered power imbalances in Western society through their expression of violence towards women, both in and outside of intimate relationships.

Within the sexually intimate realm of living, most of the participants reported that men do not use condoms with their wives, nor would they do so if asked. Most women agreed that it is usually the man who has a problem with using a condom. For Minu, it was simply a matter of preference on the part of men: "It is you know, sometimes the man wouldn't want to use it." The most frequently reported reason for not asking one's husband to use a condom, though, was the fear that if a woman did so, her husband would assume she was being unfaithful to him.

Deepa believed that there was an assumption that a wife was unfaithful if she requested condom use in the marriage. She reflected on her own sexual relationship with her husband: "But how can we change that? … If we discuss that; what's your husband gonna
think? Oh well, maybe you're having sex with somebody out of the marriage. So how will we begin to change that?

Chandra shared a similar sentiment about the issue of condom use: "I don't think all men would use that. You would never, you would never tell a Muslim man to use a condom, no. Because if you did, he would think that maybe you're fooling around." Later in the interview Chandra, recalling her return to Canada after separating from her husband for some time and living on her own in her home country, reported that even though she suspected at the time that her husband had engaged in unprotected sex outside the marriage, she still believed that there was nothing she could do to protect herself from contracting sexually transmitted diseases from him. She remarked:

Do you think even if a man is going out and you tell your husband to use a condom, they're going to tell you, "Oh are YOU fooling around? You're worried that you're going to infect me?" That's what they're gonna put on you.

Both Chandra and Sutra, even after being diagnosed as HIV positive and medical professionals had advised them to use condoms, felt that they were unable to do so. Chandra continued: "I never did [use condoms in marriage]. Though they advised me, you know, I never did. Especially with our husbands, you cannot tell them to use condoms."

Sutra's second husband adamantly refused to wear condoms despite the medical advice they received suggesting the use of condoms to reduce the possibility of each of them getting infected by the other with another strain of HIV. Her partner, who became infected with HIV as a result of unprotected sex with her after marriage, made an informed decision to engage in unprotected sex despite the risk. As Sutra said: "It is an issue with my current. Yeah, he doesn't like it. …You know even if we have to protect ourselves from co-infection, these things. It is a big issue that he doesn't want it."
The way Juhi saw it was that men do not use condoms because it conflicts with their self-image.

And, and somehow I think men have the idea that they become demasculated or un-masculated or however you want to say. Or unmasculine by using a condom. But they're somehow not completely a man if they have to use a condom.

Haifa was convinced that it was men who had the upper hand when it came to condom use:

That is the thing! That's the thing. If I say you're not using, but I'm using, there's an argument, you're bringing an argument in your marriage. Why are you using? Maybe you're having an affair with a man…. Most men wouldn't accept. Most men have a problem with using condoms.

Upon close examination of the women's responses about condom use, it is evident that their individual experiences reflect socially accepted values and norms related to condom use in their community, thus supporting the interdependency of individual attitudes and social norms. The effect of social norms is obvious. Women accept their role of not being assertive in their sexual activities with their husbands. When asked whether South Asian women would use condoms with their husbands, many respondents reported that, in general, married women in their community would have difficulty telling their husbands to use condoms for reasons including women's shyness and subservience, anticipated men's reluctance and opposition, and stigma. This interdependency is clearly illustrated in Anandi’s response:

Okay, even the man, okay. There are husbands who say I don't feel comfortable using a condom. Most men, not only the Indian men, not just South Asian, but even my husband, would say that. I said, "No." you know, of course it's not, I mean, it's not comfortable using that, but then what are you gonna say?
Similarly, Shreya stated that:

Actually married women, no they don't use them … Probably it's not something, you go buy a condom and tell your husband to go and wear a condom. No its not. … I think they're probably scared or they're shy.

Anjali clearly articulated that if women were more educated about HIV/AIDS, then they would not be so shy about buying condoms. But for Deepa, women in South Asian communities buying condoms was taboo:

No they wouldn't [buy condoms] …that's another stigma attached to that, too. People start to think automatically, not consciously but unconsciously, oh, you're a whore, you work on the street or you're a sex trade worker, like whatever you call them here, or you're prostituting yourself.

In sum, almost all of the women reported difficulties around condom use. Most of the women mentioned that men would not agree to using condoms in their marriages. Some women said that their inability to insist on the use of condoms in their marriage was related to the religious and/or cultural background of their husbands. Others spoke about women's shyness and fear of buying condoms because of the perceived social stigma attached to women purchasing condoms. But primarily the women argued that insisting on the use of condoms in a marriage was inconsistent with the submissive role of women in marital relationships.

5.2 Emotional Dependence and Husband Reverence

The theme of husband reverence was central in the women's lives. Husband reverence is based on an extreme emotional dependence and attachment to male partners, which dictated gender-based sexual behaviours that shaped the participants' contact with HIV. Listening to the women's stories, a clear interdependence between the women's individual attitudes and social norms that sanction women's emotional reliance on men was evident. Moreover, there is evidence that the women's emotional dependence is interdependent
with male power. Women's emotional dependence and admiration for their male partners exacerbated their openness to male power and exploitation, which increased their HIV risk, particularly through risky sexual practices.

Many participants mentioned having been raised in an environment that encouraged women's dependence on their husbands. The marriage partner therefore became central in the women's adult lives. According to Connell (2005; 2009), the acceptance of an ideology leads to the formation of hegemony. Doyel spoke about the prevalent notion that a woman's husband is central in her world as he is the one who takes over her care from her family of origin:

At this age and the culture we come from you tend to, you tend to, you block out everything else and your husband is your world. You know, your husband is who, who, is...That's the culture we come from. He's the man that's gonna be, who you leave your family and he's gonna be taking care of you.

Some women reported to hold their husbands in high regard, even tolerating practices they did not approve of such as infidelity and a sexual double standard. This may indicate the women's emotional dependence on husbands because of their willingness to ignore personal feelings of dislike for certain behaviours in order to adhere to prescribed submissive roles for women in families of origin and marriage relationships. As the women age, emotional dependencies within families of origin are extended to marital ones. This is clearly illustrated in Juhi's first marital experience. Although raised in Canada, Juhi reported to have lived in a traditional and conservative Indian family:

Pretty typical, you know, South Asian family. My father was the patriarch, very strict. Mom was very submissive, very in the background, you know. Wasn't into a lot of disciplining. My grandparents lived with us, so it was an extended family. Very typical.

As a teenager, Juhi rebelled against her family's traditions and ran away from home. She went to her parents' hometown in India where she became involved in an abusive
relationship with a man. In spite of this, she married him, hoping that marriage would improve his behaviour: "The only way I felt I could survive is if I married him. And so that's the kind of relationship it was."

Juhi's tendency to emotional dependence on a man is demonstrated by her decision to marry an abusive boyfriend rather than leave him and be on her own. Although Juhi rebelled against the strictness of her father, she soon found herself under the control of another man.

There is evidence for an interdependence between immigration and the social structures of emotional attachment and power relations in this study; as newcomers, many women were isolated from their social support systems, which increased their emotional dependence on their partners. Moreover, the women's interactions tended to be solely with members of their own cultural communities when they first arrived in Canada, thus further legitimizing male power.

Chandra decided to return home to Africa with her child after difficulties in her marriage became overwhelming. During the separation, she realized that her husband was a good father and she wanted father and daughter to know each other. In addition, she was raised to believe that as a Muslim the husband should be central to a wife's world, so after about 2 1/2 years, she returned to him in Canada. She remarked: "See I loved him so much. … Like, once you get married, you know that this is the only man for you and all. I felt that he's my life, you know?"

Deepa blamed herself for getting infected with HIV. She had the utmost regard for her husband and could not challenge him even though she was aware at the time that he was involved in extramarital relationships:

I was working two jobs at the time, so maybe sometimes I blame myself that maybe I was too busy. Going to school, working full-time, you know, part-time and you know, like maybe he found ways to do that. I had knowledge of what's been going on, but like I said before, it's not
something that you will just start talking about. "Hey you're cheating or what's going on, where have you been?" Like you don't question this.

Another example of emotional deferral to the husband is clearly illustrated by Sutra's situation following her HIV-positive diagnosis after a blood transfusion. Even though she was devastated herself, her husband, who remained HIV negative, thought it best to leave her in Canada and return to their home country taking two of their children with him. While Sutra did not explicitly agree with her husband's decision, she was also very concerned about people in her community stigmatizing her husband and her children because she was HIV positive. She did fight the idea initially, but later acquiesced. In the end Sutra agreed with her husband's decision because of the stigma HIV carried in the community and the general lack of education about HIV transmission. For example, Sutra and her husband believed that she might infect her husband and children if they continued living together. Even though she was a new immigrant, HIV positive, and alone, she agreed that he should leave Canada with two of her children. Despite this, Sutra pursued an amicable relationship with her ex-husband who has regular visitation with her children.

I was in a big fight with my husband every time because of that [being HIV positive] … that time when my husband left, everyone was thinking you see why he left. With him, he wanted to protect himself and he wanted to protect the kids. … if I stay with the kids, they will get it from me.

Anandi spoke about being a new immigrant and trying to get pregnant in order to improve her marriage, which she stated was characterized by arguments, verbal abuse, and her husband's increasing abuse of alcohol. Anandi remained with her husband in spite of the abuse in order to try to make the marriage work. She even agreed to move to another Canadian city with her husband to have a fresh start and continue trying to make her marriage work in order to avoid the stigma of divorce. After moving with him, the situation only deteriorated. Then Anandi received a call from the Ministry of Health telling her that she had been exposed, through her husband, to a sexually transmitted
It still took her until the birth of her second child to leave her husband and move back to her home country and her family.

In sum, women reported various examples illustrating their emotional attachment to their husbands rooted in both individual and social expectations. Their relationships were characterized by deeply held convictions around their responsibilities as women and a belief that they needed to be cared for, first by their fathers, then their husbands. In addition, the women spoke about initial settlement and the social stressors related to orienting to a new country, adjusting to a new life, and enduring alienation, isolation and spousal abuse. Even though these women identified additional stressors related to immigration, the emotional attachment to their husbands, marriages, and families meant that these were their first priority.

5.3 Desire for Trust and Fidelity in Relationships

Despite the normalized infidelity of the men in the lives of this particular group of women, all of the women had an underlying desire for trust and fidelity in their relationships. Infidelity was an accepted behaviour for men. This combined with a fear of possible severe repercussions for confronting their husbands, several women expressed feelings of silence in the face of their husband's infidelity. Given the stigma associated with divorce, the effect of social norms on the women's individual beliefs and their sexual practices becomes clear. The women's unconditional trust in what they perceived to be a monogamous relationship and their strong desire for trust and fidelity in this social context made it easier for them to ignore infidelity. Those who knew that their husbands were unfaithful to them were unable to request condom use by their husband which put them at amplified risk for HIV infection.

The interaction between power relations and emotional attachment is clear as power imbalances can only be sustained if the women have emotionally invested in them and have endorsed them. Despite the husbands' involvement in extramarital affairs, the
women's belief in the value of monogamous relationships and associated social relations was strong enough to render these beliefs legitimate. This argument is supported by the women's narratives and also provides evidence for the interdependence of individual beliefs and social norms. Because male infidelity was one of the widely accepted norms, many of the women accepted male power as part of their own reality. As the women increasingly accepted male infidelity as the norm, male infidelity became a more widely accepted social norm. Strong social norms and the emotional buy-in from the women provide legitimacy for male power.

Men's infidelity put the women at risk. The women's blind trust in their husbands and faith in the monogamous relationship put almost all of these women at risk. Even though most of the women were infected by their husband or partner, only a couple were aware of their husband's infidelity prior to getting infected. Many of the women viewed marriage as protection from HIV and their husbands as worthy of their trust. Deepa talked about her belief that marriage provided protection from HIV:

I was married at the time and … I was independent, I had a great a great job. I, you know, being a wife, being a mother. I wasn't at risk. I thought I wasn't, but it did happen, and I found out years after when I got sick. Then I found out that I was HIV positive myself. … I heard the word HIV, but it did not apply to me because I was a married woman, like I said, and having a great life, so I didn't think I was at risk. I wasn't having sex with two people at the same time, I wasn't on living on the street, I wasn't prostituting.

Although, as discussed above, many of the women felt a strong emotional attachment to their husbands, some of the women felt strong hostility towards their husbands mainly as a result of the husbands' involvement in extramarital affairs. Shortly before her marriage in India, Juhi's husband became ill, but did not disclose to her the nature of the illness. Later she discovered that he had known that he was positive prior to the marriage, but chose not to disclose this to her. Therefore, he knowingly put her at risk for infection by having unprotected sex with her. Juhi said this:
I was 19 when I got in my first marriage, right, so that's when I got infected. And then I didn't find out that I was HIV positive until [sighs] 25. Yeah, yeah, so it was quite a while and it was a complete shock because you know this man…I mean, mind you I shouldn't have taken his word for it just because of the kind of man that he was, but it was a shock. Like, oh wow, he lied to me about it.

There is evidence in the data to support the interdependency of the structures of power relations, emotional relations, social norms, and the women's individual beliefs, as seen in most of the women's stories. Those who suspected that their husbands were involved in some kind of extramarital relationship, either while they were together or during a separation, described themselves as someone who would not even consider that her partner was having sex outside the relationship. For instance, despite Anandi's devastation upon receiving the call from public health that revealed her partner's infidelity at the same time they were trying to conceive, and in spite of a doctor recommending she not continue her relationship with him, Anandi somehow accommodated his infidelity and went on to conceive her second child with him. The women's underlying desire for trust and fidelity in their relationships, their extreme emotional dependence on their partners, and their strong trust in their men to do the right thing by properly protecting themselves, combined with their lack of awareness of HIV and their inability to negotiate or enforce condom use, put them at an increased risk for HIV infection. For instance, Chandra reported that she trusted her husband to be monogamous or to protect himself by use of condoms if he did engage in extramarital affairs. She recalled her neighbour's words warning her about the possibility that her husband would cheat on her during her absence: "you have left your husband for 2 1/2 years, and at that time, he was a single guy. For sure, he's been fooling around."

Nevertheless, she felt strongly that she could trust her husband to do the right thing: "I didn't know much, I don't know much about the virus. I had so much trust that I thought maybe he fooled around, but he was protecting himself. I had trust."
Shreya explained her husband's failure to use condoms in his extramarital relationships, which resulted in her being infected with HIV:

You know sometimes guys they think that: "Oh, nothing is gonna happen to me." Because they do say that women they have more chances of getting it than a man. So probably they have that on their mind that, "I'm not gonna get it, why bother?"

Again, the interdependency of the women's individual experiences and their perception of social norms is clearly illustrated in their narratives. According to Anjali, most women assume that there is trust and fidelity in their marital relationships, thus resulting in their having a false sense of security. Anjali described her perception of women's desire for trust in their marital relationships:

In terms of women, their husband is the man that they will marry, so they don't think of any worry. But, however, they don't know where those husbands have been and what they're doing. And they come back home after they've been elsewhere.

Anjali gave an example of "elsewhere" by reflecting on her own experience living in the gay village:

Married men used to come to sleep with these gay men and have sex because of whatever fantasy they have. And my friends, these gay men, were positive and they would not disclose to these married men … and these men are going back to their wives. You know, so I don't think women perceive themselves being at risk, however, yes, I think they are at risk. But they do not perceive themselves being at risk.

Similarly, Haifa reported her conviction that this is a commonly held belief: "I think most of ladies are that, they are always trusting in men. They believe men, whatever men say. I'm one person. I think all women are the same."
Anandi also talked about the women's trust in their husbands' fidelity: "Most women know … they think that, 'oh my husband is an angel and he will never do that.' Some women are like that. Yes, the trust, they have too much."

Reflecting on the concept of trust in the lives of these women, I see the basis for trust here as the women's propensity to believe good things about their partners; given the inability to negotiate condom use and the stigma attached to divorce, the best option the women had left was to trust. For instance, when Chandra's neighbour suggested that her husband would probably not be faithful while Chandra and he were apart, Chandra wanted to believe in her husband, and she trusted that if he did have sex with someone else, he would use condoms. The importance of the concept of trust in this study is reflected by the fact that the participants themselves used the term "trust" over and over again in their narratives as a way to express what they wanted in their marriages. This can only be an indication of a compelling social norm to stay with their husbands despite their infidelity.

Moreover, the influence of immigration on the women's practices in this respect is clearly seen in the data. Since many of these women were dependent emotionally and economically on their partners as well in terms of their legal status in relation to citizenship, it was difficult, if not impossible, for them to contest male power.

According to Anandi, many immigrant women:

- Prefer to be back home [in their home country]. They want to sacrifice, but they don't know that the husband is dating and cheating on the wife. The husband only came once a year back … He might be carrying the disease … He doesn't go for a test or anything like that, so he brings the disease back.

