



HIV/AIDS Prevention for Women in Canada:

A Meta-Ethnographic Synthesis

Authors: Jacqueline Gahagan | Christina Ricci

Authors

Jacqueline Gahagan

Christina Ricci

Research Team

Jacqueline Gahagan, PhD,

Dalhousie University

Randy Jackson, MA,

Canadian Aboriginal

AIDS Network (CAAN),

PhD (Candidate),

McMaster University

Barry Adam, PhD,

University of Windsor

Margaret Dykeman, PhD,

University of New

Brunswick

Kim Thomas, BA,

Canadian AIDS Society

(CAS)

Tim Rogers, PhD,

Canadian AIDS

Treatment Information

Exchange (CATIE)

Ian Culbert, BA,

Canadian Public Health

Association (CPHA)

Judy Mill, PhD, RN,

University of Alberta

Tracey Prentice, PhD

(Candidate),

University of Ottawa

Christina Ricci, MES,

Dalhousie University



Table of Contents

Executive Summary	5
Acknowledgements	7
Introduction	8
Background	9
Rationale	10
Meta-Ethnographic Overview	11
Methods	13
Scoping Review Considerations	13
Scoping Review Strategies	14
Main Interpretative Review	16
Results	18
Sample	19
Themes	20
Gender	20
Culture and Identity	21
Aboriginal Women	22
African and Caribbean Women	27
Asian Women (Youth-Focused)	29
Youth	30
Sexual Orientation and Identity	31
Drug Use	32
Living with HIV/AIDS	33
HIV/AIDS Service Providers/Testing and Counseling	35
Discussion	37
Overarching Themes and Gaps	37
Recommendations	38
Future Directions for Research on HIV Prevention for Women in Canada	39
Next Steps: The Way Forward	42
References	43
Appendixes	48
Appendix One: Meta-Ethnography: Qualitative Critical Appraisal Screening	48
Appendix Two: Key Themes	49
Appendix Three: HIV/AIDS Organizations Contacted (Grey Literature)	50
Appendix Four: Summary Table of Academic Literature	52

EXECUTIVE SUMMARY

Over the last 25 years Canadian researchers, policy makers, and non-governmental organizations have made significant strides developing an in-depth understanding and response to the impact of HIV/AIDS.

With this in mind, Dalhousie University, University of Ottawa, University of New Brunswick, University of Alberta, University of Windsor and several national partners (the Canadian Aboriginal AIDS Network, the Canadian AIDS society, the Canadian Public Health Association, the Canadian AIDS Treatment Information Exchange) developed this research synthesis project to examine the existing qualitative HIV prevention literature related to both Aboriginal and non-Aboriginal women in Canada. Using a collaborative approach, a team of graduate students, community organizations, Aboriginal scholars and university-based researchers conducted a meta ethnographic review.

Research efforts have produced an unprecedented accumulation of in-depth, context-specific knowledge related to the prevention needs of various populations vulnerable to HIV infection resulting in improved awareness and understanding. Despite this pool of knowledge there has been a lack of attention to integrating findings into a cohesive synthesis.

This oversight has important implications with respect to future knowledge development, for the utilization of qualitative research in the practice of HIV prevention programming, as well as in the development of appropriate policy responses.



As such, the research team embarked on a review of qualitative literature to examine HIV prevention efforts aimed at women in Canada. The inclusion criteria and scoping parameters were as follows: studies from qualitative peer-reviewed academic literature, HIV prevention focused, covering the years 1996-2008 focused on women (either HIV positive or negative), and those which focused on any race/ethnicity or nationality living in Canada. The year 1996 was selected as the starting date for examining this literature given that new HIV treatments were introduced at that time.

The interrelated objectives were to identify knowledge HIV prevention needs for women in Canada and/or where there were divergences of opinion; generate a synthesized understanding of both the implicit and explicit conceptual approaches that have been expressed in the literature; provide a synthesis of information related to the effectiveness of HIV prevention initiatives that have integrated research findings into work undertaken at a federal/provincial/territorial policy level or at the local practice implementation level; and finally, produce new knowledge that can be used to improve the effectiveness and efficiency recommendations related to future HIV prevention research areas and researcher roles based upon the identification of wise practices and gaps in existing knowledge.

This project was guided by the recognition of the importance of the complex interplay of the determinants of health in understanding health outcomes, including HIV. The conceptual frameworks for this project included gender-based analysis, participatory action research, and Indigenous approaches to research. All three approaches have been detailed later in this document.

After completing the search and reviewing the literature, N=38 peer reviewed articles fit the criteria. All of the articles focused on HIV prevention related to both Aboriginal and non-Aboriginal women in Canada and became the focus of the discussion in this paper.

