Clearing Space for Multiple Voices: HIV Vulnerability Among South Asian Immigrant Women in Toronto

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Abstract

This paper shares findings from a community-based research study conducted with South Asian women living with HIV in Toronto. Using qualitative methods, specifically in-depth interviews, participants' experiences contribute to the creation of a more nuanced and intersectional understanding of HIV risk and support. Their narratives highlighted specific vulnerabilities growing out of structural inequities and gender-based power imbalances in their families and with their sexual and/or marital partners. The participants' insights have important social justice and health program development implications.

Résumé

Cet article partage les conclusions d'une étude de recherche communautaire menée auprès de femmes d'Asie du sud vivant avec le VIH à Toronto. À l'aide de méthodes qualitatives, en particulier d'entretiens approfondis, les expériences des participantes contribuent à l'émergence d'une compréhension plus nuancée et intersectionnelle du risque de VIH et du soutien aux personnes atteintes du VIH. Leurs récits ont mis en évidence des vulnérabilités spécifiques découlant d'inégalités structurelles et de déséquilibres de pouvoir fondés sur le sexe dans leur famille et avec leurs partenaires sexuels ou conjugaux. Les révélations des participantes ont d'importantes répercussions en matière de justice sociale et de développement des programmes de santé.

Introduction

Several studies have focused on HIV and women of different ethnic groups in the Greater Toronto Area (GTA); however, South Asian immigrant women have not received much attention. There is a significant gap in HIV literature as it relates to the South Asian Diaspora in North America (i.e., the dispersion of a people or culture that was formerly concentrated in one place). As a result, there is a scarcity of HIV/AIDS-related published research on South Asian HIV-infected women in the GTA. The few North American studies agree that there is a considerable amount of stigma attached to HIV/AIDS in the South Asian community. This stigma (disgrace and dishonor) results in an overall denial of and/or disassociation with HIV/AIDS as it affects community members (Abraham, Chakkappan, and Park 2005; Alliance for South Asian AIDS Prevention [ASAAP] 1999; Gagnon et al. 2010; Leonard et al. 2007; Raj and Tuller 2003; Singer et al. 1996; Vlassoff and Ali 2011).

Moreover, while many of these aforementioned studies have identified structural factors, such as male power, immigration, poverty, and discrimination, as affecting South Asian women's risk for HIV, none of them have analyzed how these structural factors affect women's behaviour. The effects of these structural factors need to be studied by exploring the unique individual experiences of HIV-infected South Asian immigrant women in Canada. To that end, this study focuses on HIV-positive or POZ South Asian[1] immigrant women[2] in the GTA. The intent is to improve our understandings of the structural factors that increase women's vulnerability to HIV infection.

In particular, our main research objective is to explore how male power in South Asian communities, legitimized by hegemonic masculinity, contributes to South Asian women's risk of contracting HIV. By way of explanation, through gendered practices, resulting from shared gendered beliefs fashioned to benefit the dominant group, hegemonic masculinity works to legitimize the dominance of men over women, increasing the latter's HIV vulnerability. In light of this, our study draws attention to oppressions through the experiences of a community of women who are rarely given a voice in HIV/AIDS research. This study further aims to provide a platform where women living with HIV can connect their lived realities with structural inequities in their own voice. Knowledge gathered through this study is new and can be used to encourage women to (a) recognize how structural factors may affect their individual risk; and (b) participate in community initiatives. The knowledge can also be used to strengthen the services provided to women living with HIV.

R. W. Connell's (1987) social theory of gender (see also Connell and Pearse 2014) informs our examination of the role of hegemonic masculinity in legitimizing male power as a contributing factor to HIV risk among South Asian immigrant women in the GTA. Through the use of one-on-one interviews, we have been able to unpack how the women "make sense" of their experiences and life situations as immigrants in relation to HIV. Using this theory, we explore the three major structures that characterize the gendered relationships between men and women: (a) the sexual division of labour; (b) the sexual division of power; and (c) cathexis (the process of intellectually investing in a person, object, or idea). Cultural and normative influences in the lives of these South Asian women and the forms of resistance they employed are also examined using an anti-racist lens.