In spite of the fact that she herself did not trust her husband, Anandi described most women as trusting. An oral presentation at the National Conference on HIV/AIDS in Toronto, Ontario in 2000, clearly demonstrates the same trend for White, Canadian-born
HIV infected heterosexual women. All participants became infected with HIV by not using condoms with regular sexual partners (husbands or boyfriends). The participants predominantly reported trusting these men rendering condom use unnecessary within their relationships. (Calzavara, Ryder & the Polaris Study Team, 2000)

Deepa was also convinced that women trusted in their husbands' fidelity to the extent that they did not feel the need for protection from HIV:

If you are married to a man, you don't do that. You don't use a condom or you don't use birth control or you don't use prevention or whatever. Not in marriage relationships that I know of. People use condoms but from a different perspective. Not in marriage relationships. Women cannot discuss that … Like if you [are in a] long-term marriage, long-term, safe secure relationship, that's not a topic that would count for discussion.

To conclude, most women spoke about their trust of their husband, particularly in his fidelity. Many of the women viewed marriage as protection from HIV and frequently spoke about their belief that their marriage partners would not intentionally harm them. Even when confronted with the certain knowledge that her husband knowingly had unprotected sex with her after he was diagnosed as HIV positive, one woman's response continued to be in total disbelief. Finally the women's trust in their husbands' fidelity combined with their lack of direct knowledge of their husbands' extramarital sexual involvements, their ignorance about who is vulnerable to HIV infection (i.e., they assumed that the only women who are vulnerable are prostitutes or sexually promiscuous), and their inability to negotiate condom use if they were aware of their infidelity, resulted in them contracting HIV from their marriage partners.

5.4 Childbearing Imperative and the Value of Motherhood

Another emotional connection that proved to be important in this group was between a mother and her children. All of the women who were interviewed valued motherhood and
most of them took risks in order to achieve it. Women who were aware of their husbands’ adultery chose to have unprotected sex with them in order to bear children. The use of condoms was therefore in direct conflict with the role of the woman as mother.

Due to the compelling social imperative for women to bear children within marriage, sex without the use of contraceptives, including condoms, was the norm. Women's cultural roles are strongly tied to pregnancy and motherhood, and strong incentives exist for women to have children (Wingood & DiClemente, 1998, 2000). Having children affirms a woman's femininity and adulthood, and thus it is a desirable goal for women. The value of bearing children for women is linked to the belief that having children affirms men's masculinity and is also a mark of adulthood for men. This belief contributes to the lack of condom use, and is a factor in the transmission of HIV (Wingood & DiClemente, 1998, 2000). The interaction between the individual and social norms plays an important role here. The childbearing imperative cannot be looked at in isolation. It must be seen in the context of the social norms in operation, the norms defining masculinity, femininity, and adult status. The effect of these social norms, through their influence on gender and traditional sexual roles assumed by the women, is to exacerbate the women's risk of HIV infection. The value the women placed on motherhood, and their extreme emotional dependence on their husbands, which is linked to their desire for trust and fidelity in their marriage, made it excessively hard for them to recognize any threats or discuss safer sex.

Even though some of the women knew or had a feeling that their husbands were cheating on them, they still engaged in unprotected sex in order to get pregnant. But even if they were not planning to become pregnant, Anjali thought that condoms were not typically used in the South Asian community:

I don't know, I don't know what women do these days, you know, but I don't think condoms would be, would be an issue, because they would either have kids or not have kids. If they're not having kids, they'd take the birth control. Again condoms is never a thing. No I don't think it's used in the South Asian community. Yeah, I don't think it's used.
When it became clear that Nandita would not be able to bear children, her husband left her for another woman in order to procreate. Nandita's friends and family appeared to accept her husband's decision to divorce her because they felt he was entitled to have children. The childbearing imperative is so strong that her husband received support for leaving his ill, HIV-positive wife, simply because she could not bear children, to find another who could. Her husband visits her even today and brings his new baby to see her as well. When asked how she felt when her husband left because she could not bear children, Nandita responded, "It was okay … my husband say it's okay, no problem."

Anandi explained that: "Women are willing to sacrifice their lives, just because of the kids. … I was trying to conceive, but he was fooling around with prostitutes and other women." Anandi recounted a time early in her marriage when, despite the fact that she had one child, she was receiving medical assistance from a fertility specialist to become pregnant again. After the government reported her exposure to an sexually transmitted infection (STI) to the specialist, she was advised that the specialist would not continue to treat her because her husband was engaging in extramarital affairs with sex trade workers, thus putting her at risk of infection with a multitude of sexually transmitted diseases. This was difficult for Anandi to accept, and her husband defiantly refused to answer any of her questions about his behaviour. She did eventually have a second child, but continued to want another until her gynaecologist persuaded her to cease the fertility treatments and to be sterilized to prevent further pregnancies with her husband. Anandi recounted her story this way:

So then they contacted my specialist and said, 'Do not treat her because we need to check her first. Because the husband is doing this'… So when I, so then he had to call me and said I can't treat you because he told me the truth … So my gynaecologist, she advised me, even in the way she saw him and all. She said, "I think he was not the right man, you know. He's not responsible and all this." But I made a choice so I couldn't back out now. It's too late, I have two kids. So eventually she said, "Don't have any more kids." He comes back drunk, you know. And she did the ligation for me. So I agreed and we had that.
While responding to questions about when her children were born in relation to the date of her marriage, Doyel reported her faith in God determining whether or not to bestow children on a marriage. She also stated that she had unprotected sex with her husband at the beginning of her marriage in order to get pregnant and, in spite of that, she did not control whether or not she would receive God's blessing of pregnancy: "Couple of years after that, and no I haven't waited, I just … [chuckling] Yeah you have kids, and when it comes, it comes and God bless you when it comes, right?"

The majority of participants in the study had at least one child. Only one married participant did not have any children. Procreation within marriage was clearly a religious and cultural imperative for the South Asian women in this study. So much so that childbearing took priority over a woman's individual happiness and well-being.

5.5 Summary

The power imbalance between husbands and wives in interaction with the emotional attachment the women typically felt for their husbands informed the marital relationships and sexual behaviour of the women in this study. The participants' emotional attachments reflected social norms and as such, were determined and reinforced by social structures.

Women reported a shyness and reluctance to insist on the use of condoms and relayed many examples of men's refusal to wear them based on their physical discomfort and/or their beliefs that because they were men, they were not sexually accountable to anyone, including their wives. The men, therefore, generally chose not to use condoms. The women also reported a strong community norm that supported these notions. When asked what they or members of their communities would believe about a woman who had condoms in her purse, participants responded that they would believe that the woman was promiscuous or possibly a sex trade worker.
Many of the women mentioned having been raised in a milieu that encouraged women's dependence first on parents, then on their husband. This often resulted in the women's acceptance of their husbands' infidelity, thus rendering them at increased HIV risk. Even women who reported marital difficulties continued to remain in their marriages. Given that most of the participants came to Canada without their families of origin, they commonly experienced the isolation that comes with being new to a country. This, along with their subservience to their male partners exacerbated their vulnerability to HIV.

Women also reported a desire to trust their husbands to be faithful to the marriage, or if not, they believed that their husbands would use condoms in order to protect their wives from HIV. Many women spoke about the marriage as a sacred and safe context for them. In other words, they believed that the institution of marriage served as protection from HIV. The findings, with regard to trusting regular sexual partners and therefore not using condoms, were replicated in one study that reported on white heterosexual Canadian-born HIV-positive women infected by husbands or boyfriends.

Most women in the study were mothers and some spoke of the social imperative to bear children. Women reported that if condoms were ever used in the marriage, it would only be to prevent pregnancy, not for protection against sexually transmitted diseases.
Chapter 6
Theme 3 – Gendered Division of Labour

The third theme to emerge from the study is the gendered division of labour, which is a social structure as defined in Connell's (1987, 1995, 2009) social theory of gender. The gendered division of labour is not just about the allocation of work, but about the nature and organization of that work. It is impossible to separate either from the distribution of the products of work—that is, the distribution of services and income. So, the gendered division of labour must be seen as part of a larger pattern, a structured system of production, consumption, and distribution.

In this chapter, I focus on the social structure of the gendered division of labour and its interaction with the structures of power relations and emotional attachment in relation to the risk for HIV. I argue that the multidimensional life experiences of the South Asian immigrant women resulting from power imbalance due to male dominance, their emotional dependence on their male partners, and their economic dependence resulting from the division of labour inform their sexual practices. Moreover, I look at the interaction of the social structures, namely gendered division of labour, power relations, and emotional attachment, with the women's social norms and personal values and beliefs. I argue that an understanding of the interdependence of these factors contributes to an understanding of the construction of male superiority and legitimization of masculine hegemony in the women's lives. The effect of immigration on the women's lives is also examined.

Based on the results of this study, it is clear that the women's households are constituted by a division of labour that defines the work of women as domestic, and unpaid, and the work of men as public and paid. The gendered division of labour reflects ideas about a "woman's place." But who defines this? The division of labour in the families in this study is partly a consequence of the husbands' power to define their wives' situation.
The gendered division of labour contains the following subthemes: job discrimination, lower-paying jobs, economic dependence and economic hardship, and care-giving/childcare roles.

### 6.1 Job Discrimination

Eight of the participants worked in unskilled jobs when they first arrived in Canada regardless of their education or employment history. Others lived on government assistance because their refugee status did not allow them to work. Several women reported experiencing discrimination when seeking employment.

One woman, Doyel, spoke in general terms about the difficulties she experienced seeking employment:

> Yeah, because you're a person of colour. It was not very easy. Nothing was easy, even back then. So yeah … But you could ask for jobs, I mean nobody would … It's the same. I know it sounds … I've grown now. I'm much braver than before. When I first came, I was timid and I was a different person than I am now. And now when I would ask for help and I would ask for things, before it was hard.

Other women, such as Deepa, were more descriptive in their recollections of what it was like to seek employment as a new Canadian. Deepa specifically mentioned that speaking English with an accent was characterized by the dominant group as an indication of inferior intelligence or ability. In addition, a lack of Canadian work experience, possession of qualifications from other countries, and being a woman of colour in a white-dominated society were mentioned as factors that affected her seeking employment:

> There is a lot of issues combining together that women of colour doesn't… They feel stigmatized, they feel discriminated, they feel language is a barrier because people think that, oh you don't speak the proper
English. If they hear you with an accent, it's a problem. "You're stupid, you're dumb," like you know sometimes, you get this [reaction] like, "You live here, why don't you speak English?" Like you know, but that's not the point. We don't speak English, but in our language we understand things differently, right?

Other forms of discrimination included a lack of recognition of the women's education and training from their country of origin. Deepa added:

And then that's another issue. There it's like society itself. Like society makes it difficult for a woman of colour, too. Because if you go and apply for a job, it's like you live here for three years? You don't have the qualifications, you don't have the experience, she doesn't…Like all these issues, they find. Like I'm a woman of colour, if somebody white Canadian-born applies for this job, maybe they wouldn't have the certificate I have or whatever. But I don't have the experience and whatever, but they have the certificate. It's like okay, they give it to that person. So like all these things, we have to live on a day-to-day basis.

Chandra reported that she had held a responsible position in her home country but had difficulty securing employment upon arrival in Canada. She said that when she applied for jobs in Canada, her training and/or education, earned in her country of origin, were not recognized or valued. She stated:

I did work [in Africa]. I worked in a school as an administrative assistant and from there I upgraded myself and then went back to a motoring firm, like it's a company that sells cars and all and I became a secretary to the branch manager. With our certificates there, you, you're looked as high, but here it's like it's nothing. So I became a secretary to the branch manager back in [Africa] before my marriage. When I got married, then I decided to join my husband here … I tried looking for a job. It was hard here in Canada because they tell you, you don't have the Canadian
experience. … But I didn't lose hope. I went through agencies and I worked through agencies here and there, but then after that I had to stop because I was pregnant.

The discrimination that these women faced prevented them for gaining meaningful employment and more control over their lives.

6.2 Lower-Paying Jobs

In general the immigrant women in this study suffered from limited earning opportunities. Two of them earned no money at all. The remaining 10 were either dependent on disability pensions, or working in unskilled, low-paid jobs. As a result, the women were unable to accumulate enough wealth to give them real choices in life.

Upon her arrival in Canada, Doyel worked at a fast food chain and also took some courses to further her education. She reported: "I worked, studied and worked. I worked cashier's job, things like that." For her first 8 years in Canada, Nandita worked in the same factory as her husband: "Just machine work. Machine operator in a make-up company."

The dual role of having to maintain a wage-earning job while taking care of a household, and in most cases children, was heavy burden for the participants. The multiple disadvantages some of the women faced and the dual role of taking care of the family and working outside the home they had to fulfill while trying to adapt to new surroundings did not give them power in their marital relationships.

Along with lower paying jobs, many of the women mentioned having to work specific shifts in order to accommodate childcare arrangements. For example, in Doyel's case, her husband helped out with childcare while she went to work: "He helped look after the kids, he also worked back then. [He] had a 12-hour shift where you get so many days off, 4 or 5 days off." While Doyel's situation was typical in that she had to schedule work
around her childcare arrangements, it was not typical in that her husband took on some of that responsibility. Doyel added that her husband helped out with child care simply to save on child care costs. Besides, her in-laws stayed with them for weeks at a time and helped out with child care, which made it easier on her husband to look after their daughter. For Doyel, however, having her in-laws was an extra caregiving responsibility and a burden since they did not speak any English and often she had to look after their daily needs such as grocery shopping, transportation, etc. For most of the participants childcare was the wife’s responsibility alone.

As articulated by Wharton (2005), immigration can result in unplanned reactive and incremental social change which often affects social identity of individuals and institutions of marriage and the family. Immigration can be viewed as determining the low-paying work most of the women carried out in Canada, which also contributed to keeping them subservient in their marriages.

In spite of the fact that all 12 of the participants had finished high school, and 6 had completed college or other training after high school, factory work and jobs in the service industry were common for them. With the exception of two of the women, who were able to obtain further training in Canada, the participants remained in low-paying work until they were too ill to be employed, at which time they needed government assistance to survive. Even though 4 of the women were able to improve their employment situations, the changes were minimal for most, due, in part, to the fact that they were immigrant women of colour in a society in which the majority were white.

Three of the participants, Chandra, Juhi, and Anandi, reported working in AIDS Service Organizations (ASOs) since becoming HIV positive. In spite of these three women being oppressed as women of colour, they managed to thrive in Canada. Chandra reported that she began to work at the ASO as a volunteer and eventually secured paid employment with them. At the time of the interview she had worked there for many years.

Yeah, yeah when I started volunteering [with the ASO] they were sharing a space with [two other ASOs], so it was three organizations together. And
they gave me a job there. I got a full-time job and I'm with them for fifteen years now.

Anandi also eventually became employed by an ASO in Canada, though it was a lengthy and painful process for her to arrive there. When Anandi returned to Canada as a single mother with her two children, one of whom was HIV positive, she had a glimpse of hope despite a sense of being uprooted and alone. Although her life was easier at home economically, she believed Canada had better health care and that HIV carried less of a stigma here than in South East Asia, which she wanted for her son. She arrived on a visitor visa with her two Canadian-born children, and was unaware of her rights as a new immigrant and believed working illegally was her only choice. In spite of her training and education, Anandi began cleaning houses and was eventually able to earn a living for herself and children this way:

Yeah, when I came, I was looking for work and I didn't have work for me. I was illegal. I mean I had my visa and everything but I didn't know how good it was. I went crazy to work under the table and everything. So finally I decided to let go of the ego and everything and I did house cleaning.

Shortly after her return to Canada, Anandi became ill with an opportunistic infection. She eventually applied to remain in Canada on compassionate grounds, but had to wait 7 years without health coverage and suffering periodic illnesses before her application was granted. During this time she was helped by ASO support workers. This inspired her to get involved with an ASO to help others, especially other HIV-positive immigrants without health coverage or government support. While serving on the board of an ASO, Anandi received an award for her volunteer work. Ultimately Anandi obtained a full-time job working as a personal support worker herself for HIV-positive immigrants to Canada. Anandi went from being an isolated, single mother forced to do domestic labour under the table, to an AIDS support worker employed full-time with benefits with a new live-in intimate partner:
I received an award for my best work that I did, yeah, in the community. And that is why they knew I was capable of doing my job, so they said I got a lot of experience being a PHA and the challenges which I've seen.

Most of the participants reported working in lower-paying positions upon arriving in Canada. They worked in factories, the service industry, and a couple of the women worked in clerical positions. Two women were able to go on to find better jobs by continuing their education in Canada and obtaining Canadian credentials. Three of the women took another route. They reported an improvement in their situation as a result of obtaining employment in ASOs following their HIV positive diagnoses. However, this did not result in any significant rise in their socioeconomic status.

6.3 Economic Hardship

All of the participants spoke about economic hardships. Five were living on a fixed income due to their poor physical health, others worked in low-paying jobs, and 3 were raising children without a partner. This was a dominant theme throughout the interviews.

Several of the women mentioned struggling to earn adequate money when they initially arrived in Canada because of having refugee status or no Canadian status at all. Anandi had this to say:

I had to support my children. Yeah, so I started out with a lady and she said she'll pay $10 [per hour] and she had a huge house. And so from there, she introduced me to her cousins, her relations and I had five houses in a week. So I made about a hundred dollars a day, so a week $500.00. At least I could pay the rent.