This synthesis uncovered several key implications for HIV research, policy and programming. Specifically, findings suggest that HIV prevention research, at both the primary and secondary prevention levels, must actively involve women living with or affected by HIV from diverse communities. Given the long absence of women actively engaged in all stages of HIV prevention research, it is crucial that the next generation of HIV prevention initiatives considers women's HIV-related needs in an effort to ensure prevention research and resultant interventions remain in keeping with women's complex and dynamic experiences in relation to HIV.

HIV prevention policies need to be more inclusive of women's unique experiences. As such, there is a need for greater recognition of the complexities of women's lives and identities and the cumulative impact of race, class, age, immigration and colonialism on the unequal distribution of HIV in Canada. There is also the need for a systematic, concerted effort in policy responses at the local, provincial and national level in a manner that will foster solidarity and cohesion.

A key factor that has been implicated in the exacerbation of HIV risk in Canada is the current inadequacy in the provision of culturally-appropriate, anti-racist, anti-oppressive inclusive healthcare services for all individuals. It is clear that there is a lack of accessible and appropriate prevention information for diverse communities of women in Canada. It is crucial that responses to the HIV/AIDS epidemic among women must begin with an understanding of the unique social, cultural and economic issues facing them.

Several implications for practice and programming were identified and included, but not limited to; employing alternative models to empowerment and education; a greater focus on the ways in which women resist oppression in HIV prevention programming; enhanced evaluations of what is working and what is not, with greater emphasis on the uniqueness and diversity of women's HIV prevention experiences and needs. Furthermore, moving away from the use of generic prevention messages for 'women' and in the process reducing the tendency to treat women as a homogenous group in HIV prevention programming and policy, is vital to prevention efforts.

The intent of this synthesis was to contribute to a better understanding of women and HIV prevention in Canada as a culturally complex phenomenon as well as a health and social justice issue in need of dynamic and multi-level interventions. Through the use of integrated HIV prevention research findings, the possibility for more effective HIV prevention practice and policy interventions can be realized for, with and by diverse communities of women in Canada.





ACKNOWLEDGEMENTS

It is with sincere gratitude that we acknowledge the contributions of all of those who provided their time, support and expertise throughout this synthesis research project.

Thank you to **Randy Jackson, Barry Adam, Chris Archibald, Margaret Dykeman, Kim Thomas, Tim Rogers, Ian Culbert, Judy Mill, and Tracey Prentice.** We also wish to thank the following national partners: The Canadian Aboriginal AIDS Network, the Canadian AIDS Society, the Canadian Public Health Association and the Canadian AIDS Treatment Information Exchange.

We would also like to thank the project manager and research assistants: Ellen Sweeney, Caryl Patrick, Christina Ricci and Alicia Benton. We would also like to extend our thanks and gratitude to all of the community organizations for sharing their wisdom and enthusiasm and to all of the participants highlighted in the research. Finally, we wish to thank our funder: Canadian Institutes of Health Research (CIHR).



INTRODUCTION

More than two decades after its onset, the HIV/AIDS pandemic remains an enormous public health and social justice challenge in Canada and around the world.

Despite the fact that HIV infection can be prevented, the number of individuals living with HIV in Canada is rising. Women now account for a significantly larger proportion of people living with HIV and AIDS in Canada (EPI update 2010). There are many complex and intersecting determinants of health that influence initial vulnerability to infection as well as health outcomes among women living with HIV.

Women's vulnerability to HIV infection has been shaped by determinants of health, including gender, income, education, unemployment, access to stable housing, early childhood development, physical environments, access to health services, support networks, social environments, sexual violence, culture, among others. Gender and gender-related expectations, such as power inequalities between men and women, and issues of sexual and reproductive autonomy are examples of how such determinants of health factor into issues of HIV infection. The intersection of such factors influencing women's health underscore the urgent need for approaches to HIV prevention that address the underlying context of HIV infection rates.

Canadian researchers, policy makers, community members, and non-governmental organizations have made significant strides developing an in-depth understanding and response to the impact of HIV/AIDS. However, there has been a lack of attention to integrating HIV prevention findings into a meaningful and cohesive synthesis across sectors. This has important implications with respect to the next generation of HIV prevention approaches, including policy, research, programming and frontline responses. An important first step is to identify, assess, and interpret the existing Canadian pool of peer-reviewed knowledge.

BACKGROUND

Data from the Public Health Agency of Canada's 2010 HIV/AIDS *Epi Update* estimate that at the end of 2008, approximately 65,000 people in Canada were living with HIV infection including AIDS (*Epi Update, 2010*).

This represents an increase of about 14% from the 2005 estimate of 57,000 (*Epi Update, 2010*). In addition, the number of people with HIV living longer is expected to increase as a result of new treatments. These facts suggest more is needed to address both primary and secondary HIV prevention in Canada.

Current data also indicate that women now account for both a significantly larger number and proportion of people living with HIV and AIDS relative to the beginning of the epidemic. As of 2008 women accounted for 26.2% of such reports. Despite HIV prevention advances, the number of women becoming HIV positive continues to grow.