Rather than making generalizations about HIV-infected South Asian women, one should consciously speak from the standpoint of women's voices. The stories told by the women are unique, specific, and connected to their settlement history. They are not necessarily representative of broader narratives of South Asian immigrant women. Their accounts of "culture," such as collectivism, upholding an ideal of female purity, and tolerance towards male promiscuity, are specific to these particular women and may not represent other South Asian women's understandings of "culture." The fact that the women are living with HIV may also have influenced how they see and interpret these "cultural" traits. As such, as per the tenets of narrative research, the findings of this qualitative study are not intended to be generalized to South Asian men, South Asian women, or the South Asian culture.

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 refers to the circumstances or events that form

the environment within which something exists or takes place. Context varies from one individual to the next and even within individuals themselves. Regarding the latter, context depends on personal attributes and the way individuals interpret their daily life experiences. These specific contexts are also shaped by social relations between individuals and diverse, shared, and cultural behavioural expectations. Because of the link between social relations and behavioural expectations, context requires further exploration relative to the study's research objectives.

R. W. Connell and James W. Messerschmidt (2005) are aware of the need to understand context so as to assist in determining what upholds gendered power relations, how they may be challenged, and how the system as a whole works. 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 (Connell and Messerschmidt 2005). The local setting in this study is South Asian immigrant woman living in the GTA.

Specific Contexts of this Research

It is important to discuss the context within which the women's narratives in this study are embedded. This study reflects the perspective of a particular group of South Asian HIV-infected immigrant women in the Greater Toronto Area. In-depth interviews helped us to examine the women's personal resistance to and reinforcement of gender relations and their constructions of HIV risk in the context of their own families, work, and their immediate communities. In some cases, their HIV status is a result of heterosexual relationships, which may have changed their views on men, patriarchy, and community. Most of the women reported psychological and emotional abuse at some point in their lives as well as severe stigma resulting from their HIV status. Their life experiences may have been colored by their feelings and attitudes towards their partners and their own communities.

Methodology

This was a community-based research study, which focused on bringing to the forefront the voices of South Asian women living in Canada (greater GTA) with HIV. It was decided that a qualitative methodology using in-depth interviews was the most appropriate research design. Through this medium of data collection, participants were able to share rich and meaningful responses that provided data on structural inequities, gender roles, and HIV risk.

Given the specificity of the study, a non-probability, purposive sampling strategy was adopted to reach self-identified HIV-infected South Asian women residing in the GTA who could communicate well in English. Participants were recruited through local AIDS Service Organizations (ASOs) working with South Asian POZ women and through snowball sampling. The ASAAP in Toronto was a key partner; however, because stigma was recognized as a key barrier to accessing some of the South Asian POZ women, we had to rely heavily on word-of-mouth and referrals to reach participants. The recruitment process was affected by the challenges associated with stigma and other health and structural factors that affected participation (such as long working hours or shift work and HIV-related illness). In the end, twelve women of diverse ethnic, religious, and socio-economic backgrounds were recruited for the study.

Once recruited, the intersecting issues affecting the lives of participants created very real challenges in scheduling and the data collection process. However, concentrated efforts led to successful data collection and analysis. All interview transcripts were subjected to preliminary thematic analysis (Strauss 1987). Using a general inductive approach, the intent was to formulate summary themes and categories from the raw data. The primary purpose of this iterative data analysis process was to allow research findings to materialize from the frequent, prevailing, or central themes emergent from the raw data (Thomas 2006).

Findings

This section is organized into two parts. The first provides a demographic, socio-economic, and socio-cultural profile of the twelve participants. This is followed by the presentation of the findings from the thematic analysis.

Sample Profile

As demonstrated in Table 1, the women differed considerably by language, country of origin, levels of

education, marital status, and age. The participants spoke many languages, including Gujarati, Hindi, Tamil, Punjabi, and Marathi along with other local African or Caribbean dialects. Each participant 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 twenty eight and fifty with an average age of forty two at the time of the interview. Six women had some community college or university education and six had only attained a high school diploma. All participants were married by age twenty four with the exception of one who was married in her early thirties. Four were married in their teen years.