Haifa spoke about the struggles of being ill with HIV and not being able to work while raising a child alone:

It's only now that I'm alone it's really hard because you have to pay the rent and get the kid stuff. Most of the time, whatever I get at this moment,
I pay my rent and my bills and I'm done. I don't have extra money. I have to access food from the food bank or sometimes the dad brings the food or that stuff. Like if he's around in the area, then we'll get but if he's not in the area then we don't get anything.

Several of the women reported receiving assistance from government workers to find appropriate resources. Anandi described a good experience she had:

I had a good worker at that place [Ontario Works], and he was very sympathetic. Oh my God, and he showed me every loophole that you could make money out of. So that's the way I started to learn how. Ontario Works they don't tell you where you can get this. So through him I learned other ways you can make money. He knew that I was HIV positive so he said apply for Ontario Disability Support Program (ODSP) so immediately he got me the form to take it to the doctor, get them to sign and you can get extra money for your son. So I went through that process and everything so, it was really very hard, it was not easy life, but then we managed it.

Some women reported having been affluent in their home countries and families of origin, which made a sharp contrast to their life in Canada, characterized by poverty and economic hardships, where they had to work both outside and inside the home. For example, Anandi, as a member of the Brahman caste, was economically privileged. She indicated this when she spoke about her honeymoon, just prior to coming to Canada with her new husband:

Then a month later we left to Germany to go on the honeymoon. It was a nice wedding and everything was grand and we went for honeymoon to Germany for two months. … That's when we came to Canada and we claimed refugee status at the time.

Because she and her husband came to Canada as refugees, they were forced to live on a fixed government benefit until they received permission to seek employment.
Similarly, Minu reported that she came from a middle class family in India and was not expected to work at all. She did not enjoy school, though she did complete high school. Following high school, Minu attended art classes. She lived with her family of origin until her marriage at age 21.

Sutra, who lived in Africa with her husband for several years before coming to Canada, talked about what her life as a wife was like in Africa when she was first married and a new mother. She stated that in Canada, they could not live on one salary nor could they afford home or childcare services. Sutra described the differences between life in Africa and life in Canada:

> Yeah, there it's different. Here we cannot afford the help [chuckling]. But there, thank God, I had two people working for me in the house. One person only taking care of the kids and another one was taking care of the house, cleaning and cooking and everything. Yeah, so when I get home from work, I only taking care of my kids and sit down with them, helping them with the homework, and stuff like that. Yeah it was totally different … Here is very hard. Here is like you have to be sharing, both of you. You know, otherwise, one person cannot handle everything.

6.4 Economic Dependence

While discussing the control of finances in her marriage, Deepa contrasted living in India with her life in Canada. In India she felt more financial control in the marriage because there the family could meet many of its basic needs without depending on the free market economy:

> Here you have to have x amount of money for rent every month and you know, food and everything. Back home, you plant your garden and you have fresh vegetables and you know, all this kind of stuff, you might own a chicken. You know it's, it's totally different. Here you have to buy everything. … money, everything, so. I used to have my own money.
When Anjali was married, she left Canada for her husband's country of origin in Africa. Anjali had earned an undergraduate degree and held a government job in Canada, but she was unable to use these strengths after her marriage as her husband was both wealthy and controlling. In Africa she had limited control over her own life.

The interdependence of the division of labour and power relations are clearly illustrated in the women's narratives. The economic hardships faced by most of the women translated into economic dependence on their partners, which increased men's control over finances, ultimately increasing their power in the marriage. Most of the women in the study reported limited economic control in their lives. Men were charged with making decisions about the large expenditures such as a house, car, or major appliance, whereas women, as the subordinate party, had authority over menial purchases such as groceries or children's items.

Chandra talked about sharing incomes, even though the family was just surviving on the income that she and her husband earned. This is how she described her situation for the first several years she lived in Canada:

Whatever I was making it's what we were, I mean we shared rent and food and everything. There's nothing much you can do because you don't earn much anyway, so we were surviving. So it was just to keep us going.

Doyel still felt the economic control exercised by her husband, despite his sharing of daily chores including housework and childcare. Doyel was in charge of purchasing small items such as groceries and things for the children:

So if I want anything I'll buy it. But of course he's the one who looked after major stuff. He bought, he bought a house. He bought a car, you know, I'm not the one. I'm not gonna go out and buy. I never drove in those days and so I didn't go out and buy a car. I didn't go out and buy fridge and washing machine and stuff like that. He's the one who would be doing those things. He's the one who paid the bills. Me, I'm the one who
buys food, you know, go to the laundry store and those, the lingerie store, [chuckling] go to the baby store, you know, those are the things I did.

Immigration also plays a role in maintaining the imbalance of economic power that reinforces the subordinate social location of women. All of these factors play a role in vulnerability to HIV infection as the wife's economic survival is tied to her dependence on her husband. Deepa described her experience as a new immigrant in Canada as follows:

I was working, I had money but I didn't have too much. It was difficult because it's a new life, it's a new culture, it's a new country, you know everything from the life that you knew and the life that you had, it's totally different. You know, like back home you never used to pay rent, like you know you just work and you pay your bills and that's it.

Minu, whose husband sat in on the whole interview, talked about having access to the safe that contained the money. Taking care of the key to the safe was part of her household duties. When asked what she could buy, Minu recounted personal items and groceries for the home. She did not mention the purchase of larger items because her husband was in charge of that. Some women constructed their husbands' economic control as an act of looking after or nurturance of her as his wife. Anjali simply said: "In terms of money, he took care of me."

Even though most of the women spoke about having some control over money, especially while working and living in Canada, and a few reported some equality in their marriages, the reality can be seen to be otherwise. For a few of the women, there was a perception of some changes in the gendered division of labour; the role of local agency can be seen as some of the women worked at changing their partners' behaviour in the domestic sphere. Despite the fact that some of the women's husbands shared their incomes and helped with household chores and childcare, they never compromised their economic control over the women. Power relations supported by strongly adhered to social norms that value the role
of the woman in the home, remain the structure most resistant to change and the most influential in sustaining the legitimacy of male power.

The women were conditioned to accept economic inequities in marriage through cultural and traditional norms: taking care of the family was deemed to be a more important responsibility than earning money for the family for women. The economic dependence on their partners that resulted left them without the resources or power necessary to negotiate safer sex practices, thus their vulnerability to HIV infection was increased.

6.5 Care-Giving and Childcare Responsibilities

Given a lack of training or of job-related skills, the sexual division of labour in the workplace is a powerful system of social constraint. This can be true for immigrant women regardless of the skills and training they bring to their new country because of the difficulty in getting these recognized. Equally important, is the sexual division of labour in the home, notably with respect to housework and care giving, including childcare. The consistency with which divisions of labour and differences of income operate lead to the allocation of childcare to women. The norms or sexual division of labour underlying this has strong support in many cultures, including the South Asian culture. Most of the women in this study were responsible for childcare and other care-giving responsibilities for much of their lives. According to Wharton (2005), "gender inequality is reproduced through the processes of institutionalization and legitimization. As gender inequality becomes institutionalized, it is built into social structures and the everyday routines that sustain them" (p. 225).

Childcare and other care-giving duties were basic to the division of labour in the women's families. Since their husbands were in control of the division of labour in the family, they made the decision whether or not to help with childcare, reflecting their dominance and power. Many refused to participate in childcare, reflecting the social norm that this is women's work, and thus of lesser value.
The effect of immigration on the social structures of gendered division of labour, male power, and emotional attachment is clear in this study. Through my conversations with the women, I was able to closely examine the role immigration played in sustaining the patriarchal authority in these families. Many of the women worked in low-paying and menial jobs in addition to their domestic and childcare responsibilities, but the income they brought into the family did not compromise their husbands' domestic authority. Because of the women's emotional reliance on men, their investment in their role as mothers and care givers, and their adherence to social norms that value motherhood and reinforce their role in the domestic sphere, whether they worked or not, traditional roles were maintained in their homes. Women's work was characterized by periods of irregular employment and tended to be part-time to accommodate child birth and child rearing. That the women took responsibility for the children and/or the home allowed the men to focus on work outside the home, which increased their earning potential and gave them more power inside the home.

Sutra spoke about the common practice among immigrants in Canada to not only care for their children, but to also support family members in their country of origin. Sutra believed that this was an important social obligation she needed to fulfill, even though she was one of five siblings. This responsibility placed additional financial burdens on women who are already burdened by work outside as well as inside the home. Sutra talked about the obligation she felt to support her parents:

[My parents] are very important to me. Yeah, like right now, even if we have a family of five kids; I still take care of my family, because my dad is retired. He's not earning anything now, and my mom, like I said, she never worked. So I feel like I'm responsible for them too, so I do take care of them, you know. They, I feel like they're a part of me. You know, it's my responsibility for me to take care of them, as they did for me when I was a kid.
A couple of respondents mentioned the fact that they were living with in-laws. Often, as in Noor's case, the in-laws assisted with childcare. However, according to Noor, it is not uncommon for women to have to look after aging in-laws as well as their children:

Yeah, she [mother-in-law] is cook and she is look after my daughter.
Before she is live with me and now she is ah lives with my brother-in-law.
Well mostly men earn, earn money and women stay at home. Women look after in-laws as well.

Nine of the women who were interviewed had children and that affected the division of labour in their households. Several women talked about the burden of juggling work and child care duties. Childbearing, care of young children, and, for some, care of members of the extended family, were mostly done by the participants themselves. This had a particular prominence in the domestic division of labour since it represented a big chunk of the women's daily domestic duties.

6.6 Summary

The gendered division of labour was experienced by the women in the study in a number of different ways, both inside and outside of the home. Participants reported experiences of discrimination when applying for jobs because they were women of colour in a white-dominated society. The perception that they lacked education or training and their lack of Canadian experience resulted in them only being able to get lower-paying jobs. The economic hardships resulting from immigration and a lack of opportunity resulted in economic dependence on men. The social structures of the sexual division of labour, emotional attachment, and male power in the context of their own beliefs and assumptions and the norms of their cultural communities led them to assume the majority of the responsibility for care giving and the home.

All of the women in this study were faced with discrimination, assumed care-giving roles, had lower paying jobs and as a result suffered from economic dependence on their
husbands and overall economic hardships. That, in turn, negatively affected their ability to negotiate safe sex practices, which increased their risk for HIV.
Chapter 7
Theme 4 – Social Norms

This chapter discusses the fourth and final theme in this study: social norms. The three interdependent but distinct social structures discussed so far in the study interacted with the women's individual attitudes and the social norms they adhered to, and thus influenced their sexual practices. The interactions of the social structures and individual attitudes with the fourth and final theme in the study, namely social norms, are discussed in detail in this chapter.

Connell used the terms culture to represent the totality of social norms. According to Connell (1995), culture is communicated through norms and related behaviours, which are defined by:

Individual perceptions about the generally held attitudes of others in the system. Individuals derive beliefs about what is valued within the social system by their perceptions of attitudes generally held by others, especially when they need to negotiate norms and behaviours with others in public. (p. 33)

Social norms do not form an individual's attitudes, but they impact them and are impacted by them.

Patriarchal practices or male dominance are sometimes justified by evoking notions of culture as a way to legitimize or understand them. This may lead to increased women's vulnerability to HIV. The link between patriarchy and culture is constantly being created through practices, some of which I make reference to in my thesis. As such, it corresponds with my overall contention regarding the need to focus on practice for HIV research and interventions. To not do so, I would run the risk of imposing and reinforcing a stereotypical or 'Orientalist' perspective which is constructed by the West as a way to 'other' non-white people and their life experiences, thus leaving themselves and their own cultures unexamined. Women in the study reported on social norms within their communities that resulted in related emergent subthemes which are: prohibition on the
Discussion of sexuality, modesty and restrained sexuality, family honour and shame, keeping religious practices, and strong attachment to community.

7.1 Prohibition on the Discussion of Sexuality

Discussion of sexuality either between husband and wife or parent and child was considered taboo, which made it next to impossible for women to negotiate safer sex practices with their husbands, thus placing them at increased risk for HIV. Most participants reported that neither in their families of origin, nor in their own families, did parents and children ever discuss sexually transmitted disease or any other aspects of sexuality. The role of the interdependence of social norms and the social structures of power relations and emotional attachment in explaining what is legitimizing and sustaining male power in the lives of these women is evident. Because sexuality is a taboo topic, there is no acknowledgment of women's sexuality and their roles, rights, and responsibilities in relationships, which reinforces the dominant position of men. Women are not provided the social avenues within which to educate themselves or their children about sexual risks.

Male power starts with fathers forbidding their daughters to be involved in premarital sex before marriage, and continues with husbands establishing their own rights to have sex outside the marriage while forbidding this to their wives. Husbands can be unfaithful without being accountable for the negative consequences to their wives or families such as the transmission of STIs. Further, the exclusion of women, their emotional attachments to their husbands, and their desire for trust in the relationship have promoted submissiveness or silence about condom use with their husbands even when the women knew their partners had engaged in sexual relations outside the marriage. Placing the husbands' sociosexual needs above their wives' right to live without disease has indeed reinforced their real risk for HIV infection. Most of the women (8 out of the 10 who were able to identify the source of their infection) in this study were indeed infected with HIV by their regular sexual partners or husbands.
Most of the participants stated that there was an absence of dialogue about sexuality in their families of origin. Anjali reported that this lack of discussion was consistent with her identity in her family of origin. Because sex and dating were not allowed, there was no need to discuss these issues with children.

As part of my identity in family, sex was never discussed, condoms were never discussed. … Sex was not allowed until after marriage. Boyfriends were not allowed before marriage.

Another woman, Haifa, reported that her mother did not talk to her about sexuality, including the risk of pregnancy, while she was growing up:

My mom has never come out to me. My mom has never sat down with me. My mom has never talked to me. Nobody ever told us. Even today ... even when you get your period, nobody tells you that, oh, you know, you're more likely to get pregnant or something. Nobody ever would come and sit down and talk to you about those things. Nobody has done this.

Deepa, who was born in India and married at age sixteen, explained that she grew up in rural India. She stated that there was no mention of HIV while she was growing up. She wondered whether she would have been more aware of HIV if she had been raised in the city. As it was, she had never even heard of the disease until she came to Canada with her husband:

I grew up in the countryside, like I was born in the city and then I grew up in the country so. And these are topics not discussed like maybe if you go in the city, like you will hear more, you see more billboards or you see more information or you see blah, blah, blah but in your country like, you don't have this information.

Both Minu and her husband, who also participated in the interview, agreed that sex was not discussed with children in their culture. Minu said:
Basically they [parents] don't want to talk about sex. Okay … In India, never talk. Never, okay … it's like you know what they are talking about. It's sick, it's not good. It's not good to talk to your kids, okay.

Not only was there an absence of dialogue about this topic, it was looked down upon to engage in this behaviour. They both mentioned repeatedly that the lack of open dialogue was a major barrier to education and changes in behaviour with respect to HIV in the South Asian community.

When asked whether sexuality was discussed in her household, Shreya responded: I don't have a daughter so I don't know, but I'm sure if they are Indians, they are not going to talk to their daughter about that."

Anandi, who speaks in public, including at schools, about how she was infected with HIV, relayed that when she asked South Asian children whether or not they had talks of this nature with parents, they always told her that this was forbidden: "No, you cannot talk about this topic at home. I even asked that at the school. Do you ever talk about HIV at home, or even sex?"

Most of the women described sexuality as a taboo subject for children, and for females in particular, both while growing up and as married women. Some of the women had never even heard of HIV prior to their infection, and would never have thought that their husbands would engage in any behaviour that would put them at risk. Most participants, therefore, confirmed that there is a real lack of discussion about sexuality in South Asian families. The women's subordination to the men in their lives, father then husband, is evident in the lack of communication about sexuality. These factors contributed to the women's vulnerability to being infected with HIV by their husbands as they were not equipped to look out for themselves.
7.2 Modesty and Restrained Sexuality

Most of the participants agreed that gendered sexual conventions, compulsory virginity and modesty and restrained sexuality for women were crucial to the establishment of their social norms. Foisting social order in and through social norms takes lots of effort. To see how this was accomplished, I look at how and why the women conformed to the ideals of purity, modesty, and obedience.

Imposing a patriarchal order requires the mobilization of resources, the expenditure of energy, and, sometimes, the use of direct or indirect force. However, once such an order is established it must be maintained. The role of social norms in legitimizing male power is extremely important. Many women internalize their own oppression by learning to conform to the established norms. Anjali, who came to Canada as a young adolescent, described her daily life growing up as socially contained and governed by a prohibition on contact with the opposite sex. In fact, she said she was allowed very little social contact with her schoolmates in Canada. Anjali spent her time helping her mother in the home, not playing with schoolmates or neighbourhood children: "I was just always home. … It wasn't an issue at the time [and] I just accepted it."