Particularly, African, Black and Caribbean and Aboriginal women in Canada are disproportionately affected by HIV/AIDS relative to women of other ethnic or racial backgrounds. The evolving epidemic among women demonstrates the need for further data on HIV trends, risk contexts, geographic differences, and health outcomes related to HIV and AIDS. In order to develop gender-specific and culturally appropriate HIV prevention initiatives and programs, additional, contextual data, including greater attention to the underlying structural factors that place women at increased risk of HIV infection, are required.

There is an urgent need for prevention responses to address the unique aspects of the HIV epidemic for women in Canada. There is also a need to improve the availability and quality of data (both epidemiological as well as biopsychosocial data) to better understand the intersecting factors related to HIV and AIDS. Recognizing that epidemiological data can only offer a snap-shot of reported infections, our study unpacks the concerns related to gender-appropriate HIV prevention strategies and responses which acknowledge the diversity of women's experiences from a qualitative, context-rich perspective.

To achieve this, the research team systematically reviewed the published qualitative literature from 1996 (when new HIV treatments were first introduced) to the time the review was conducted in spring/summer of 2008 using a meta-ethnographic approach.



RATIONALE

The lack of synthesis of qualitative research studies related to HIV prevention, including both Aboriginal and non-Aboriginal women, is problematic.

The rising rates of HIV infection among women, and specifically Aboriginal women, in Canada is further cause for concern. In fact, the Federal Initiative on HIV/AIDS identifies Aboriginal peoples and women among “the most vulnerable individuals and groups in society [...] this reality demands a national HIV/AIDS response that addresses human rights, determinants of health and gender dimensions of the epidemic” (PHAC, 2004).

Previous research related to women’s HIV-related experiences indicates efforts are needed to understand the system-wide impacts of the social determinants of health, including the effects of poverty (Goldstone et al., 2000), unstable housing (Corneil et al., 2006), the experience of violence (Evans-Campbell 2006), post-traumatic stress (Sledjeski et al., 2005) and addictions, particularly injection drug use (Goldstone et al., 2000), that have all been shown to increase the likelihood of HIV seroconversion. For these reasons, this meta-ethnographic review aligns with several of the thematic areas identified by the partnering Canadian Institutes of Health Research Institutes and Canadian Institutes for Health Research Knowledge Transfer strategic plan (CIHR, 2007).

This research project also directly responds to the demands put forward in the “Blueprint for Action on Women & Girls and HIV”. The Blueprint for Action on Women and

Girls and HIV/AIDS is a multi-sector coalition of HIV-positive women, Canadian and international HIV/AIDS organizations, and a variety of woman’s and reproductive rights groups advocating for better prevention, services and support for women, trans women and girls infected and affected by HIV/AIDS.

Women and girls of all cultural backgrounds and life experiences are effectively absent from the HIV/AIDS research agenda and research decision-making at all levels... The long and brutal legacy of colonization of Aboriginal people [in Canada and] globally has created an HIV epidemic in urban, rural and isolated Aboriginal communities that impedes access to prevention and education in these communities. Susceptibility of Aboriginal peoples to HIV and barriers to treatment are compounded for women and girls through the living legacy of the colonization process. (Blueprint, 2006, p.2).



Through our Knowledge Transition Plan, this synthesis of research evidence will strengthen the capacity of researcher users engaged in the HIV/AIDS community-based response who have extremely limited time and access to available evidence to inform decision making regarding HIV prevention initiatives.



META-ETHNOGRAPHIC OVERVIEW

Using a collaborative approach, the research team employed a meta-ethnographic approach (*Noblit & Dwight Hare, 1988*). This approach was used to guide a structured systematic review of findings from completed Canadian-focused HIV prevention qualitative studies.

Such an approach allowed the team to bring together expertise from diverse disciplines and backgrounds to comprehensively integrate findings of completed qualitative studies involving both Aboriginal and non-Aboriginal women in Canada. Taking a meta-ethnographic approach facilitated the identification of themes and allowed for the creation of new interpretations of previously published findings. The research team utilized this approach to ensure that the methods used were appropriate, rigorous and feasible.

Given the nature of qualitative studies, an appropriate methodological paradigm was crucial to facilitate an inductive perspective (Marshall & Rossman, 1995). This synthesis included the following steps: (1) An initial scoping exercise to search the research literature using agreed upon inclusion criteria; (2) A quality appraisal of relevant studies meeting the search criteria for inclusion in a synthesis of HIV prevention research; and (3) A main interpretative review guided by a meta-ethnographic approach that is informed by both a gender-based perspective and an Indigenous approach to research. This final stage involved the integration of themes from across the studies that met both the inclusion and the quality criteria.