Table 1
Diversity in Study Sample

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

Table 2
Diversity in Study Sample

Category	Frequency
Highest Level of Education	High School – 6 Community College - 4 University - 2
Number of Children	None – 3 1 Child - 4 2 Children - 3 3 Children - 2
Perceived Mode of Infection	Husband/Partner – 8 Blood Transfusion - 2 Unknown - 2
Number of Years since Diagnosis	0-5 years - 4 6-10 years - 4 11-15 years - 2 16-20 years - 2
Marital Status at Time of Infection	Married: 10 Divorced: 2

Marital Status at Time of Interview	Divorced – 5 Married - 4 Remarried - 2 Widowed - 1

The length of time the women had been in Canada ranged from three years to over thirty years. Given that foreign education and training are commonly unrecognized in Canada when immigrants apply for employment, it is not surprising that most participants worked in low-paying, unskilled jobs upon arrival, such as the restaurant work, factory work, retail, textile, house cleaning, or self-employment in their own family business.

The length of time since their HIV diagnosis varied among participants. Four women were diagnosed less than five years prior to the time of the study and two were diagnosed over fifteen years prior to the time of the study. There was a strong desire among the women to have children. In fact, despite suspicions of infidelity in their marital relationship, some women engaged in unprotected sexual relationships in order to conceive and to strengthen trust in their marital relationships. Nine of the women had children and one participant discussed her struggle with raising a child who was also living with HIV.

According to the participants, eight contracted HIV through their husbands or sexual partners, two by unknown sources, and two by blood transfusions. After their diagnosis, 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 the women were diagnosed. The divorce of these women can be attributed to HIV-related stigma and discrimination and is also reflective of a power imbalance in their relationships. Although, in most cases, they believed they had contracted HIV through unprotected sex with their husbands, if the woman was the first to be diagnosed, the husband was likely to leave. Two of the women remarried. Also, following their diagnosis, most women suffered economically as a result of losing employment due to illness. Seven women were living on social assistance benefits or their savings.

Thematic Findings

Analysis of the data led to four overarching and overlapping themes: power relations, emotional relations, gendered division of labour, and social norms. In the presentation of the main themes, the social norm theme is interwoven throughout their discussions. All four themes spoke to the vulnerability that heightened the women's risk of HIV. As per the research objectives, our analysis revealed that clear connections could be inferred about how the women's experiences of gender were constructed in ways that legitimized male power. Also, these constructions played critical roles in their risk for and vulnerability to HIV and, more broadly, their sexual health. The women not only discussed risk in relation to male power, but also in relation to resistance. Through varying experiences shared with us through in-depth interviews, women demonstrated the rewards and consequences of such resistance.

Theme 1A: Power Relations and Resistance in Early Years of their Lives

Gendered roles and male authority in the families of origin had profound impacts on the women in this study, which manifested primarily in the intimate relationships established later on in their lives. In households where their brothers, fathers, and uncles were superior, women reported growing up with weighty messages about their limited power in the world. In addition, unlike their brothers, they were not permitted to explore their sexuality or to date potential partners. These social norms were reinforced during the most developmentally significant time in their lives – while they were determining who they would be and what their lives would be like in the future. All women reported strict gendered roles in the household. These rules required that (a) women performed household duties, such as cooking, cleaning, and childcare; and (b) men worked outside the home to provide food and a home for their families.

These roles were 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. In most of the women's lives, males, husbands, and partners continued to dominate. Despite being based in gender inequality, these women

still expressed a desire to transfer these same rules to their children, particularly to their daughters.

Connell's (1987) theory holds that the legitimization and contestation of hegemonic masculinity can occur simultaneously. Despite the fact that most of the participants described conforming to the strict rules about females having associations with males outside marriage (either by dating, having sex, or choosing their marriage partners), some women 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. 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 (Connell and Pearse 2014).

To illustrate, both Anjali and Haifa felt strongly about the value of sexual experimentation before marriage. Consequently, both contested male power, but chose to do so in a rather secretive way when they were younger 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.

Minu married for love when she was twenty-one 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 eventually becoming comfortable with the arrangement afterwards. Actually, Minu lived happily with her husband and they had two children. 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 where she met her future husband with whom she had a romantic relationship. However, he 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. Although it meant going against her parent's wishes, it was important for Anandi to marry the person she loved:

> 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…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.

Power relations in marriages are determined both by 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 of and adherence to socially entrenched norms established in childhood and extended or replicated in their adult years.