In Chandra's family of origin, her father and her brothers played an active role in enforcing standards of female modesty:

Like maybe if my dad heard anything about my brother having a girlfriend or anything, he would just grin like this and he won't say anything. You know ... my brother, one day he found me walking with my boyfriend, who was my husband after that. You know just we were walking, he was escorting me from school to go home and [my brother] warned me first time and second time he saw me and when I got home, he slapped me on my face! Yeah, it's not allowed, really. And he said, "What will people say about you, you know, you're walking with a man in the street!"
Religious institutions also played an instrumental role in legitimizing and enforcing these social norms. The parties, including the women themselves, who enforce the social norms governing women's behaviour do not necessarily reap the benefits of the social order they support. They are, rather, participants who adhere to shared social norms by which the power of men and subordination of women is sustained. Along with most of the other women in the study, Doyel reported that she was taught that having sex before marriage, particularly for girls, was strictly forbidden in both Muslim and Christian doctrine.

You would not do, [have sex before marriage] and its actually haram [meaning sinful] Even in the Christian faith, it's bad. … if you happen to have a boyfriend, it's really behind everyone knowing; it's a sneaky thing. You sneak in the back of the school or the back of the church or in the back of the mosque or something. … I think it was no for boys too, but I guess it's more definitely no for girls. So yeah, I would say it’s not really a good thing.

Chandra sees both her religion and her culture as requiring female modesty and restrained sexuality. In Islamic teachings, female modesty is valued and premarital sex is strictly forbidden. She expressed a desire to teach these norms and values to her own daughter. In spite of her belief that it is more difficult to sustain these values while living in Canada, she said would attempt to do so because she strongly believes in passing on her childhood values to her daughter:

It was against, it was against dating. I mean no family would want to know that their child is dating a boy and all because you are brought up being told that when you get married you have to be a virgin, so that's a cultural thing which we really respect, and I would really want my daughter to still keep it. And I'm trying hard, but bringing up a child in Canada, it's hard.

Yeah, but it's a cultural thing which I would love to. It's in Islam and a cultural, so.
As has been mentioned, individual beliefs are not always consistent with social norms. Four of the women in the study contested male power by resisting their upbringing that dictated a form of asexuality for females, except for procreation with their husbands. The women wanted to "experiment" in what seemed at the time to be a safe venue. But they contested male power secretly for fear of the severe repercussions that may have resulted if they had opposed a socially sanctioned norm such as female virginity in public. Social norms remain the most important factor in legitimizing male power and keeping order in the lives of the women.

Many accounts of patriarchy give the impression that it is a simple, orderly structure. However, the women's stories show that behind the facade is a mass of disorder and anomaly. As illustrated by the women's narratives, the perceived ideal of purity, modesty, and obedience may never have existed in the lives of these women.

Anandi, Juhi, and Anjali engaged in premarital sex with their boyfriends who they later married. Haifa also engaged in premarital sex, but with a boyfriend to whom she was never married. Haifa and Anjali both dated and had sex with a man following the demise of their marriages. Haifa described having a clandestine premarital sexual relationship with a boy when she was 15 or 16 years old: "Yeah, we dated, yeah. Mm, no, I can't remember how many years. Maybe 3, 4 years." When asked whether she used condoms while having sex, Haifa responded, "Oh, we don't use that."

Anjali, who described her upbringing as "very traditional" even though she grew up in Canada, reported that when she was much older and in university, she indulged in sexual activities, which she kept secret from everyone in her family. The man involved eventually became her husband:

Until university came, a little bit of experimentation and that was hidden. It was never, even in university, it was hidden. It was never brought up and I, I, I did have sex before marriage, but they didn't know it.
She later contracted HIV through unprotected sex with a casual partner after separating from her husband.

I came back in ’89 and in ’89 when I came back I was very depressed cause I was freshly married and freshly separated and divorced. … I met this guy that I got infected from and I had an affair with [name of sexual partner]. He was positive and didn't tell me. I didn't know about condoms cause I still had my IUD.

The interaction of norms with the women's individual practices and the social structures of power relations and emotional relations is clearly illustrated here. A socially and religiously sanctioned norm of modesty for girls, in particular, premarital sex was forbidden, is inconsistent with discussion of condom use and protection from HIV.

Most of the women in the study reported that male authority figures (fathers, brothers, and husbands) enforced the sexual rules and norms for females, and in particular the requirement that a woman remain a virgin until marriage. Growing up, the participants were explicitly prevented from dating boys, some with the threat of violence, others with the knowledge that the repercussions of violating the cultural and/or religious norms around female sexuality would be severe.

Power relations, as exemplified by the power imbalance in marriage, reinforce the psychosocial dynamic of male superiority and female submission. This, in turn, allows the men to determine and reinforce behavioural norms, including sexual norms. Because the women were emotionally and economically dependent on their husbands, and most of them were subjected to ongoing emotional or psychological abuse in their marriages, they were not in a position to require that their husbands use condoms, even if they knew that their husbands were engaging in sex outside the marriage. Further, regardless of their lot in life, whether it was domestic violence or HIV infection, the women, encouraged by their religious beliefs, accepted this as their fate and did not protest in either word or deed. The stigma attached to divorce in their cultural community reinforced their lack of power.
In spite of powerful social and religious dictates, a small number of participants reported contesting male power. These incidents involved going against the narrowly prescribed sexual norms for women, including compulsory virginity before marriage, no dating or contact with the opposite sex prior to marriage, and no un-chaperoned contact with other men while married. Most women reported that they submitted to the norms governing female behaviour and sexuality. They also expressed their acceptance of male sexual norms, such as being allowed to date and have both premarital and extramarital sexual relationships. This acceptance coupled with the women's lack of freedom and lack of information about sexual health contributed to their inability to protect themselves from HIV infection.

### 7.3 Family Honour and Shame

Valuing family honour and condemning those who bring shame to their families were social norms to which the women in this study strongly adhered. For some families, male figures, such as fathers and brothers, were responsible for maintaining the family honour. Sutra gave this example of the lengths to which a father might go to protect his family's honour:

> Of course, yeah, yeah. I remember one day, my dad, one of my cousins, who got pregnant out of marriage, and he came to me and he was like, "If you do that, I'm gonna kill you!" you know, and he was really serious. And every time, he was always talking to me about that, you don't bring shame in the family, so it was really conservative.

Many women spoke about the importance of family unity in both their families of origin, and their own families. This was most often expressed within the context of discussion of marital infidelity. The women reported norms that dictated that a woman stay with her husband even if he brought STIs, including HIV, home. Most of the women did not leave their partners; instead several were left by their partners upon discovery of their HIV-
positive status. Many of them reported that divorce would bring shame upon their families therefore it was a step that the women avoided and/or did not take easily.

With strongly endorsed norms that value family honour and condemn those who bring shame to their families, most of the women stayed in their marriages. The women's words exemplify the rather complex interactions that legitimize male power. Even though individual attitudes are not always consistent with social norms, the women still, for the most part, lived according to the norms of their cultural community. Staying in their marriages, in some cases in spite of warning signs, and bowing to social norms and male power increased the susceptibility of the women to HIV infection.

In response to a question about whether women get involved in extramarital relationships, Deepa said that she did not believe that they did. She went on to explain that many men do because they are men; therefore it was normative for them to engage in this behaviour. Further, she reported that even women who know their husbands are involved in extramarital sexual behaviour or who are being abused in their marriages, do not leave their husbands. Deepa said that a woman would experience extreme social disgrace and personal stigma if she ended her marriage under any circumstances.

It can be an abusive relationship. If your husband is abusing you, you still have to be in that marriage because it's a shame. It's a disgrace actually to be divorced or to be a single mother or to be a woman that has been married and left her husband. People see you as … Something is wrong with you. They see you as something bad, right? You don't exist anymore.

Chandra reported that although she believed that her husband infected her with HIV after being infected himself through having sex outside the marriage, she remained in the marriage because this is what she was taught to do. Even though Chandra took her daughter and went to stay with her parents for 2 1/2 years, she eventually returned to her husband:
See, I loved him so much. Like us when you please parents and we all have to … Like once you get married, you know that this is the only man for you and all. I felt that he's my life, you know? … because I don't want a bring shame in my family back home that I divorced and all.

One participant, Sutra, illustrated the importance of extended family in the maintenance of her marriage, which was, at times, abusive, largely due to her husband having sexual relations outside the marriage. Instead of ending the marriage and bringing shame upon the family, her parents were called in to deal with the conflict in order to maintain the relationship.

Even though some of things which I didn't know he was doing behind my back. Like every family is like that, some of the family. But sometimes when things get rough, we sit down and talk or maybe sometimes we get, we fight. And then the parents, like we involve parents. We sit down and you know. It happened a couple times, we fought and then after that we get together, you know it's like a normal married life.

Haifa, who was infected with HIV by her husband, reported that he was also the one who initiated the separation. She stated that even though she has a daughter from another relationship, she has not, nor would she ever disclose the separation to her own parents. She explained that she kept her situation from them in order to protect them from the social stigma related to divorce. She also described the experiences of other women she knew who would not leave a marriage even if their husbands were abusive or unfaithful to them. She said women were too scared to go against their values and, thus, had to forego their individual happiness in order to please their families:

I think with South Asian women, they're scared to do it. If they have the background, like what their parents gonna say back home or what is someone gonna mention in their families … They might just be afraid; oh, my mom might get upset or my parents might get upset or something or
people back home. Nothing to do with here, but something to do with back home or their family. So they might just keep quiet or ignore it.

Immigration also plays a part here. It is clear because these immigrant women in Canada were without the support of their families, their husbands could cheat on them freely, knowing that the consequences will be minimal. It is less obvious, but also important, that the behaviours of the men who hold the power in these women's lives can be constrained as well. The women's husbands and partners are empowered in their relationships with the women, but the patriarchal order also puts women under the protection of their fathers and brothers. Some of the women indicated that their husbands would not have been able to engage in adultery without reprisal if their fathers or brothers knew about it. Chandra said:

Maybe if my parents were here and they knew what he was doing, yeah I would have insisted, yes, you know … Maybe I would have, yeah. I've already entered back Canada and I know I have all the support in the country, of course I would have done that.

Although 9 out of the 12 women stayed with or would have stayed with their husbands (in several cases the husbands left them), Juhi, Anandi, and Anjali left their husbands of their own volition. The decision for the women to leave their husbands was clearly a difficult one. The interesting question is, "why?" According to Connell (1995), there are two primary means by which dominant groups maintain their hegemonic power over subordinate groups: the threat or actual exercise of force, and control over ideology and what counts as "legitimate" discourse. Of these two mechanisms, control over discourse and ideology are often preferred. Moreover,

hegemony is likely to be established only if there is some correspondence between cultural ideal and institutional power, collective if not individual. Further, it is the successful claim to authority, more than direct violence, that is the mark of hegemony. (Connell, 1995, p. 77)

Juhi, Anandi and Anjali talked about their husbands' involvement in several extramarital affairs and the ongoing emotional and psychological abuse that they were subjected to by
their husbands. As gender inequality is reproduced through the processes of institutionalization and legitimization, it is built into the social structures of power relations, emotional attachment, and the gendered division of labour via the everyday routines that sustain them. However, crisis tendencies can develop in the social structures of gender relations (Wharton, 2005). While the presence of abuse in the lives of these women helped to sustain the legitimacy of power relations for a time, it also challenged it. As previously noted, abuse suggests the failure of legitimacy. In the case of these women, the crisis tendency brought about by ongoing abuse and infidelity and the accompanying risk of being infected with STIs and HIV, resulted in cognitive dissonance that led these women to contest male power. The crisis led to individual beliefs that were no longer consistent with the strongly adhered to social norm of preserving family honour.

Also, these 3 women had contested hegemonic masculinity before. Anandi dated her husband-to-be in college and lost her virginity to him. She then challenged her parents by marrying him in spite of the fact that he was from a lower caste than hers. Juhi rebelled against her parents at age 17 and left her home in Canada to go to India to live on her own. There she met her boyfriend and had premarital sex with him before they were married. Anjali met her husband-to-be while at university where he was in Canada studying on a student visa. They became involved in a sexual relationship. She followed him to Africa to marry him at age 26.

Anandi spoke about feeling disgraced upon her return home from Canada with her children, following her husband's mistreatment of her as a new mother and immigrant. Her only option, it seemed, was to return to her family and country of origin in spite of the negative effect this would have on her family. As she said: "It was not an easy life when I went back because, being my parents, they said, 'you're the first to leave your husband and it's a disgrace to your family'."
7.4 Keeping Religious Practices

The respondents practiced a variety of religions including Hinduism, Islam, Sikhism and Christianity. The large majority reported having been raised in households where religion was a major part of life. All of the participants who continued to practice their religion were raised in homes that nurtured these behaviours while they were growing up. Religion was also an important consideration when choosing a marriage partner.

There were many commonalities in the women's accounts of the role of religion in their lives. Many of the women talked about religion being part of their daily life and about the importance of passing on religious practices and rituals to their children and other family members. Two of the women reported being raised in mixed religious homes and having relationships with men whose religions were different than their own as adults. Both, however, had talked with their husband about choosing one religion and raising their children accordingly.

A religious conception of fate played a large part in several of the women's lives. They said things such as it was their fate to stay in their marriage regardless of health risks or abuse. Specifically, the women mentioned religious fate as a reason for their acceptance of anything that came up in their lives, including their husbands' infidelity and being infected with HIV.

A couple of respondents also talked about religion as a source of comfort and said that it was key to their surviving suicidal thoughts and to their well-being as people living with HIV.

Shreya spoke about religion as part of her daily life and said that she passed on her religious practices to her son:

    Same thing, to pray every day in the morning and there's certain days we don't even eat meat, we're pure vegetarian. …There's certain days where there's no meat, no eggs, nothing.
Shreya also depicted her relationship with religion as crucial to her well-being and said that it was integrated with other aspects of her life. She illustrated this by describing daily private family rituals in her home and weekly attendance at temple. While at the temple, besides praying, she and her family participated in a social gathering at which food was contributed and shared with other members:

Yeah [religion] is very important. Upstairs I have like a small temple, so we do the prayers and then every Sunday we go to the temple because so many families, they do work. And Saturday is the day everybody wants to clean and cook and do laundry and stuff like that. So Sunday I believe everybody, they leave it for temple … [while there] Oh we pray … sometimes we stay half a day … we have people who cook downstairs and we donate food. You take rice, milk; you take everything. Then after the prayers are finished everybody goes down, eats food, and then you go home.

Noor, a Sikh woman who was infected with HIV by her husband, described the various ways she and her family observed their religion while living in Canada. At times they attended the gurdwara from two times per day, but more commonly they attended once a week, mainly on Sundays. As in Shreya's case, Noor confirmed that there was an important social component to her religious activities. These are Noor's words:

Yeah and we are going to gurdwara…. [we] go like two times a day; …Sometimes we mainly go on Sunday. They read the holy book and we can listen and they have lungar; lungar means they have something to eat.

Anandi spoke about the importance of religion in her life, however she also relayed that she viewed other religions as equally important. She didn't describe herself as adhering solely to Hindu dictates, but rather she recognized values shared across religions, such as not stealing, lying or perpetrating harm on another, as part of who she is. Anandi described herself as a proud Hindu who believes in the way she chooses:
I'm a Hindu and of course we do pray. I'm not a staunch Hindu; yes we go to temple….To me what I believe is God; all God is one God, it doesn't matter whether you're Hindu, Muslim or Christian. …I believe there is a creator and you don't do harm to anybody. You don't steal, you don't lie; that is my policy, and that is how I believe, even until today. Yes, I know I'm a Hindu, but I go to temple; I go to church, wherever. Yes, I do believe. But don't come and tell me Hindu is right. So I had arguments with my mom but I still don't let go. I'm proud to be a Hindu, but don't preach to me.

Deepa reported that all aspects of life in her culture are shaped and affected by religious beliefs: "Yeah, yes, this has a big part to do with it. … Cause our culture, our parents, our identity, you know, everything, it's around our religion, right?"

Doyel, who was raised in a family of two religions and was married to a man of another faith, confirmed that adopting her husband's religion, Christianity, and raising her children that way made it easier for the family in Canada, even though she continued to keep some Muslim practices herself:

Okay, okay, so it was easier to associate with Christianity, and even after my husband passed away, I stayed as a Christian … I still say my Muslim prayers … my kids, they are raised Catholic. He had baptized them.

Haifa was also married to a man of a different faith. When asked if he ever attended temple with her when they were together here in Canada, Haifa replied that he did not. However, Haifa reported that her attendance at temple began with her mother taking her and her siblings when they were children and she has continued the tradition by taking her daughter there. Further, she said that religion brought her inner contentment:

More like he never used to come, but I used to go and I still take my daughter … If you believe in something and you talk to God it seems, you never ask for anything so. My mother used to always take us, so it's a good
idea to take my daughter. It's helpful, it's peaceful; it calms your head down.