The research team valued the principles inherent in the above-mentioned conceptual frameworks and are described as follows:

Participatory Action Research – PAR is an approach that facilitates the tangible relevance of research and is premised on the notion of empowerment as an approach to community research that requires thinking consciously and critically about power relations, cultural context and social action. It is an approach to knowledge development that seeks to change the conditions of people's lives both individually and collectively (Kemmis & McTaggart, 2000). PAR involves consulting or collaborating with diverse individuals, groups, and communities as part of the process of illuminating people's lives and social issues. Fundamentally "[a]ction research can help [participants] to claim [their] own perspective and speak from [their] own experience. It can show [participants] the richness and complexity of [their] experience. With this knowledge, [participants] are in a better position to develop realistic and workable strategies" (Barnsley & Ellis, 1992, p. 15).

Gender Based Analysis (GBA) – Gender, as a key determinant of health, is a crucial issue to consider in understanding the differential impact of HIV/AIDS on the lives of women, men, boys and girls (Commonwealth Secretariat, 2002). In this context, gender refers to the different socially constructed and reinforced roles and responsibilities faced by men and women and which are connected to and mediated by other determinants of health such as income and social status, education and literacy, culture, social environments, among others (PHAC, n.d.). According to Status of Women Canada (1998), GBA is “a tool for understanding social processes and for responding with informed and equitable options” (p. 2). The utility of GBA in the case of HIV/AIDS is that it allows for a thorough understanding of how such gender related roles and responsibilities can explicate the potential impacts of HIV/AIDS policies, programs and services in women’s and men’s lives (Beasley, 2005).



Indigenous Approach to Research – Despite centuries of colonization in Aboriginal communities, Aboriginal people continue to value their cultural traditions (Jackson & Reimer, 2005; Jackson, Cain, Collins, Mill, Barlow & Prentice, 2006a; Jackson et al., 2006b). The history of research and its colonizing effects have failed to distort underlying cultural values, beliefs, and perspectives. As Lavalee and Clearsky’s (2006) research call to arms states: “[our] tacit resilience is found within our Aboriginality. We need not rely on Eurocentric ways of knowing to know ourselves” (p. 5) and this involves providing Aboriginal people with opportunities to tell their own stories through their own frameworks. This approach suggests, therefore, the “need to be, mindful of the need to be reflective in our work [and] understand how we may contribute to our continued colonization and oppression” (Lavalee & Clearsky, 2006, p. 5) in the context of research, and, as a countermeasure engage in processes that adopt Aboriginal centered approaches. To do otherwise is to invalidate Aboriginal encounters with research within mainstream academic settings and to perpetuate discriminatory research practices (Tuhiwai Smith, 1999).

Tuhiwai Smith (1999) proposes the need for reflexivity in research to uncover discriminatory practices that perpetuate colonizing research practices before infusing the process with an Aboriginal centered “Indigenization” of research methods that seek to promote the inclusion of uniquely Aboriginal thematic constructs. The approach to this synthesis, therefore, is to interact with the literature and to question ‘Western’ research assumptions that frame Aboriginal HIV prevention research, and to “Indigenize” our interpretation through Aboriginal participation in this meta-ethnographic synthesis. In so doing, it is hoped that this contribution can make HIV prevention research more culturally appropriate and supportive of Aboriginal women in particular and non-Aboriginal women in general.

METHODS

Scoping Review Considerations

The following section articulates the scoping parameters for our comprehensive review of the prevention studies, including setting topical, population, temporal, and methodological parameters, as well as search strategies. Parameters were set given the research team's expertise in the subject area and by the research objectives themselves.

As we have seen over the course of the epidemic, HIV prevention is a domain in which public and human rights policy (e.g., Cuerrier [Elliot, 1999]), professional and community intervention (e.g., social marketing campaigns, etc.), individual behaviour (e.g., decisions related to the use of condoms, etc.), and socio-cultural context (e.g., ethnicity, social status, etc.) intersect, converge or collide. Our research team was particularly interested in both Aboriginal and non-Aboriginal women's experiences of prevention (our topical parameter) efforts in Canada and how this might inform future public policy and/or practice in the prevention field that will be useful and meaningful to the populations involved.

For the purpose of this synthesis study, population parameters for inclusion were limited to studies involving women (either HIV negative or positive) of any race/ethnicity or nationality living in Canada. With respect to Aboriginal peoples, given shared socio-historical experience (e.g., colonization), the population parameter for Aboriginal peoples includes Inuit, Métis, and First Nations (both Status and non-Status as defined by the Canadian Constitution).



This synthesis included reports of qualitative studies from 1996 (when effective new treatments were introduced) to the time the review was conducted (Spring/Summer 2008). This synthesis therefore excluded studies in which no humans participated, studies using mixed methods in which first person accounts about the target population cannot be separated out, or journalistic and other non-research accounts (Sandelowski & Barroso, 2007).