Theme 1B: Power and Resistance in Current Families

In addition to discussing power relations in the earlier years of their lives, the women also described gendered power relations in their current families as manifested in their marital relationship, domestic abuse, normalized male infidelity, and strict gendered roles. Closely examining these familial dynamics, as shaped by religious dictates and communities, reveals a psychosocial context of tremendous HIV vulnerability among the immigrant women interviewed. The fact that most of them said they contracted HIV through unprotected sex with their husbands (n=8) is powerful evidence of this vulnerability. From the stories that the women shared about their lives with their husbands and partners, we were able to see how power-generated identities and practices conform to an ideal of masculine hegemony and how that power was contested.

The women reported enduring various types of abuse in their marriages. Only one woman spoke about physical abuse with others mentioning ongoing emotional and psychological abuse, which they described as worse when they were newly married. Despite the risk, the women in the study contested male power whenever possible. For example, the isolation and lack of family support that Chandra experienced as an immigrant made it very difficult for her to live in Canada. In spite of being pregnant at the time, she packed her belongings and went back home to India to stay with her parents. As she stated, "*I was already five months pregnant when I came [to Canada] 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, partying and staying out late, she was the only one striving to make the marriage work. Further, when she confronted her husband about 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."

Three of the participants who reported abuse in their marriages left their relationships. Given the belief among these women that divorce under any circumstances is forbidden, their actions took a lot of courage. To illustrate, 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 emotional 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. She was compelled to leave the marriage in order to protect her children from the ongoing stress and the fear they experienced when she and her husband fought. She was aware that her husband's verbal abuse was harming her children. Anandi left her marriage and returned home to Malaysia. 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. She described the situation as follows:

> 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.

Due to the stigma of divorce, she also reported that women will not put their children at risk of community scorn. However, Anandi left her husband and returned to Canada despite being 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.

Theme 2: Resisting Emotional Dependence (Social Norm of Husband Reverence)

The issue of husband reverence was central in these women's lives. Husband reverence is based on an extreme emotional dependence and attachment to male partners. This reverence seemed to dictate gender-based sexual behaviours that shaped the

participants' contact with HIV. Listening to the women's stories, a clear interdependence was evident between the women's individual attitudes and the social norms that sanction women's emotional reliance on men. Moreover, there was evidence that the women's emotional dependence is interdependent with male power. To illustrate, 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.

Some women reported holding their husbands in high regard and even tolerating practices they did not approve of such as infidelity and a sexual double standard. The women's 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, may indicate the women's emotional dependence on husbands. As the women aged, emotional dependencies within their families of origin extended to marital ones. This assertion was clearly illustrated in Juhi's first marital experience. Although raised in Canada, Juhi reported that she 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 abuse, 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 toward emotional dependence on a man was 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. From a different perspective, after difficulties in her marriage became overwhelming, 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 father and daughter to know each other. So, after about two and a half 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?"

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. This underlying desire for trust, combined with a fear of possible severe repercussions for confronting their husbands, led several women to remain silent 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 became 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. Although most of the women believed they contracted HIV from their male partners, only a few women were aware of their husband's infidelity prior to their diagnosis.

Despite the fact that their male partner's sexual activities with additional partners placed many of the women at risk, these women still viewed marriage as protection from HIV and their husbands as worthy of their trust. In effect, they exhibited harmful cathexis; that is, they intellectually and personally invested in a person and patriarchy-related ideas. 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. That said, regardless of having a strong emotional attachment to their husbands, some of the women concurrently felt strong hostility towards their husbands, mainly as a result of the husbands' involvement in extramarital affairs and their resultant HIV status. 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 HIV positive prior to their marriage, but chose not to disclose. Juhi said:

> 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.

Theme 3: Gendered Division of Labour

The findings clearly indicated that the women's households were constituted by a division of labour that defines women's work as domestic and unpaid and men's work as public and paid. This gendered division of labour reflects ideas about a "woman's place." But who defines this division? The division of labour in the families in this study is partly a consequence of husbands' power to define their wives' situation. All women reported strict gendered roles in the household. These rules required (a) women to perform household duties, such as cooking, cleaning, and childcare; and (b) men to work outside the home to provide food and a home for their families. Once they left their husbands, the women were forced to find their own employment (or gain social assistance), in effect challenging the gendered division of labour rule. Their role now extended beyond the home in order to take care of themselves and their children.