Many of the women specifically mentioned accepting one's fate in relation to being a South Asian woman who was married to a partner who was probably unfaithful and HIV positive. Even if a woman suspected her husband was unfaithful, she would not question him about his behaviour, nor would she question remaining in the marriage herself. Anjali stated: "But if it's a traditional couple, I don't think [she would leave]. Basically she just waits … She is waiting for her fate." Chandra spoke about fate when she discussed her returning to her husband after leaving Canada with her daughter for 2 1/2 years. She viewed this return, and her subsequent HIV infection, as something that was written for her and something that she could not have escaped because of her belief that she had to go through that experience as part of her life here.

When I went back [to Africa], you know, when you have a child, you see everybody there with their own fathers and mothers. When he used to call his daughter, I just felt that I am keeping her away from the father. And I gave him another chance. Maybe God has brought me back just to come and get infected. If [I] had been strong … maybe I would have been healthier. But I believed that it's meant for me to [become infected].

Chandra further reinforced her opinion that she was meant to have HIV:

Being a Muslim woman, having faith that this is what's written for me, I don't keep hard feelings; I say it's meant for me to [be infected]. I believe that if it didn't happen with him, it would have happened with another man.

When questioned about her thoughts and feelings about being infected with HIV by her husband, Shreya, a practicing Hindu, acted surprised at the question almost as if she had never given it any thought. Her response was brief, but indicated the role of religion in her life: "Ah, I don't know actually. [chuckling] Nobody usually asks me that question. I don't know. I guess I believe in God, yeah, so I'm not complaining."
When she was informed by a health agency that she may have been exposed to STIs or HIV, Anandi was told to discuss this possibility with her husband. Anandi ended up accepting her situation after being explicitly told by her husband that he was free to do whatever he wanted: "This is my fate; this is what I have to do." Anandi has since become well informed about HIV and has devoted her life to being an AIDS support worker for people who are immigrants like herself. But she wondered what her life would have been without HIV:

We Hindus believe that this is a Karma....So I don't know what I did in the past; it came back to me and I'm paying for it and God knows. And sometimes I tell myself if I didn't have this illness, would I be doing what I'm doing today? I'd be ignorant like the rest of them. And that is where I always go, yeah, that's what I always say.

Anjali spoke about religion as a powerful influence within her family of origin as well as her social network both in the past and at the time of the interview. Specifically, Anjali discussed her return to her religion and reported that it has brought her much contentment and comfort as an HIV-positive Muslim woman:

Religion is a very, huge part of, not only spirituality, but in terms of a social network as well. Religion plays a very large influence in our family; it always has and is still does until today. Personally, I abandoned religion for about 10 years after HIV and now I'm back with it and I find a major difference. I find it very comforting to have religion back in my life.

Sutra reported drawing on her religious beliefs about the afterlife. This gave her the strength and will to live with HIV in spite of wanting to take her own life. She stated that religion had been important to her for her entire life.

That's the only thing which made me alive until today because when I was first diagnosed, I almost wanted to kill myself. But because being Muslim, I was raised in a religious environment. I told myself, that if I do that, it's
not the end of my life. Even after I'm dead, then I'll get punishment, so it's better to get the punishment in this world, rather than there. You know that's why, so religion has played a big role in my life.

While religion clearly reinforced gendered roles within the marriages and families of origin of the women, thus legitimizing power, it also served other purposes in the lives of many of the women in the study. All women in the study purported they were raised with religion in their households, Hindu, Muslim, Sikh, or Christian. And although a couple of the women were raised in religiously mixed households, they currently adhere to one of the religions and are raising children in Canada in that faith.

One major role that religion played in the lives of the women was to reinforce a belief in fate. The women specifically mentioned that it was their fate to have unfaithful husbands and to contract HIV. In this way, too, religion reinforces masculine hegemony. Importantly, religion also helped the women to cope with the challenges in their marriages and to their health.

7.5 Strong Attachment to Community

According to Lieberman (1990), immigration can result in people feeling like outsiders as they move into unfamiliar territory with a new language and traditions. Often, immigration results in "a shattered sense of one's identity" (p. 104). Moreover, places devastated by war and turmoil and the ensuing by damage of educational establishments that have customarily "upheld their sense of personal dignity produce emigrant who experience a cultural quandary as well as a personal one" (p. 105).

Several of the women indicated that they experienced discrimination when they first arrived as immigrants to Canada, which resulted in them being isolated. This led them to look to their own cultural community for support. Community as defined by these women were others from their home or with similar background or ethnicity such as other South Asians or other members of their religious group. Many participants reported
psychosocial stressors specifically related to separation from their families of origin, as well a separation from partners in cases where partners immigrated to Canada separately.

Nandita had an arranged marriage in India, then immigrated to Canada with her sister. Following a period of separation from her husband, she sponsored him to come to Canada to join her.

Haifa spoke about the stressors related to both discrimination and separation from her family of origin. She described the decision to leave her home to come to Canada as a difficult one in spite of the threat of violence towards herself and her family from her country's government. In addition, she described the disbelief of some people she met here in the circumstances that led to her claiming refugee status in Canada. These incidents left her feeling isolated from her family as well as her cultural community in Canada:

Oh, it was the hardest decision to come. It was a very hard thing to leave family, home, come all by yourself with no friends, no relatives, you don't know nobody here. And people look at you and wonder what's wrong with you; why you come. And when you tell them your story, they look at you and think that you're lying. So it was really, really hard.

The community's reactions to the immigrant women were not always positive. Once they settled, however, the women felt more at ease about establishing ties with members of their community and subsequently formed a strong attachment to their community. Sutra described the social contact she and her husband had when they first arrived in Canada. Even though it was with people who shared her country of origin, and she enjoyed the contact, she did not immediately feel supported by them:

After some time then we started living with a family from [Africa] because they were having like parties or sometimes weddings, but that's how we connected … So we're getting a lot, it's not really support, but we did get connected with other, other friends and sometimes get together, eat, party…
Eventually Sutra became familiar with a women's group that met at her mosque. Currently she meets regularly with other women from her cultural and religious group for social discussion and the sharing of food:

Myself, I do go to the Women's Islamic School, which is in my community. Yeah, so we meet once, twice a week, twice a month. … Usually we talk about Islam and sometimes if there's anything in the community we want to discuss and every time, everybody brings food. It's like potluck. So we do the socializing.

Women, such as Chandra, who left lifestyles of some privilege to live in Canada on a minimal government benefit also expressed difficulty coping without the support of their friends and families. Chandra's experience of being newly married and pregnant did not play out for her as she'd anticipated:

At that time, we were refugees, so we were getting welfare, and it was really hard and living, coming from a middle class family, just coming from your family, you know the warmth, the love and your dreams that if I get married, I'll be near my mother when I get married, it will be near my family. So getting to know a man, like a marriage, being pregnant, this was not my dream, like I'll be far and start on my own …I had nobody, so between that time, between the time when my daughter turned 2, it was too much for me.

Chandra also spoke about the harsh and unfamiliar winter weather in North America that made it more difficult to deal with the absence of the support of her family. Although Chandra was surrounded by others from her home country, most were male and friends with her husband rather than a source of support for hers. She said: "There were people from our community, like lots of guys, who came as refugees, but then that's not my life. So I just decided I'll just take and go back home." But Chandra came back to Canada to rejoin her husband because of pressure from her family.
After returning to Canada, Chandra stated that she primarily affiliated herself with people from her own community. And although working at an ASO had provided her with opportunities to have social contact across many cultures, she continued to practice her own cultural traditions. Even though she had some friendships at work from other cultures, when it came to entertaining, Chandra socialized strictly with families from her own community. It was important for her and her own family to be around others from her own community: "It's hard …I'm a working person, but I'm mostly a family person. So if I had time I would have company so that we all are family and kids grow up together…. I still keep my culture."

Some women came to Canada when they were young wives, and the only person they knew was their husband. Some of these were not even that familiar with their husband. These women reported that isolation made the challenges of adjusting to a new country and a new role, that of wife, more difficult. While discussing who Doyel and her husband socialized with when they first came to Canada, she confirmed that most of her contacts were with: "South Asians…we were involved in the South Asian community."

The women who experienced discrimination and racism in Canada felt more acutely isolated from their new society. Anjali, who immigrated to Canada as a young child, had extensive experiences of bigotry in her predominantly white school. She recalled several experiences of racism throughout her life in Canada, including several incidents in her neighbourhood that occurred around the time of the interview. Anjali also mentioned that while she suffered as a youngster from racist remarks and physical abuse from other children, she believes her parents suffered more than she did:

Growing up here was very difficult in the 1970s because there was a lot of discrimination with being a person of colour. I was Brown so I was called Packie. I was beat up, but then I beat them up too because I wasn't gonna take abuse from anybody. … We were not white and we spoke with an accent at the time, so we were discriminated against but in a couple of years, it didn't take long, cause kids blend in. My parents suffered more, I think, in terms of discrimination.
Later in the interview, Anjali talked about creating a social network as a way for her to deal with the discrimination and racism that she faced while growing up. Connecting with other kids in her community gave her a sense of identity and the strength needed to face racism.

Yeah, because I had a social network in Mosque, for the religion. You could talk to boys and girls in Mosque. That's as far as it went, then you came back home … But that's the kind of life I knew and that's the life I had.

In spite of growing up in Canada and being exposed to children from many cultures, Juhi described a childhood that was somewhat socially insulated in that she did not mingle with children from different cultural backgrounds than her own:

We kept to our own kind. So mixing with other communities, like whether they're Caucasian, Black, Chinese, whatever, we didn't do a lot of that. It was just our community and that's it.

Most women in the study confirmed they socialized primarily with others in Canada who were from their ethnic or cultural community. As Noor remarked: "But mostly our friends, who come and visit and you go and visit are mostly East Indian."

Shreya reported that although most of her social contacts in Canada were with people from the South Asian community, she also had social relationships with people from cultural backgrounds that are different from her own: "Yeah, just friends, like are they mostly Indian…yeah, but I have other friends too, like they're white, Black friends, so it's all over."

The women's strong attachment to their cultural communities included a strong adherence to those communities' social norms. Perceived group attitudes or norms regulate the behaviours of individuals within a group. The strong sense of community shared by many of these women influenced their individual behaviours and, as interdependence suggests,
social norms are also influenced by individual behaviours. Adherence to social norms strengthens them.

We can also see complex interactions between social norms and the social structures of gendered division of labour, power relations, and emotional attachments. The women identified themselves as belonging to communities with strong social and gender norms, resulting in a clearly defined gendered division of labour. Also, the women's experiences of discrimination influenced their decision to work at home and assume childcare responsibilities. The division of labour increased the women's economic dependence on their husbands and resulted in an increase in the women's submission and emotional attachment to their husbands, which in turn strengthened male power in the relationship. Thus attachment to the community influenced the women's behaviours in this case in such a way as to increase their risk for being infected with HIV by their husbands. Nevertheless, attachment to the community can also provide support for the women.

The women's stories were quite consistent in regard to their adherence to "cultural norms." The women talked about keeping the South Asian culture alive through food and tradition, the transmission of South Asian traditions and cultural norms, including norms related to sexuality, to their children, and thus the perpetuation and maintenance of gendered sex roles. Even in Canada, where South Asian culture is a minority culture, the women adhered to the ideals and beliefs that they perceived to be fundamental to their identities as South Asians.

Given that women were responsible for household duties, when it came to discussing cultural traditions, the examples the women gave had to do with the food they cooked and their child-rearing practices. Within the context of a discussion with Anandi about her second husband, who is not South Asian, she described some of the challenges she faced due to their differences. One of the ways she kept her traditions alive in their relationship in Canada was in food preparation. She recalled the first time she cooked her culture's food for him and then explained how they managed to honour both their traditional diets. She stated:
When he first came and I cooked chicken curry for him; he said, "I can't believe it; it is so good." … And he said their [Indian South Asian] cooking is too spicy. I said well I'm not an Indian South Asian, but I'm from Malaysia, we cook totally different. We don't use a lot of spice and stuff like. Other than that, he got used to eating with us. …So then Monday to Friday it's all South Asian food; only Saturday and Sunday it's his food. But we still eat no pork, no beef; mostly it's chicken … So we still have our cultural values.

Many of the women described traditions they participated in while living in Canada. Doyel—who was born in the Caribbean and described herself as "mixed"—reported that her children were Indian and participated with her in their enjoyment of South Asian traditions and recreational activities, as well as the consumption of Indian food, but: "They like Caribbean food too … So yeah, they are mixed."

Nandita confirmed that when she was married, she kept South Asian traditions such as the cooking of Indian food and she and her husband had friends who were members of the same cultural community as they were. Nandita also reported regularly attending temple in order to maintain relationships with members of her religious community.

Haifa also spoke about South Asian traditions in terms of food. And she mentioned listening to Indian music and practicing her religion as aspects of her cultural affiliation:

Yeah, I cook Indian food like rice and dahl. Most of my cooking is mostly Indian. It's not more like white, no, it's mostly Indian. And most of the time we listen to Indian music and we do prayers.

Sutra, who was from a mixed cultural background, reported that her mother valued South Asian traditions and taught them to her and her siblings. She recalled celebrating cultural holidays by eating Indian food and watching Indian movies. In addition, the influence of
South Asian culture was apparent at weddings and other family gatherings she attended as a child in Africa. She stated:

Yeah, we were also like if, if it was a holiday, like that, we were watching Indian movies; you know, eating the Indian food. We are Muslim … So it's not like she didn't keep. She was keeping, like sometimes we have weddings and we have this kind of celebration at the wedding, so we do, yeah, have this; like when we have a family gathering.

Shreya spoke less about specific traditions or cultural norms and more about what it meant to her to be Indian woman in Canada. Because adherence to values and being Indian was important to her parents, she in turn considered it integral to her identity. She talked about her South Asian background with some emotion and pride:

Well, it means everything to me because my parents are Indians and I'm Indian. I don't want to be white or I don't want to be anything else; I just want to be Indian. Because I am Indian. …But I love being Indian, yeah.

Interestingly Juhi went to India in order to seek relief from the cultural conflict and be surrounded by a more hegemonic South Asian one, rather than getting her own housing somewhere else in Canada. Perhaps she sought refuge in a culture that was immersed in the traditions she grew up with.

Practices of child rearing reflect and reinforce the male superiority and female subordination through the inclusion of more sexually restrictive norms for girls. When it came to child rearing practices, the women reported imposing more social restrictions on their daughters than on their sons, but advising both to remain virgins until marriage. Even though they reported that establishing these norms for their children was more difficult in Canada, they continued to try to maintain these gendered roles for the next generation. Several women mentioned the importance of maintaining gendered roles among their children while living in Canada. All reported being more concerned about their daughters' sexuality than their sons'. 
During a discussion with Doyel about her South Asian identity, she recounted what she kept from her own upbringing. She stated that she watched Indian films, cooked Indian food and tried to keep control over both of her children with respect to their sexuality, for example, by forbidding dating. She admitted that she would like to influence both her daughter and sons to remain virgins until they marry, but she could not control her sons because they wouldn't allow her to. Doyel accepts that her boys will not be controlled by her because she conforms to the norms that legitimate male power. Doyel stated:

Yes, I am more protective of her and I would like to know exactly where she is and how she is. And the boys, I do want to know too, but they, they're more free than her, yes.

Like Doyel, Chandra does not expect to be able to control her son's behaviour. Chandra said that even though she was living and raising her children in a culturally diverse country, she wanted to keep particular cultural traditions in the raising of her daughter, in particular she wanted her daughter to remain a virgin until marriage. As a South Asian mother, she was charged with the job of protecting her daughter's chastity as is socially dictated and reinforced by religion. Chandra spoke about the differences in how she will treat her son and daughter when it comes to dating:

Because it's a boy, they think a boy can do anything, but a girl has to be..

Even if now, like I'm here with my daughter, if my son was her age, I mean I'm sure he would be bringing his girlfriends here and I would have no say, but I wouldn't want to see my daughter bringing a boy into the house. It's a cultural thing which I really want to keep, but it's hard.

Later on in the interview Chandra spoke specifically about the importance of teaching her children to remain virgins until marriage:

Yeah, so we still want to keep that. You know which, true we are in our multicultural country and all that. We want our kids to grow up that way. We try our best but …You educate them, you teach them and then you leave it in God's hands, you know?
Haifa, one of the younger women in the sample, had a slightly different view on raising her daughter. When asked about whether she would be raising her daughter according to South Asian traditions, her response was: "Yes, but I'm gonna give her freedom. She can do whatever she wants to do. I want her to be free."

Some participants spoke about their children continuing their cultural traditions in their own families. Anandi stated that her son, who is HIV positive as well, kept their South Asian traditions by performing ritual prayers. She contrasted her son's willingness to say prayers for his grandfather with his cousin's refusal to do this:

Yeah, yeah, my son did prayers at my sister's house, and I did notice the changes. My son is 21 and he still has the cultural values like pray for the dead, we do that prayer. And when I saw my sister's son and she said, "It's your turn, come and do it you know, for my father," you know he refused. He said, "Why should I do?"

Doyel also spoke about her son being more Indian than his cousin who resided in the Caribbean. She reported that her son listened to Indian music, watched Indian movies and ate Indian food, although she described him as Caribbean as well as Indian.

### 7.6 Summary

Most of the participants stated that there was an absence of dialogue about sexuality in their families of origin. Most of the women described sexuality as a taboo subject for children, and for females in particular, both while growing up and as married women.