This project employed three Research Assistants who were located in Halifax, Ottawa and Edmonton and who were supervised by one or two members of the research team throughout the project. The entire research team met regularly via teleconference and also had access to a secure, password protected online forum for discussion between meetings.

The search strategy was divided between the three Research Assistants by year (1996-1999, 2000-2003, 2004-2008). After working with the librarians at Dalhousie University and getting consensus from the research team, the agreed upon search terms used included: HIV + AIDS + prevention + Canada + Aboriginal (Inuit, Métis, and First Nations) + women + girls + female between 1996-2008. Additional search terms included the Public Health Agency of Canada's Determinants of Health which include: income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender; and culture (PHAC, 2001).



The three Research Assistants were all given access to the library databases at Dalhousie University. The following Social Science databases were systematically searched: SocIndex, Sociological Abstracts, Social Services Abstracts, Academic Search Premier (EBSCO), Research Library, CBCA Full-text Reference. The following Health Sciences databases were also systematically searched: PubMed, Cinahl, Embase, and Web of Science. It should be noted that there were unexpected challenges that arose in utilizing the databases, including that some have not updated their search terminology and/or are American so the search strategy had to be refined to include the following keywords: “Indian,” “Indigenous,” “Indigenous people,” “Native [American],” “American Indian,” and “Eskimo,” as well as truncated versions of the key words.

In addition to the electronic database search, backward and forward chaining search strategies were utilized. Backward chaining refers to follow-up of references listed in the database retrieved literature, whereas forward chaining refers to searching relevant citations contained in retrieved electronic databases. Additional search strategies included hand searches of relevant journals, books, HIV prevention study reports, and edited volumes, as well as author searching to determine what individuals have produced other than completed works in the same topic area.

Scoping Review Strategies

The initial scoping review yielded approximately 150 articles. Three widely-used appraisal methods were employed to assess the relative merit and inform decision making with respect to inclusion of retrieved literature into this proposed meta-ethnography; individual Professional Judgment, the Critical Appraisal Skills Programme, and Comparative Appraisal. Briefly, each appraisal method is outlined below:

Professional Judgment – Based on professional qualitative skill and/or organizational knowledge and experience relative to the area of HIV prevention, each team member “relied solely on their own expertise to form a judgment about the quality” of each retrieved research report using a process similar to peer review processes (Dixon-Woods et al., 2007, p. 43). Individual research team member’s decision-making with respect to this area was recorded in a virtual electronic database.

Critical Appraisal Skills Programme (CASP) – Developed by the Milton Keynes Primary Care Trust (2002), CASP is “a widely used tool that has been employed in previous syntheses of qualitative studies to inform decision about exclusion of poor-quality papers” (Dixon-Woods et al., 2007, p. 43). This tool directs the reader of retrieved literature to ask questions in three broad areas including methodological rigor, overall credibility of presented findings, and relevance of findings to the main focus of the synthesis. This is accomplished through asking ten specific questions of each published report retrieved (Refer to Appendix 1). This assessment tool was developed for those unfamiliar with qualitative research and its theoretical perspectives.

Comparative Appraisal – Following individual appraisals, a comparative appraisal was conducted. “Comparative appraisals allow [the research team] to create cross-study summaries and displays of key elements included in reports and prepare [the team] for integrating findings in these reports” (Sandelowski & Barroso, 2007, p. 79). All information gathered during the course of appraising via professional judgment and CASP was entered into tabular format (e.g., in an Excel spreadsheet) which facilitated further analysis, such as “meta-study inferences and, thereby, provide [a beginning] interpretative context” toward the final meta-ethnographic synthesis (Sandelowski & Barroso, 2007, p. 79).

Finally, it is also important to note that the methodological approach did consider other sources of information outside of peer reviewed academic journals. Knowing and recognising that some of the most promising programs are less likely to be disseminated through peer review channels, the three research assistants contacted experts all over Canada working in HIV/AIDS organizations.

The method for collecting the names of HIV/AIDS organizations in Canada involved an internet search using the key words “HIV/AIDS organizations and Canada,” as well as searching the websites for affiliate organizations or additional contacts. In addition to searching the websites, some organizations were contacted by email or phone.



Research assistants contacted (n=97) community organizations (Refer to Appendix 3). These organizations were located across Canada with a mandate to work with HIV/AIDS and/or women. There was an immediate positive response from organizations. Many organizations were pleased to learn that more research was being conducted and if they did not have any material they could share, they forwarded contacts they thought could assist us in our search. Those with materials on hand sent us documents or directed us to appropriate web links. The methodology for collecting grey literature was limited to searching the internet for organizations, and looking on their websites for any affiliate organizations and related materials. Similar to the peer-reviewed articles, the research assistants independently screened each website and document to ensure they pertained to HIV prevention and women. The most common reason why material was excluded was that it did not focus on women or HIV prevention, or the information provided was fact sheets and not qualitative research studies.