Regarding employment, three of the participants reported working in AIDS Service Organizations (ASOs) since becoming HIV positive. In spite of the oppressive circumstances of their lives, these three women managed to thrive in Canada. Most of the other women held factory work and jobs in the service industry even though all had finished high school and six had completed college or other post-secondary training. 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. Four of the women were able to improve their employment situations; however, for the rest, the changes were minimal.

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. Some of them perceived nominal changes in the gendered division of labour in their home. And, the role of agency was evident for those women who worked at changing their partners' behaviour in the domestic sphere. But for most of them, the reality seemed to be otherwise. Even in households where husbands shared their incomes and helped with household chores and childcare, they still did not compromise their economic control over their wives. Power relations supported by the strongly-adhered-to social norm of "woman in the home" remained the structure most resistant to change and the most influential in sustaining the legitimacy of male power. Both factors increased the women's vulnerability to HIV.

Discussion and Conclusions

The intent of this study was to improve our understandings of the structural factors that increase South Asian women's vulnerability to HIV infection. For the participants in this study, their risk was exacerbated by such factors as isolation, economic dependence on their husbands, investment in psychologically and emotionally unhealthy relationships (cathexis), combined with the absence of support from their family of origin. Four themes emerged from the women's narratives pursuant to these structural factors: (a) power relations (before and after marriage); (b) emotional relations during and after marriage; (c) gendered division of labour during marriage; and (d) social norms related to women's roles relative to men. Women are supposed to revere men and abstain from sexual relations or any discussions thereof. They exhibited harmful cathexis; that is, they intellectually and personally invested in a person and in patriarchy-related ideas (social norms).

Patriarchy is not universal in or inherent to South Asian cultures (Bannerji 2005; George and Rashidi 2014; Jiwani 2005). That being said, the most significant finding of this study was the reinforcement of the relationship between South Asian culture and patriarchy/male dominance. Any initiatives related to promoting the inclusion and integration of HIV-infected South Asian women into Canadian society need to be aware that patriarchy dominates in these communities and in these women's lives. This is evident in the women's acceptance of and adherence to socially entrenched norms established in childhood and extended or replicated in their adult years. This seemingly self-defeating adherence to patriarchal ideology persisted even in the face of their HIV status.

The findings further reflected the interpretations of culture that are imbued with personal biases based

on social locations, context, and histories. In an ideal world, the local context allows for agency in everyday discourses and practices (Connell and Messerschmidt 2005). This was apparent to some degree in this study. The women's narratives showed that resistance was a part of some women's lives. In most instance, the conscious, and sometimes not so conscious, push-back choices they made were transformative if not always successful. Indeed, Meenakshi Thapan (2009) found that the choices women make can 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" (xv).

By exploring the more overarching theme of patriarchy across landscapes, our research has cleared space for multiple voices previously silenced by dominant ideologies. It draws attention to gender-based and other intertwined oppressions including race, class, and ethnicity (Bannerji 2005) through the experiences of a community of women who are rarely given a voice in the context of research on HIV/AIDS. Most important, this work has given a voice to South Asian immigrant women in Canada by providing an opportunity to tell their stories, which would otherwise remain untold. Because male power in South Asian communities, legitimized by hegemonic masculinity, contributes to South Asian women's risk of contracting HIV, it is imperative that women's voices be heard.

One of the anticipated benefits of this study was to use the new knowledge to strengthen the services provided to South Asian women living in Canada with HIV. From a pragmatic perspective, the findings confirmed there are many entry points to begin to develop culturally relevant and appropriate HIV-education and prevention programs in South Asian communities that address the unique needs of the entire family, including women, men, and children. All HIV-related program efforts should be supported by influential social institutions such as places of employment, worship, community and health centres, public schools, and even the media. Key messages should attend to the power of patriarchy and aggression against women while identifying and addressing interrelated problems of housing, poverty, racism, and gendered labour division. HIV prevention initiatives need to concern themselves with how to approach the complexity of this disease in communities of colour. Front line workers need to be actively cognizant about social dynamics when working with South Asian women and HIV prevention. Finally, HIV program designers must consider how women living with HIV and their lived experiences can beneficially inform prevention messages and HIV-related programming.

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Endnotes

[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 self-identify 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, Pacific (Fiji), and European countries who trace their origin to the Indian subcontinent and continue to describe themselves as South Asians (CASSA, 2000).

[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. She moved from Canada to India on her own as an adolescent and resided there for several years.

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