Most respondents also reported adherence to social norms as part of their keeping their traditions alive in Canada. Not surprisingly, the women talked about cooking Indian food as an illustration of how they kept South Asian traditions.
Some women also reported a devotion to norms related to sexuality and relationships with members of the opposite sex. These norms reinforce women's subordination to men and dictate the parameters of male–female relationships. Compulsory virginity before marriage for females and warnings of dire consequences of premarital sex were part of the teachings the women received when they were growing up. These are meant to ensure that females remain under their father's rule until marriage, and then are passed to their husband's control. Most of the women wanted their daughters to also accept these social norms.

These beliefs in particular were legitimized by the fact that they were intergenerationally reproduced norms that also reflect religious teachings. Ultimately that cooking and child-rearing rituals are the woman's domain keeps women in the home and not out in the world as men are. It also positions them as teachers of narrowly defined rules about women's place and women's sexuality. The women accepted social constructs arising from gendered cultural dictates that govern the most intimate area of their lives, their sexual expression.

Many of the women in the study reported a strong attachment to their religious communities in Canada. The women described the difficulty of being away from families of origin during major life transitions, such as marriage and child birth, as new immigrants. Thus, many of the women felt isolated as immigrants to a new country. Of these women, some described experiences of racism and discrimination, which increased their feelings of isolation. Women reported that being separated from their families of origin often prompted them to seek out and maintain social contacts from within their cultural communities in Canada. Even though some women reported that they had contact with people from many cultures, most continued to maintain their cultural identity by associating with members of their own cultural group.

The current study examined and explained the interactions between individual, structural, and normative factors without essentializing culture. Attachment to members of their
communities provided support to the women by validating their own sense of identity and giving them the strength and courage needed to face racism in their lives.
Chapter 8
Conclusions and Recommendations

8.1 Study Conclusions: Overview

As previously indicated, one of the goals behind conducting this study is to explain what is legitimizing male power so that I can understand the factors that contributed to these immigrant South Asian women becoming infected with HIV. I have also addressed both limitations in Connell’s theory (1987, 1995, 2009) described in Chapter 2. First, the analysis of the data in this study shows that it is possible to take account of the interactions between and among social structures, individual attributes and social norms in individual’s lives, thereby taking into account individual women as social actors within the context of their South Asian families. This analysis shows precisely how structural, individual and normative factors interact to legitimize hegemonic masculinity in that context, which contributed to the HIV risk of the South Asian women. The structural relations of power in the lives of these women were accompanied by a belief system that valued male power, thus reinforcing a hierarchical gendered relationship. The women's strong ties to their religious institutions and to their ethnic/religious communities reinforced their beliefs, which in turn reinforced the beliefs of others and helped sustain acceptance of a gender-based social hierarchy, demonstrating the interdependence of the social structures and social norms. Through this interaction hegemonic masculinity was legitimized and the women were controlled by the men in their lives and the social norms by which they lived. Indeed, according to Connell (2005), hegemony is best established when the dominant group can claim authority without the use of physical violence, although violence is at times resorted to in support of authority. While there was little physical abuse reported by the women in the study, emotional and psychological abuse in family and marital relationships was frequently reported.

Second, the interviews with the women provided a specific local context in which to examine the interdependencies of the social structures described by Connell in their lives
from childhood to adulthood. By focusing on the experiences and interactions of HIV-positive South Asian immigrant women within their families and their immediate community through in-depth interviews, I gained a better understanding of gender relations in the lives of South Asian immigrant women in the GTA. The in-depth interviews helped me examine the women's personal resistance, personal reinforcement of gender relations, and their constructions of HIV risk in their own lives. In telling their stories, the women articulated their struggle as HIV-positive immigrant women, which shed light on the way hegemonic masculinities are enacted.

In the following sections, I discuss how the data in the study provide detailed evidence of the interactions among structural, individual and normative factors, demonstrating that these are interdependent, and the role of immigration in fostering this interdependence. In particular, I revisit the interdependence of the social structures power relations, emotional relations, and the social norms that the women adhere to in order to show how these women constructed male superiority in their lives, and how hegemonic masculinity was legitimized. I also describe improvements to HIV education and prevention programs for the South Asian community, the influence of this research on that community, in particular its influence on the strategies of the Alliance for South Asian AIDS Prevention, the AIDS Service Organization that supported this research at every step. The substantial strategies for HIV education and prevention that I have included in the last section of this chapter were informed by the results of this study and the ASAAP's Women's Health and Support Coordinator.

8.2 Interactions among structural, normative, and individual factors and the immigration experience

In her article, *Building from Marx: Reflections on Race and Class*, Bannjeri (2005) states that:

Race, gender and class come together and are expressed through the concept of 'intersectionality'. It is said that each is developed through its own 'social terrain' and then crisscross and overlap with each other. In
reality, lived experiences of women happen all at the same time, not separate or even related to the women's personal experiences of them. They should be thought of as cumulative and happening all at once within the person. (p. 144)

The women's stories provide a specific context for examining the interdependency of the social structure described in Connell's theory (1987, 1995, 2009). To these are added social norms and the immigrant experience. The study assessed the risk factors associated with all social structures (power relations, emotional relations, and gendered division of labour) described in Connell's theory. The social structures in their interaction with normative influences and the challenges around immigration adversely affected the participants' risk for HIV. It is important to note that gender patterns in the lives of the participants in this study changed over time and that the most significant change was in their family relations.

There is also support in this study for the contention that the tendency to crisis inherent in gender structures, as proposed by Connell (1987, 2005, 2009), leads to change in gender dynamics. While some participants in this study contested male power, factors such as acculturation as a result of immigration and becoming HIV positive led to crises that affected patterns of gender relations in the lives of these women. Women spoke out, engaged in acts of resistance, and recognized that they could exercise agency in different contexts. A few women in the study decided to leave their partners and end unhealthy relationships.

In their adaptation of Connell's social theory of gender to investigate women's risk for HIV, Wingood and DiClemente (2000) built upon the interdependency of the structures of sexual division of power, sexual division of labour, and cathexis proposed by Connell. According to Wingood and DiClemente (2000), one effect of the sexual division of labour is the limitation it puts on women's access to paid employment, which results in a gendered inequality in economic means. This strengthens women's economic reliance on men which results in an increase in their "economic exposures" to HIV. There is support for this association in this study since many of the women stayed home at some point in
their lives to look after their children. All of the women worked in low paying jobs so they were economically dependent on their husbands and stayed in relationships that put them at risk for HIV.

Both the sexual division of labour and the sexual division of power are intricately connected in relationships. The participants' economic dependence on the men in their lives exacerbated their vulnerability to male control. Sexual division of power, interwoven with sexual division of labour, increased the women's "physical exposures" to HIV infection, mainly through physical and emotional abuse, which was exercised in one form or another in all of the women's lives. Socially accepted norms and religious practices promoting the role of the women as mothers and gatekeepers of tradition, coupled with an unfamiliarity with condoms and a stigma associated with the use of condoms in marital relationships, shaped the women's "social exposures" to HIV.

Because most of the participants in this study accepted conventional mores and convictions, their susceptibility for HIV was fashioned by several systems of gender disparity that translated into a discrepancy in sexual power in support of men. There is support in the literature for the contention that family relationships have a direct effect on women's health. In their qualitative study involving 47 South Asian immigrant women in British Columbia, Grewal, Bottorff, and Hilton (2005) concluded that a combination of factors, such as

the dual role of homemaker and paid worker, oppression and exploitation in their jobs, difficulties associated with adjustment to a new country, and lack of support from the extended family system that they depended on in their countries of origin, put South Asian immigrant women at a greater than average risk for health problems. (p. 260)

8.2.1 Power Relations

Power relations emerged as a major theme in this study. In Connell's social theory of gender (1987, 1995, 2009) it is a structure in gendered relations referred to as sexual division of power, which, among other things, is maintained in relationships through
hegemonic masculinity. Through the stories they told, the women in the study demonstrated how they constructed male superiority in their lives and, thus, how they participated in the legitimization of hegemonic masculinity.

I have argued that the participants' individual beliefs in male superiority and widely accepted beliefs and norms of male dominance are interdependent with power relations as a social structure, and that without this interdependency there is no basis for the hierarchical relations of power between the women and the men in their lives. I have also argued that this interdependence influenced the women's sexual practices, thus contributing to their risk for HIV.

Abuse, either emotional or psychological, perpetrated by husbands in order to reinforce the subordinate status of the wife is well documented in the study. Possessiveness and combativeness were commonly reported forms of abuse, though physical violence was also mentioned by five women in the sample. While abuse is an indication of the illegitimacy of male power, it was used as a way to keep women in line with widely accepted social norms. Some of the women suffered from abuse when they first immigrated and were isolated and more vulnerable to their husbands' control. This finding of abuse is consistent with previous studies that examined the experiences of South Asian sponsored brides in Canada. In these studies, women indicated that they exposed to harsh physical and emotional mistreatment by their husbands (Cote et al., 2001; Husaini, 2001; Merali, 2009).

It was also found that immigration had an effect on power relations. Many women reported that their immigration experiences exacerbated existing relational inequalities, starting with their childhood experiences and later on in their lives with their partners. These results are in agreement with the literature on South Asian immigrant women. Talbani and Hasanali (2000) studied the "social and cultural experiences of adolescent female belonging to South Asian immigrant groups in Canada". Based on their qualitative study, the authors concluded that while...
South Asian families undergo acculturation (the integration of cultural elements from their new country into their own culture) family and community structure continue to be male dominated. Moreover, gender roles are maintained through gender segregation and control over the social activities of girls. (p.623)

Because their families of origin had stricter rules for female socialization than for male, the adolescent girls in the study perceived there to be "a high social cost attached to protest" and opposition, thus they accepted the status quo (Talbani & Hasanali, 2000, p. 623).

As immigrants to Canada, participants in this study reported being isolated from their social support systems and insulated from the culture of their new country; faced with racism in their lives, the women restricted their social interactions to people from their own cultural communities, thus limiting their experience to the social norms of their own communities. The women adhered to these, which ultimately further legitimized male power.

The effect of immigration on power relations observed here has been documented in other studies in the literature. Many South Asian immigrants to Canada report feelings of being socially ostracised and as a result their socialization is limited to others who are part of their social networks (Cote et al., 2001; Husaini, 2001; Merali, 2009). Further, social relations that result in gender disadvantages may actually be strengthened through the process of immigration rather than diminished, since new diasporic identifications may reinforce existing patriarchal relations (Dwyer, 2000).

According to Razack (2005), this is what "culture clash" would accomplish. It constructs Canada's role as that of the rescuer and an icon of tolerance that would save people, especially women, from their patriarchal cultures that de-value them. Since the events of 9-11, Razack purports a specific "geo-political terrain" has been promoted world -wide. allowing an undeniable racism to be expressed in the name of feminism and it is this which is to be attended to by anyone working in service or striving to promote understandings of immigrant women groups– whether Muslim or not (p.12). This "geo-
political terrain" is characterized in part, by a violent "culture clash" between the West, which views them as modern, good, civilized, secular and democratic and the Islamic world, as its opposite: non-modern, evil, uncivilized, religious and barbaric (2005, p.12).

It is important to note that while the women's retreat to their own communities and religious institutions may not be always a safe haven for them, it provides them with acceptance and validation, which become a source of strength and resilience against the various oppressions in their lives.

In their study involving women in the slums of Delhi, Magar (2003) addressed gender-based violence by establishing a model of empowerment in which agency is a fundamental concept in women's emancipation and liberation. According to Magar (2003), "agency is the individual's capacity to act on their life situation and make strategic life choices using capabilities and resources such as knowledge and skills, critical consciousness, and gender awareness available to them" (p. 520). Moreover, where anti-immigrant emotions are prevalent and extreme, "the reality of immigrants of colour [becomes] one of constant negotiation, adjustment, and retreat into the cultural community. And in the Canadian context where racism is more 'polite' and insidious, the processes of negotiation are more nuanced and often confounding" (Jiwani et al., 2001, p.2).

Even though many of the South Asian women in the current study lacked capabilities, including knowledge, dexterity and resources both materialistic and social, they all displayed acts of contestation in their marriages in one way or another, giving them strength and courage. While some were trapped in unhealthy marital relationships in which they endured male infidelity and control, others were able to make changes and move on in their lives.
8.2.2 Emotional Relations

According to Connell (1987, 1995, 2009), the system of hegemonic masculinity has emotions as one of its components. Emotion is integrated into Connell's social theory of gender as a structure in gendered relations called cathexis or emotional attachment. The emotional relations described by the women in this study demonstrate an HIV vulnerability entrenched in family history, religion, and social norms. These are reinforced by individual women's belief that they are subordinate to men in marriage and sexual relationships.

Through the women's stories, I was able to shed some light on the interaction between emotional relations and power relations to better understand the factors that put these immigrant women at an augmented vulnerability for HIV. South Asian women's minimal control in sexual relationships is supported in the literature. For instance, in their study involving 122 South Asian men and women in Montreal, Gagnon et al. (2010) found out that less than half (42.2%) of the sample believed that a woman could protect herself from a sexually transmitted infection her husband had. The researchers concluded that even though condoms were not commonly accepted in the South Asian community, women who were more nearly equal in their relationships had a greater ability to protect themselves and felt more able to ask an infected partner to use a condom.

Findings in this study suggesting that there is a relationship between the quality of the marital relationship and HIV risk are supported in the literature. A study involving 216 HIV-positive and 243 HIV-negative women from urban and rural areas in Chennai, India, indicated that women who were infected with HIV were considerably more likely to report marital dissatisfaction, a history of forced sex, domestic violence, depressive symptoms, and husband's extramarital sex than HIV-negative women. Specific factors related to the quality of the marital relationship, such as domestic violence, marital dysfunction, and depressive symptoms, may be related to HIV-related risks for women. (Gupta, Wyatt, Swaminathan, Rewari, & Locke, 2008, p. 260)
8.2.3 Gendered Division of Labour

There is support in the literature for the proposition that the social structure of gendered division of labour, best exemplified by labour market constraints, low wages, having an occupation of low social status, and childcare responsibilities, results in women's economic dependence on men, which, in interaction with the social structures of power relations and emotional attachments, explains women's subservient behaviours, which in turn increase their risk for HIV (Wingood & DiClemente, 2000). Through the women's narratives, I was able to explain how male power has been legitimized and thus the factors that contributed to these immigrant South Asian women becoming infected with HIV. I have argued that the interdependency of social structural factors, the division of labour, power relations and emotional relations, and individual factors embedded in the women's personal values and beliefs contributed to an understanding of how these women constructed male superiority in their lives and how hegemonic masculinity was legitimized.

My findings echo studies discussed in the literature review chapter of this thesis. For example, in her qualitative study involving 25 South Asian immigrant women in the GTA, Maitra (2007) found the politics of gender to be quite obvious in her sample: most of the women took care of their household and children while running home businesses to sustain their households. Participants reported feelings of inferiority as their work being done from home was often devalued by their own family members and their husbands' jobs took priority. Being uprooted and transported to a new country, participants in this study relied on their husbands and other members of their cultural community for support. Because social contact was restricted to members of their own communities, the women had limited exposure to the new Canadian culture and adhered to a set of "ideal" prevailing beliefs in their community that accepted and perpetuated traditional gender relations.

In their study on the Canadian immigration experiences of Pakistani women, Khan and Watson (2005) reported that the women in their sample had experienced multiple losses,
primarily loss of their social safety net, and joblessness was at the top of their concerns. The women also experienced deteriorating family relations, such as problems with husbands, stemming largely from financial struggles.

8.2.4 Normative Influences

It was important for me to explore how social norms interacted with the women’s personal beliefs and the social structures of power relations, emotional relations, and division of labour. I was able to provide evidence for the interdependence of social norms and structures of power relations and division of labour. Gendered roles within the household agree with the norm that men work outside the home and earn money for the family. This reinforced their power and control over women. More power for the men meant that they had control over the division of labour in the home; thus they were able to relegate women to the domestic sphere, while they were the public face of the family, which gave men even more power, which further reinforced male power as an accepted social norm. Another example of the interaction between power relations and social norms in the families of the women in this study is the normalized notion of male infidelity: men are given permission to engage in sexual relationships outside their marriage, whereas, women are strictly forbidden from doing so. Social norms that are tolerant of male infidelity give legitimacy to male power within families, which, in turn, reinforce the normalization of male infidelity.

Social norms, such as compulsory virginity before marriage and warnings about the dire consequences of premarital sex that are given to women when they are young, ensure that women remain under their father's rule until marriage, at which point they are transferred to their husbands' control. Participants mentioned the importance of teaching these social norms to their own daughters. Khan and Watson (2005) found that many of the women in their study worried about their children acquiring sexual values that conflicted with their own, and attempted to shield them from the new culture. The influence of social norms and power relations on the women's individual attitudes and behaviours, including sexual practices, became clear. Many of the women in the current study were tolerant, at least to
some extent, to their husband's infidelity, influenced by the social acceptance of male infidelity. Even though most of the women in the study were aware of their husbands' involvement in extramarital affairs, none of the women were able to contest male power as evidenced by their inability to negotiate condom use as a way of protecting themselves from HIV infection. This finding has support in the literature; in India, for example, women often identify themselves with marriage and children. They are frequently involved in care giving responsibilities for their immediate and extended family members which reinforces their social role as care as care givers and affects their ability to negotiate health practices (Segal, 1999; Wyatt et al., 2002).