A similar process to the CASP analysis described above was utilized for analyzing the grey literature. The Research Assistants answered specific questions related to the grey literature documents including the research objectives; geographic region; ethnocultural group; participant characteristics; sample size; sampling methods; recruitment techniques; recruitment partners; methods, facilitator and venue; type of material and methodology; ethical considerations; main findings; strengths and limitations of material; and overall value of the material.

Methodological challenges that arose during the collection and analysis of the grey literature by the Research Assistants included restrictions surrounding the time and geographical constraints of the project.

The majority of the organizations did not carry out their own research and focused on distributing key information to the populations they serve. When organizations did conduct research activities, they tended to incorporate academics, researchers, and other relevant professionals to assist with ethical, research design, and review processes. Since many of these organizations focus on providing needed services, and considering that their publications are often not subject to lengthy ethics/peer-review processes, their activities and priorities may reveal trends in the Canadian HIV/AIDS epidemic sooner than the academic literature.



Main Interpretative Review

The approach to the main interpretative review adopted a meta-ethnography as an orientation to interacting with all published accounts that satisfy the above noted inclusion criteria and quality assessment appraisals. “Meta-ethnography is a way of using qualitative research techniques to synthesis multiple written interpretative accounts [...]. The output of a meta-ethnography is a new, ‘higher order’ interpretation or theory that satisfactorily accounts for the available body of evidence” and leads to an interpretative synthesis rather than aggregative account (Mays, Pope & Popay, n.d.). An interpretative synthesis recognizes that “although each case study tells a story from a different perspective, embedded in the synthesis of these stories might be new, overlapping and/or additional examples and interpretation that can contribute to knowledge and understanding” (Doyle, 2007, p. 321). Given that HIV prevention has been chosen as the domain area, that strategies for the retrieval of literature and that quality assessment strategies have been articulated above, at this stage three additional strategies were employed to synthesize the literature into an interpretative account: **Repeated reading** to identify overarching themes arising from the written accounts, **assessing how studies may be related** to one another, and translating the studies meeting the criteria and quality into one another that leads to **a synthesized account** (Mays, Pope & Popay, n.d.). These activities are concerned with developing the processes to be used to determine **relationships** and for the **translation of studies** into one another. Where repeated reading has already been discussed (e.g., under quality appraisal) the reading focus relates to determining the process that will be used for assessing relationships and for the integration of studies in a synthesized whole.

A Synthesized Account Consistent with Noblit and Dwight Hare's (1988) original conceptualization, our approach to meta-ethnography is an additive process that strives toward resolution through re-conceptualization by offering an overarching interpretative account of HIV prevention knowledge specific to both Aboriginal and non-Aboriginal women in Canada. To achieve this synthesized account we utilized an inductive approach premised on the principles and procedures of taxonomic analysis. According to Sandelowski and Barroso (2007), in the context of our approach to meta-ethnography, "taxonomic analysis has much in common with axial and selective coding associated with grounded theory [...where] conceptual range of findings [...] provide a foundation for the development of conceptual descriptions and models, theories, or working hypotheses" (p. 199-200). In applying this approach, all studies meeting both scoping review considerations and quality appraisal were entered into Microsoft Excel, where they were categorized (e.g., coded) into domain areas (e.g., involvement in IDU, challenges with use of condoms, etc.) by properties and dimensions (e.g., X is a type of, a cause of, a reason for, a way of doing Y, etc.), and variation in findings across studies marked for inclusion using a qualitative comparative method (Doyle, 2007). The goal of this approach is to generate a synthesized statement of both implicit and explicit conceptual understanding that has been expressed in the literature (Sandelowski & Barroso, 2007). Finally, a synthesized account is drafted and successive revisions made until a coherent whole is formed. This **outcome** is aimed at the development of a variety of academic publications, conference presentations and community reports aimed at charting practice in the field or towards guiding future research endeavors.

In addition, this synthesis contributes to new observations from a research-users perspective in two overarching ways. First, this project contributes to a better understanding of HIV prevention as a culturally complex phenomenon possibly requiring dynamic and multi-level interventions. Second, research users can

be guided to address gaps in our understanding that contribute to the high rates of HIV infection in women in Canada.





RESULTS

After reviewing both academic literature and grey material, a total of 38 articles met our search criteria.

After the relevant articles were identified, a number of research team members met face-to-face on two different occasions to develop and then finalize the codebook. The first meeting was held in January 2009 to begin this discussion and the second daylong session was held in September 2009 to finalize the code book. The research team identified 10 themes which would frame and guide discussion for the final paper including: Determinants of Health; Risk Settings, Perceptions/Attitude/Knowledge; HIV Transmission; HIV Risk; Targeted Approaches; Ethnocultural Populations; Programming Implications/Prevention; Policy Implications; Prevention; and Living with HIV: Supports and Barriers. Several sub-themes were identified within each main theme. Once the codebook was finalized, a Qualitative Analyst was hired from September 2009-January 2010 to help code the 38 relevant articles. It is important to note that the discussion piece of this overview report was guided by the development of this codebook (Refer to Appendix 2).

Although for the purpose of our synthesis we adopted a definition of HIV prevention that included both primary prevention (e.g., preventing the occurrence of the initial HIV infection) and secondary prevention (e.g., preventing the onwards transmission of the virus), there is some debate in the studies about where HIV prevention efforts should be directed. Repeated reading of the qualitative studies by the research team revealed that although each study tells a unique story about HIV prevention from the perspective of the individual woman or groups of women included in these studies, embedded in the synthesis were recurrent themes specific to the influence of gender, culture, ethnicity and identity on HIV prevention. The identification of themes, incongruities and gaps helped contribute to our understanding of how to address the challenges in developing appropriate HIV prevention programming and policy to better meet the needs of the diverse populations of women in the Canadian context. (For a complete summary of the articles reviewed, please refer to Appendix 4).

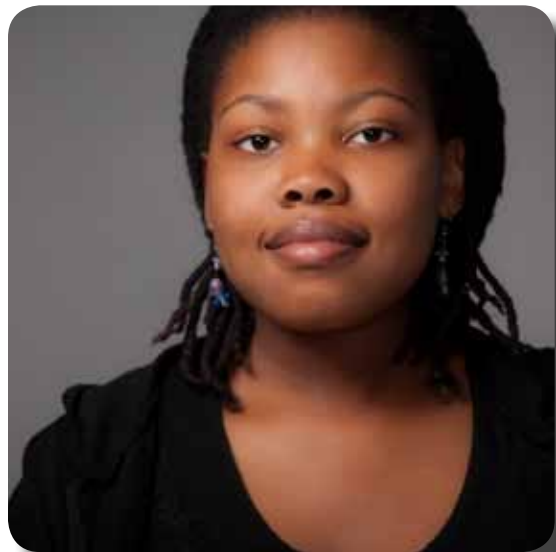
Sample

The studies varied greatly in terms of their specific focus (i.e. HIV prevention in relation to injection drug use/ culture/sexual orientation/secondary prevention), participant characteristics and methodologies. Specific populations of women included in the studies reviewed were young women, women living with HIV/AIDS, Aboriginal women, Black women, Asian women, lesbian women, bisexual women, sex workers, mothers living with HIV/AIDS, women who use drugs, immigrant and refugee women, and women in prison. Services providers were also included, such as nurses, HIV/AIDS prevention workers, social workers and doctors (see Appendix 4).

The age of participants across the various studies ranged from 14 years of age to approximately 60 years (several studies did not specify the upper age limit of participants). Methods used included one-on-one interviews with women, key informant interviews, focus groups and document review for discourse analysis. Most studies used an exploratory, descriptive approach and conducted thematic analysis. The use of participatory action research (PAR) techniques and community advisory committees were described in several of the research studies. For example, in the study by Gardezi et al., (2008) researchers worked with a Community Advisory Committee (CAC). The CAC advised on community needs, recruitment of participants, research instruments, interpretation of study results, dissemination of findings and future actions.

Although the synthesis focused on studies that recruited women, many studies also included men. Unfortunately, several studies with mixed male and female participants did not include a gender based analysis (GBA) or provide sex-disaggregated results. Many of the studies explored the impact of one variable on HIV prevention (e.g., ethnicity), but did not discuss how social determinants of health, such as gender and culture may overlap to create layered barriers to HIV prevention, care and treatment, or the need for integrated policies and programs.

Finally, geographic location varied across Canada. However, the majority of the research studies took place in Ontario, British Columbia and Alberta. Yukon Territory, Northwest Territories, Nunavut, Prince Edward Island and Newfoundland were not represented in this synthesis. While several research studies were conducted in rural and remote areas, the majority of studies took place in urban settings.



THEMES

What follows are the key themes and sub-themes which emerged from the synthesis of the qualitative literature on HIV prevention among Aboriginal and non-Aboriginal women in Canada.

Gender

Gender has been generally defined as shared expectations and norms held by society about appropriate male and female behaviour, characteristics, and roles. Such norms are said to both influence and regulate social interactions (Gupta, 2000). Gender differs from the concept of sex in that it refers to socially prescribed gender-specific roles and expectations, whereas sex refers to biological sex differentiation. Gender inequality refers to differential social opportunity and power based on gender (Commonwealth Secretariat & Atlantic Centre for Excellence in Women's Health, 2002). Those with less social opportunity and power are more likely to have their needs overlooked or marginalized. According to feminist theory, women who are marginalized (firstly by gender and also potentially by race, culture, class and sexual orientation) will have less access to social and health care systems and be at higher risk of contracting communicable diseases, including HIV (Arber & Khat, 2002).