A strong belief in collectivism, reinforced a culture of silence in which women are socialized into enduring adversity and suffering if necessary in order to preserve family unity. In her qualitative study of "English-proficient and non-English-proficient South Asian brides" who immigrated to Canada, Merali (2009) shed some light on this culture of silence. The author concluded that:

Even when South Asian women are armed with knowledge about their human rights, cultural values emphasizing collectivism, … cultural socialization processes focusing on women's endurance of suffering and life adversity, and a desire to uphold a positive view of one's ethnic group to the larger society … promoted passive responses to abuse. (p. 336)

Bhanot and Senn (2007) examined the relationship between attitudes toward violence against women and levels of acculturation in a sample of 100 men of South Asian ancestry in Canada. Results of their study indicate that men who are less acculturated and exhibit traditional, conservative attitudes to gender roles reported higher tolerance of aggression against women in the form of wife abuse.

Deconstructing the racially prejudiced convictions and beliefs that support culturalist reactions is needed to meet head-on cruelty against women. In her article Examining Legal and Social Responses to Forced Marriages, Razack (2004) engages the reader to acknowledge and confront patriarchal violence without sliding into culturally deficit accounts. While reflecting upon the experiences of immigrant Muslims to Norway, Razack reports an anti-racist response to tackle aggression against women.
She concludes:

We have to begin with the racism itself, tracing the many ways in which it shuts down opportunity for meaningful anti-violence strategies. In sum, you can't fight violence against women with racism because racism is likely to strengthen patriarchal currents in communities under siege. Through its exclusive emphasis on culture as the sole source of patriarchal violence, culturalist approaches obscure the multiple factors that give rise to and sustain the violence. (p.132)

Keeping tradition and religious practices also emerged as normative influences in this study. Because of the symbolic role of immigrant South Asian women as gatekeepers of tradition and religious practices, many of the women in the study felt the need to stay in their relationships. This is also reflected in the literature. In her study of 49 British South Asian Muslim women, ranging in age from 16 -18 years, Claire Dwyer (2000) talked about "new diasporas", which are created by postcolonial emigrations, in which the gendered expectations of women as the keepers of cultural and religious integrity are strong. Most of the participants in her study reported an expectation that as future mothers, they were bound to replicate the traditions with which they were raised. A Canadian study that looked at arranged marriages in "first- and second-generation South Asian immigrant women" also demonstrated the emphasis on the role first-generation women play to instil Indian social traditions in their children (Samuel, 2010).

As I eluded to earlier, many immigrant women escape racism by finding comfort and validation in their own communities. This reinforces and strengthens their roles as gatekeepers of tradition in their own communities. In general, respondents in the study reported adherence to social norms by keeping their traditions alive even while living in a country that is culturally diverse such as Canada. In the absence of a larger societal reflection of their cultural values and traditions, the South Asian immigrant women in this study continued to perpetuate these beliefs and practices as fundamental to their lives and identities.
In the next section I discuss HIV risk and strategies for HIV education and prevention taking into account the role of social structures, social norms, and individual beliefs and attitudes in HIV risk as revealed in the study.

8.3 HIV Risk Contexts and Suggestions for Educational Strategies

Any initiatives have to be multifaceted, given the interdependency of the social structures, power relations, division of labour, emotional relations, and the normative influences that affect the risk of HIV infection. In this section I propose some concrete strategies for HIV education and prevention informed by the results of this study, suggestions from the participants and the ASAAP's Women's Health and Support Coordinator.

8.3.1 Racism and Exclusion

Results in this study clearly support the fact that race, class and gender are structures that contributed to the women's oppression. Thus, addressing the women's vulnerability to HIV using anti-racist frameworks helps to minimize the interaction of multiple relations of domination and subordination that these women faced. In this sense, HIV prevention initiatives need to attend to the interactions between individual, structural, and normative factors without essentializing culture.

Culturally sensitive programs should be understood within a larger critical understanding of the social power relations and history of Canadian immigration patterns and include an awareness of the current East versus West and anti-Muslim sentiment perpetuated by the media. Although, clearly, not all South Asian women are Muslim, others may view them as such and as a result, this may perpetuate negative assumptions about this group, such as their 'need to be rescued' by the West.
When putting forward the relationship between South Asian culture and patriarchy/male dominance, it is important to reiterate the heterogeneity of the South Asian culture and that interpretations of culture are imbued with personal biases based on our own social locations and histories. As such, it is crucial to mention here that patriarchy is not universal or inherent in South Asian cultures. Programs that promote inclusion and integration of South Asian women need to be aware of that.

Further, it is vital to understand the notion of cultural deficit. In her critical analysis of "culture" as a concept, Yoosun Park (2005) argues that "culture is inscribed as a marker for difference which has largely replaced the categories of race and ethnicity as the preferred trope of minority status" (p.11). Cultural constructions are always "ideological", and as such, are situated within the forms and modes of power functioning themselves in a particular time and place. "Culture is conceived as an objectifiable body of knowledge constituting the legitimate foundation for the building of interventions. But such interventions cannot be considered other than an instrument which reinforces the subjugating paradigm from which it is fashioned" (p.11). Given Canada's immigration history and the influences of imperialism, and racism, it is important to keep these in mind when addressing prevention initiatives for the women in this study.

8.3.2 Ignorance and Denial of HIV

Many of the women spoke about members of their community's ignorance about HIV. Most participants reported that people in their community tended to believe that there was no HIV infection in their own particular religious group, for example. Participants also mentioned specific groups, such as women, men, or health care providers, in their communities who are particularly in denial about the presence of HIV. A number of the participants reported that their community is saturated in HIV stereotypes that do not reflect themselves or their lifestyles. In particular, the belief that only sex trade workers, gay men, and intravenous drug users have HIV was mentioned. For this reason, many in their communities do not perceive HIV to be a problem.
Situations characterized by community denial of HIV, particularly by members of the medical profession, were described as personally painful and as perpetuating HIV discrimination and stigma. Some doctors, for example, refused to see patients with HIV. This results in HIV-positive community members going further underground. Therefore educating and sensitizing health care professionals, particularly general practitioners, about HIV stigma and its impact would have the desired effect of minimizing the rejection of HIV-positive people from their medical practices.

Specific suggestions for prevention are many and run the gamut from private family conversations to the use of HIV-positive community members as role models in order to address widespread denial. Other suggestions include developing and delivering culturally appropriate HIV-prevention education through workshops, targeted outreach programmes and sexual health resources such as brochures, posters, and fact sheets. Encouraging South Asian media outlets to promote safer sex and HIV-prevention messages is also a viable suggestion.

Addressing community denial and stigma are paramount to the development of effective strategies that target women, men, and children. Prevention efforts require partnerships with HIV-positive South Asian people in order to demonstrate that HIV is found among South Asians and influence target groups to make appropriate behavioural changes. In order to do this people with HIV would have to be persuaded to take the risk of disclosure. Selective disclosure or non-disclosure of HIV status was the norm among the participants. Most were not comfortable telling friends, community members, or even family members about being positive due to fear of discrimination. In addition, many participants reported that parents do not speak to their children about sexual health out of discomfort and due to a lack of modeling of this kind of conversation in their own childhoods.

Addressing stigma and discrimination is integral to any education strategy. People will not view themselves as being at risk for HIV if they don't know that members of their community are HIV positive. People deny their own vulnerability as a result of the belief...
that only certain groups of people, such as gay men or sex trade workers, are at risk for HIV. This is particularly true for married women who are in denial about their partner's infidelity.

8.3.3 Non-Disclosure Due to HIV Stigma and Discrimination

Most of the participants did not disclose their HIV status to anyone in their communities, including family members and friends. The reasons repeatedly given for non-disclosure were HIV stigma and discrimination against people who are HIV positive. Some participants spoke in general about the discrimination they perceived in their cultural communities. Others offered personal examples of reactions they had to their illness. Some reported rejection and even name calling by family members and the community at large. Symington (2011) found:

Many women experience great difficulty in disclosing to men on whom they are dependent and disclosure can be particularly challenging for those who feel disadvantaged by their age, attractiveness or ethnocultural background. HIV disclosure can also be a prelude to violence. (p. 25)

Five of the participants were abandoned by their husbands after they were diagnosed as HIV positive. Many participants in the study reported that in fact they did not disclose or only selectively disclosed their positive status to family members even though they may have benefited from having their support if they had disclosed. Some women spoke about the importance of protecting their families and their belief that knowledge of their HIV status would put family members in a difficult social position.

Stigma towards people living with HIV is still alive and well in the Canadian society; a significant number of Canadian People Living with HIV/AIDS still experience stigma as a result of their status and think that work in areas such as education and treatment is needed. A web-based survey, *HIV+25 Survey*, released in November 2008, studied the impact that HIV had on the lives of 381 people who are HIV positive. Questions in the survey included the participants' knowledge levels of HIV, their contentment with the
health care they received as well as with the treatments available (Symington, 2009). Key findings from the survey were:

More than 8 out of 10 respondents had been stigmatized because of their HIV status. Just over half reported that the stigma affects their ability to find a job. In addition, 44 percent said that their coworkers were not aware of their HIV status; 55% said that they were depressed; and 45 percent reported feeling isolated as a result of living with HIV. The survey concluded that there is a need to combat stigma and improve education. (Symington, 2009)

Allison Symington (2011) argued that:

Criminal prosecutions for HIV exposure and the sensational media coverage they often generate can contribute to stigma and discrimination against people living with HIV. Such cases place the responsibility for preventing HIV transmission entirely on PHAs [people with HIV/AIDS] and they risk portraying all PHAs as vectors of disease and potential criminals. Increasing stigma and discrimination is counterproductive to HIV prevention efforts and to the well-being of PHAs. (p. 25)

Because of the counterproductive effects of HIV stigma both on the lives of those with HIV/AIDS and on education and prevention efforts, "HIV-prevention initiatives that promote safer sex and empower individuals to take control of their sexuality and sexual health are therefore more effective than those that focus on disclosure" (Symington, 2011, p. 25).

The stigma associated with HIV also affects peoples' willingness to access available resources. Some of the women in this study said that due to HIV stigma, people will not attend a culturally specific ASO because this might be interpreted by members of their community as disclosure that they are HIV positive. One participant suggested that ASOs are so stigmatized that people do not want to be seen anywhere near them, especially those who are HIV negative. She believed that only HIV-positive people would be seen accessing them. As a result the ASO serving her community is not able to do the kind of outreach and intervention needed to meet the needs of HIV-negative members of her community.
Suggestions to address stigma and discrimination involve the use of community organizations from both inside and outside South Asian cultural communities. I believe that education efforts could be geared towards integrating HIV-education programs with respected community institutions or community gatherings, such as places of worship and school programs. In addition, frank discussion about stigma and discrimination is essential to provision of accurate prevention information. It is also fundamental to the creation of prevention strategies because if open dialogue is not possible, many will not receive the HIV-prevention information they need.

8.3.4 Infidelity

Most of the women in the study spoke about the risk of other women in their communities being infected with HIV by their husbands. Many believed that men are responsible for the spread of HIV in their communities by bringing HIV back to their wives after engaging in unprotected sex outside their marriages.

Participants also spoke about the lack of social norms or role modeling for conversations about sex, and specifically the use of condoms, between husband and wife. This lack of dialogue is exacerbated by some women's reverence of their husbands which results in trust that they will be faithful to the marriage.

In light of the extensive reports of HIV stigma, it is not surprising that many of the participants' preferred preventive efforts would be carried out in ways that are private and controlled by the individual, such as educational programmes and messages on television, specifically on the South Asian channel. As well, it was suggested that prevention efforts should come from respected institutions such as places of worship, perhaps in the form of premartial counselling that included topics such as communication about sexuality and trust. In addition, existing support groups, such as a Muslim women's group at mosque, could be encouraged to address HIV risk and prevention and sexual health issues in general. In addition, community educational programmes should be offered in neutral locations, such as community health centres or settlement agencies, rather than ASOs.
One suggestion about the content of programs would involve having HIV-positive wives and mothers representing various cultural and religious groups telling their own stories of HIV infection by trusted marital partners. Another would be to have women, using anti-racist frameworks, counselled upon immigration or at settlement agencies after they arrive, about their rights to assert themselves and the support offered in Canada to help them to leave a marriage if they desire. Having anti-violence awareness programs offered in places of worship or community centres for the whole family, including South Asian men, as part of transformative justice would be another feasible suggestion. Conversation circles and informal discussions can also help people talk about difficult topics.

8.3.5 The Resistance to Talking to Children about Sex

Many of the participants reported that parents do not commonly discuss sex with their children due to a lack of social norms governing conversation of this kind, and to the stigmatization of this type of discussion. They believe that a lack of open dialogue with their offspring lays the groundwork for both girls and boys to be at risk for HIV. But they were hopeful that the next generation would be more comfortable and more likely to engage in discussions of sexual health with their own children. Some suggested that schools respond to this by holding experiential information sessions for all parents to increase their comfort level with and knowledge of sexual health issues.

These educational sessions could take place on school property and parents could be invited to participate through outreach efforts by community members, particularly other parents who are already involved in school life (e.g., school council). Resource people from specific communities could be asked to help develop the program and conduct sessions with interested parents. Offering workshops about how to talk to children and young people about sexuality and sexual health education programs targeting young South Asian women and their parents through community centres and places of worship would also further the goals of HIV education and prevention.
8.3.6 Personal Lack of HIV Knowledge among South Asian Women

Most respondents reported an almost complete lack of knowledge about HIV before receiving their HIV-positive diagnosis. Many stated that if they had heard of HIV before this, it was as a disease affecting stereotypical risk groups that they did not identify with. At least one participant reported that she became infected because of ignorance of HIV transmission and of the symptoms of HIV/AIDS. Although her fiancé was very ill during their engagement, she didn't suspect he was positive, so took no steps to find out. He subsequently infected her with the virus through unprotected sex.

In order to create more personal responsiveness towards HIV risk, education resources need to be written in clear, simple language, as English may not be the mother tongue of the target audience. Scientific or technical terms commonly used in more mainstream education should be avoided. As well, there is a need to provide education to women that focuses on increasing their assertiveness in general and also encourages them to take control of all aspects of their health. One suggestion is to develop coalitions to organize the building of sexual health clinics in GTA neighbourhoods with a large South Asian population. Working alongside a number of community organizations in the area would be a natural fit as well for steering a needs assessment study involving youth groups and improving access to HIV and sexual health information in the area.

One woman in the study reported that although she was highly ignorant about HIV prior to her diagnosis, she has since taken time to educate herself thoroughly. As a result, she aspires to overcome her discomfort and disclose her HIV status to other women in her community. She believes that because they could relate to her as a pious, married mother, they would accept that she was infected by her husband, and see her as an example illustrating that anyone can be infected with HIV. This may highlight their own vulnerability to HIV infection in their marriages due to an unfounded trust in their husbands' fidelity and/or religious beliefs that pose barriers to condom use in marriage.
8.3.7 Use of Condoms

Most women in the study reported that they were uncomfortable with the use of condoms and that they believed that this discomfort was common in their cultural community. They also reported a specific stigma related to women purchasing condoms based on stereotypical beliefs that women who use condoms are either sex trade workers or promiscuous. In addition, women repeatedly remarked that it was not possible for a wife to negotiate condom use with her husband due to an assumed reluctance to use condoms on the part of men, and the power imbalance in their marriages.

Due to the stigma attached to women's purchasing, owning, or using condoms, none of the women in the study used them. Even HIV-positive women, who have been advised to do so in order to protect themselves from re-infection, did not always use condoms due to a lack of the assertiveness and/or social support needed to negotiate this with their husbands. One suggestion is that a campaign targeted to men be developed to encourage the use of condoms both in marriage and in extramarital sexual relations. Free condoms and lubricant could be made available in neighbourhood health centres and the media could be used to promote the use of condoms via advertisements on community stations. For instance, an innovative campaign, "Wrap It Right", by ASAAP was first introduced in 2007 on OMNI TV and in transit ("Canada: One Size," 2009). The purpose of the campaign which portrayed gay South Asian men intimately engaged in a conversation around sex and condoms as well as women of different age groups was to create awareness and promote condom use among South Asians. The impact of the ad was very strong as ASAAP received hate and homophobic calls from members of the community. Similar advertising initiatives can create prospects for dialogue with members of the community and a stronger commitment to community research. Public service announcements such as these can be tailored as these would open up a variety of opportunities that would justify the need for an increased funding for HIV prevention and education programs involving ethnocultural groups and delivering information in a social context.
8.4 Community-Based Research

ASAAP has acknowledged a need for research to inform its practice. This community based research will give ASAAP research that can be integrated with frontline work already being done.

This study will have an impact on the broader community as well. The main objective behind this community-based research is to share information with the broader community. This study could also inform programs of the Ontario Women's Health Framework by promoting advocacy and empowering women to be proactive when it comes to their health. The Framework is a tool used by policy leaders for enhancing women's health in Ontario and keeping and maintaining a high caliber health system in the province (Bayoumi et al., 2011). The Framework identifies three strategic priorities to improve women's health in Ontario which include reducing gendered health inequities resulting from women's social roles and status by securing decent income, education, and freedom from violence, stigma and racism; designing and implementing care delivery systems that strengthen the quality of care by considering the unique needs of different groups of women and removing barriers for seeking out needed services; and mandating planning and accountability requirements that reflect the priorities of women. (Bayoumi et al., 2011, p. 11)

I am hoping that this study will have an impact on women's health through knowledge transfer by ensuring that the findings of the research are understood by the stakeholders and the South Asian community. The CBR model followed in this study will help create competence in the community to warrant that adequate services for women living with HIV are available. It is the hope that through proper dissemination and exchange of knowledge that theory will inform practice.
8.5 Concluding Remarks

In this thesis, I have looked at how male power is legitimized in order to better understand the factors that contributed to the study participants being infected with HIV. Through gendered practices, resulting from shared gendered beliefs favouring those in power, hegemonic masculinity becomes the recognized response for the issue of male dominance since it provides assurances that men will remain in power. After all, according to Connell (1987, 2002a, 2005, 2009) the main goal of hegemonic masculinity is to legitimize patriarchy. I have argued that the participants' individual beliefs in male superiority interact with the social structures of power relations, emotional relations, and gendered division of labour and without this interdependency there is no basis for the hierarchical relations of power between the women and their partners. It was critical for me to assess the risk factors of all social structures (power relations, emotional relations, and gendered division of labour) incorporated into Connell's theory (1987, 2005, 2009) as they interacted and adversely affected the participants' risk for HIV. Throughout and whenever possible, I examined the role that immigration played in these mutual dependencies.

While the above discussion helps to analyze the factors that put these immigrant women at a higher risk for HIV, the picture is not complete. In order to better understand these factors, I needed to explore what was legitimizing and sustaining male power in the lives of these women and the role the women played in sustaining the system. Hegemony, for Connell, is an ideology that functions to make "culturally constructed" relations seem normal to rationalize existing social situations as inevitable: the "ideology of supremacy" of men over women (Connell, 2005). Yet hegemony puts forward a new concept that goes further than the mix of personal convictions and social structures: social norms, the last theme that emerged in this study. Indeed, social norms referred to by Connell (2005, 2009) as "culture," work to regulate hegemony.
According to Razack (2005), "gender, unmoored from class, race, and culture, facilitates this imperialist move as does culture equally removed from history and context" (p.27). In order to facilitate meaningful connections, dialogue and social change for South Asian women infected with HIV, living in Canada, gender and culture need to be situated in social and historical context. She states:

We must also refuse to come into being as subjects against women constituted as culturally different. This exploration of the "geopolitical terrain" in which we find ourselves illustrates the dire need to reject explanations that locate patriarchy in pre-modernity and positions Western feminist as poised to help their Muslim sisters into modernity. (Razack, 2005, p.28)

The women's narratives show that resistance was central in their lives and their dilemmas, and the conscious, and sometimes not so conscious, choices they made were transformative even though not always successfully so. Indeed, as Meenakshi Thapan (2009) indicated in her work, based on interviews with women in contemporary India, the choices that the women make transform their experiential living out of an embodied identity. This undeniable reality gives them a strength and dignity that is of their making, driven by their awareness and understanding, and therefore lies outside the domain of what is socially approved or normative behaviour. (p. xv)

This thesis has given a voice to the South Asian immigrant women and an opportunity to tell their stories, which would, otherwise, remain untold.

For the participants in my study, factors such as isolation, economic dependence on their husbands, investment in psychologically and emotionally unhealthy relationships, combined with the absence of support from their family of origin exacerbated their risk of HIV infection. Clearly, there are many entry points to begin to develop a culturally relevant and appropriate HIV-education programs in South Asian communities that address the unique needs of women, men, and children. All efforts should be supported by influential social institutions such as places of worship, community and health centres, public schools, and the media. Key messages should attend to aggression against women, while identify and addressing interrelated problems (i.e., housing, poverty, racism, etc.).
There is a concern in how prevention initiatives can approach violence (or any social need) in communities of colour. Front line workers need to be actively cognizant about these social dynamics when working with South Asian women and HIV prevention. Further, programs should take advantage of the special expertise of HIV-infected South Asian women in order to get across the point that anyone can become infected. This study challenges stereotypical portrayals of South Asian women and their communities and explores the more over-arching theme of patriarchy across landscapes. This work has cleared space for multiple voices which have been previously silenced by dominant ideologies; it draws attention to gender-based and other intertwined oppressions including race, class and ethnicity through the experiences of a community of women who are rarely given a voice within the context of research on HIV/AIDS.

I am hoping that this study will provide concrete data to help ASAAP identify gaps in the services provided to HIV-positive women and ultimately gain more funding to help support women PHAs and improve the services provided to them. In the long run, my hope is that the new information provided by the study will be used as a tool to encourage women to participate in community initiatives as well as help ASAAP better focus on the needs of women. For myself, this study provided me with an opportunity to grow as a researcher as well as gain a deeper understanding of the issues faced by South Asian women with HIV and the South Asian community in general. I hope that the new findings of this study will be helpful for Ontario's HIV prevention strategy, South Asian women, women with HIV, and the field of women's sexual health in general.
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Appendix A
Sociodemographic Questionnaire

Greetings! My name is Roula Kteily-Hawa and I am a Ph.D. candidate at the University of Toronto. I am conducting research regarding women and HIV risk perception in the South Asian community. I am particularly interested in finding out more information about your risk and factors that contributed to contracting HIV. I would also like to know how you feel about the problem of AIDS and what it means to you to be HIV positive. You will have an opportunity to express your thoughts and feelings about the disease and share your experiences of being an HIV positive woman who is an immigrant to the country. This knowledge and insight may help other women in your community have better access to HIV prevention/intervention services in the long run.

If you have any questions or concerns, feel free to contact me at the address below. My supervisor, Dr. Kiran Mirchandani, can also be contacted at the same address. Her direct telephone number is 416-923-6641, extension 2309.

Also, feel free to contact Ms. Bridgette Murphy, Ethics Review Coordinator at 416-946-5606, if you have any additional questions about the study. She can be reached by mail at:

The Ethics Review Office, Simcoe Hall, Room 10A
27 King’s College Circle, Toronto ON M5S 1A1
or by email at ethics.review@utoronto.ca.

Respectfully yours,

----------------------------------------
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Note: A copy of the first page was given to each participant.
All the information collected will be kept confidential and under no circumstance will your identity be revealed. I would like you to answer the following basic information before we start the interview:

1. What is your date of birth?

   Day    Month    Year

2. What is your country of origin?

3. What year did you immigrate to Canada?

4. Where were you living before coming to Canada?

   For how long?

5. What is your mother tongue? (language you speak)

6. What other languages do you speak?

7. When were you diagnosed with HIV?

Thank you for your time!

Roula Kteily-Hawa
Ph. D. candidate
Appendix B
Interview Guide

Participants may be asked some or all of the following questions. As noted in the letter of consent, participants are free to decline to answer some or all of the questions posed. All transcripts of the interview will be kept in a secure location and will be confidential. The interview takes roughly between 60-90 minutes, based on the 2 pilot interviews that have been already conducted.

1. BACKGROUND/HISTORY:
I would like to know more about your life history, or the story of your life. Can you tell me about your life up to the point?

PROBES
a. Can you tell me about the family that you grew up in?
   i. What subjects did you like?
   ii. What were your educational or job/work goals?
   iii. If you dropped out, when and why?
b. How far did you go in school?
   i. Is/was religion an important aspect of your life?
   ii. What did you do after school?
   iii. Did/do you work?
      iv. If so, do you control the money that you earn?
      v. What do/did you spend it on
   iv. What was it like when you first came to Canada?
   v. Were you in a relationship?
   vi. Did you work? What kind of job? Did you study?
   vii. How was the money used?
   viii. Have you ever been married or in a permanent relationship?
   ix. Are you currently in a permanent relationship?

MARRIAGE/RELATIONSHIPS PROBES:

- Are you in a monogamous relationship?
- How did you meet your partner/husband?
- Is your partner in a monogamous relationship?
- How old were you when you got married?
- Have you ever been married before?
- What types of marriage arrangements?
- Do you have any children?
- If yes, how many children do you have?
- How do you describe your partner?
- How do you describe communication skills between you and your partner?
- Who makes major decisions related to children (education, discipline, purchases, etc.)
• Any alcohol or drug history?
• Any abuse in the relationship?
• Any abuse towards children?
• Do/Did you use family planning/birth control methods/protection?
  vi. If yes, which method and why? If not, why not?
  vii. If yes, does your husband know that you are using it? If not, can you say something about why he doesn't know?

ECONOMIC PROBES:

• What are the main sources of income at your household?
• In your household, how do you decide on the allocation of responsibilities such as child care, cleaning, cooking, etc.?
• Who actually gets the money?
• How do you pool your money, or do you keep separate accounts?
• How do you decide on allocating money for household things that everyone uses?
• Who makes the main decisions at home related to money?
• List the areas that you would have control over in your household?

2. SOUTH ASIAN IDENTITY

• What does it mean to be a South Asian woman?
• Traditions in your culture
• Typical roles of women in the South Asian community
• Typical roles of women in your family
• Typical roles of men in the South Asian community
• Typical roles of men in your family
• How important is your family of origin?
• In what ways does your family influence you?
• What are the expectations that your family has for you?
• Freedoms and decision making in relationships
• How important is religion in your life?
• What about values related to female sexuality?
• Male sexuality?
• Any other expectations in general?
• Any other comment about what it means to be South Asian and HIV positive

3. IMMIGRATION EXPERIENCE

• What was it like when you first arrived to Canada?
• Why did you immigrate to Canada?
• How did you adjust to this new experience?
• Any support networks (family, friends, etc.)
• Who did you associate with when you first came?
• Who do you associate with now? Any different cultures?
• Any surprises when you came?
• How often do you travel back home?
• How much have you kept from the SA traditions over the years? When you first came? Is it different now? In what way?
• Now that you are HIV positive, do you prefer to be in your country origin or here in Canada?
• Where do you think you have more support? (medical, social, etc.)

4. HIV/AIDS RISK, RISK PERCEPTION, AND EXPOSURES
• Do you think that AIDS is a problem in your community?
• Do you think it is more of a problem to women or men? Why?
• How much of a problem?
• Why is AIDS a problem?
• Do you know many people with AIDS?
• Do you think women in your community are worried about getting infected with HIV?
  i. Why or why not?
  ii. If they aren't worried, when do you think they would start worrying?

• Do you think men in your community are worried about getting infected with HIV?
  iii. Why or why not?
  - If they aren't worried, when do you think they would start worrying?

• What are some of the things that put people here in your own community at risk for AIDS?
  iv. What is a risk factor for AIDS in your community? Why?
  v. Is having multiple partners a risk factor for AIDS for people in your community?
  vi. Why do women go outside marriage?
  vii. Why do men go outside marriage?

• What puts women at risk in your own community?
  viii. What do you see as the MOST important risk factor for women?
  ix. What are some other reasons why women are at risk?

• What puts men at risk in your own community?
  x. What do you see as the MOST important risk factor for men?
  xi. What are some other reasons why men are at risk?
5. PERCEIVED BARRIERS AFFECTING APPLICATION OF HIV PREVENTION/INTERVENTION KNOWLEDGE:

- What are some of the reasons that people in your community might find it hard to protect themselves from AIDS?
- What are some of the barriers that women in your community face against protecting themselves from AIDS?
- Why would someone want to use condoms?
- Do women/men use condoms mostly inside or outside the marriage?
- What does a wife/husband think if their spouse introduces a condom into a marriage?
- Do women buy condoms?
- What do you think when you see a woman with a condom with her handbag?
- Do you think other community members feel the same way? Why or why not?

6. WHAT ARE SOME OF THE WAYS THESE BARRIERS MIGHT BE OVERCOME?

- What do you think would be the best way to prevent AIDS?
- What can women do to prevent AIDS?
- What can men do to prevent AIDS?
- What can people do to reduce their risk?
  - i. What can women do to reduce their risk?
  - ii. What can men do to reduce their risk?
- Are women/men in your own community able to reduce their risk of AIDS?
  - iii. Why or why not?
- What can your community do to fight AIDS?

7. EXPERIENCE OF BEING HIV POSITIVE

- What does it mean to you to be HIV positive?
• How do you feel about it?
• To what extent do you feel that being an immigrant has affected you as an HIV-positive woman?
• Do you think it would have been different (easier or more difficult) to be HIV positive in your own country?
• How do you perceive your own risk for HIV?
  - Tell me about how you think you contracted the virus?
  - When did you know about that? What are the contributing factors towards your perceived risk?
  - Do you think you have enough knowledge about HIV and the transmission of the virus?
  - Are there any particular practices/situations/factors, in your opinion, that put you at risk?
  - To what extent, do you think, you had/have control over these situations/factors

Thank you very much for your time!
Appendix C
Consent Form

Your signature in the bottom of the form indicates your consent to participate in the interview for the study. Please feel free to ask me any questions about the study before signing the consent form. I'll be more than happy to answer your questions.

I, _________________________________ (print name), agree to take part in a thesis project on HIV risk among South Asian immigrant women. I understand that as a participant in the study, I will be asked to respond to a set of interview questions. I understand that I will be audio-taped during the interview and that the findings may be published or presented publicly. I understand that participation in the study may involve answering questions such as:

- Do you think women in your community are worried about getting infected with HIV?
- What are the contributing factors towards your perceived risk?
- What are some of the reasons that people in your community might find it hard to protect themselves from HIV?
- What do you think would be the best way to prevent HIV?
- Are women/men in your own community able to reduce their risk of HIV?

I understand that the interview will take between 60-90 minutes and will occur at a time and place that is convenient for me. I am under no obligation to participate in this interview and am free to withdraw my participation at any time. Further, I am free to answer all, none or some of the question posed to me. If I decide to withdraw, none of the information I provide will be used.

I understand that all my audio-taped responses will be kept confidential. I understand that only the researcher or thesis supervisor will have access to the raw data. This information is completely confidential and will not be relayed to any physicians, nurses, social workers, etc. Neither the name of my workplace nor my name will be identified in any documents that may arise from this study. Tapes are destroyed at the end of the research and transcripts, with no names on them, will be kept for 5 years after the completion of the study before they are destroyed.

I understand that the potential risks for me are that I may discuss things about my personal life or other situations that can be emotional or upsetting. I understand I may want to seek professional help for any situation that I may have difficulty dealing with, and that the researcher will allow my withdrawal from the study at any time, without penalty. Also I am aware that I may not get personal value in seeing the findings, but may learn some things. I know I will be adding to the knowledge of women's health and scholarship in this area. By signing this, I also acknowledge that I am aware that there is only minimal ($25) compensation and that the only treatment available to me in the event of research-related injury is in the usual medical services in Canada, which includes emotional health support. I understand what this study involves and agree to participate. I have been given a copy of this consent form.

Signed _________________________________ Date: ______________________
Appendix D
University of Toronto Ethics Approval Letter

UNIVERSITY OF TORONTO
Office of the Vice-President, Research and Associate Provost
Ethics Review Office

PROTOCOL REFERENCE #18459

March 8, 2007

Prof. Kiran Mirchandani
Dept. of Adult Education and Counselling Psychology
Ontario Institute for Studies in Education of the University of Toronto
252 Bloor Street West
Toronto, ON M5S 1V6

Ms. Roula Kteily-Hawa
Dept. of Adult Education and Counselling Psychology
Ontario Institute for Studies in Education of the University of Toronto
252 Bloor Street West
Toronto, ON M5S 1V6

Dear Prof. Mirchandani and Ms. Kteily-Hawa:

Re: Your research protocol entitled, "A Constructivist inquiry into the Meaning of HIV Risk among Newly Immigrated HIV Positive Women in Canada"

ETHICS APPROVAL

Original Approval Date: March 8, 2007
Expiry Date: March 7, 2008

We are writing to advise you that the Education Research Ethics Board has granted approval to the above-named research study, for a period of one year. Ongoing projects must be renewed prior to the expiry date.

The following consent documents (revised February 20, 2007) have been approved for use in this study: Information Letter to Participants, Consent Form, and Contact Information Sheet. Participants should receive a copy of their consent form.

During the course of the research, any significant deviations from the approved protocol (that is, any deviation that would lead to an increase in risk or a decrease in benefit to participants) and/or any unanticipated developments within the research should be brought to the attention of the Ethics Review Office.

Best wishes for the successful completion of your project.

Yours sincerely,

Bridgette Murphy
Ethics Review Coordinator

xc: Prof. A. Cole (Chair, Education REB)