The study of gender has contributed vital information to our understanding of HIV and its differential impact on men and women, boys and girls. By studying gender in relation to other social determinants of health, specific risk factors that increase women's vulnerability to HIV have emerged. Social stereotypes around women's sexuality and early misconceptions of women's HIV risk placed women at an increased risk for contracting HIV (Jenkins, 2000). Social norms, which sexualize women, yet vilify them for being sexual, condone male sexual promiscuity, place birth control responsibilities on females, limit public discourse on sex and sexuality, and perpetuate uneven sexual dynamics that are harmful for women's health. Additionally, barriers to health care often specific to women, such as lack of childcare, respite care or transportation, will impact women's ability to engage in health resource seeking behaviours (Beadnell et al., 2003). For these reasons, gender-based analysis that explores the experiences of both men and women is an important element to consider in the design, delivery and evaluation of HIV prevention efforts.





In our synthesis we uncovered the following gender-based themes: ongoing

sexism and discrimination

experienced by women in HIV research, programming and policy; women's inclination to rank HIV low on their hierarchy of needs/priorities; competing social roles ('woman', partner, caregiver, mother, daughter, IDU, sex worker, etc.); women's perceived passive role in sexual relationships with male partners which may lead to a lack of power to negotiate safer sexual practices; safety concerns related to sexual abuse or family violence; existing service barriers embedded within the formal health care system; unique secondary prevention considerations around finding peer support and family considerations; prenatal testing; and the interconnectedness of women's formative years and their HIV risk. Many of the women in the reviewed literature spoke of the historical, cultural, socio-emotional and physical wounds that have affected their health, language, identities, self-respect and very survival as women (Benoita et al., 2003). Violence, poverty, discrimination, racism, oppression, social isolation, stigma, substance abuse, trauma and violence were also commonplace in the lives of many women.

Much research and frontline work is still needed to ensure gender based analysis remains an HIV prevention and care priority. Examples of gender-appropriate interventions are: services offered in existing health/women's centers; both female and male involvement in initiatives; relationship-based HIV prevention negotiation skills training; empowerment-based programs; and female controlled technologies, such as microbicides and female condoms (Public Health Agency of Canada, 2003).

Given the complexities associated with HIV prevention, researchers must continually advocate for the routine integration of gender based analysis into research, programming and policy. Although there has been some success at ensuring the inclusion of gender in several government working documents, it does not always filter down into program planning and policies at the various sectoral levels (Jurgens, 2004). Lack of capacity, funding or other resources to implement this level of analysis is often at issue. Given that mainstream health care systems are still largely organized around the biomedical model of health care, there remains an assumption that both males and females needs are being addressed by a system originally designed for men (Jurgens, 2004). In addition to recognizing how and why women and men's HIV prevention needs are different, we must also recognize that women are a highly heterogeneous group with vastly different experiences that serve to shape HIV risk and HIV-related health outcomes.

Culture and Identity

Culture and ethnicity were the focus of the majority of the articles reviewed in this synthesis. Specifically, 40% of included studies focused on HIV prevention relevant to Aboriginal women. An additional 13% looked at HIV prevention issues as experienced by African and Caribbean women, one study looked at the experiences of Asian youth and the remainder of the studies focused on Caucasian populations. Although many studies did not specifically investigate the impact of culture or ethnicity on their population, in many cases study populations were disaggregated by ethnicity, or ethnicity was discussed as it evolved out of the interviews or focus group discussions. In general, the research indicated that HIV prevention services were usually not culturally-tailored or sensitive and if programs did consider ethnicity, they often ignored the diversity within ethnic groups (Flicker et al., 2008).

Aboriginal Women

The tension between a Western biomedical approach to HIV and traditional Aboriginal approaches to health and illness.

Several of the studies described Aboriginal women's experiences of a disconnect between their traditional or cultural understanding of illness and healing and the Western biomedical approach to HIV espoused by most mainstream Canadian health care services (Benoit et al., 2003; Bucharski et al., 1999; Clarke et al., 2005; Larkin et al., 2007; McKay-McNabb, 2006; Mill, 1997; Mill, 2000; Mill et al. 2008; Ship & Norton, 2001; Wardman & Quantz, 2006). Specifically, there was a lack of focus on holistic health (body, mind, spirit and emotion). Many participants in these studies described healing or health in terms of journeys (healing path), connections to nature and spirituality (Tree of Life, the Creator), traditional medicine models (the medicine wheel) or in reference to community-based traditional healers or Elders (Mill et al., 1997).

Women's experiences with HIV-related services, however, were characterized by a lack of Aboriginal health practitioners and a lack of focus on Aboriginal-specific issues. For example, in McKay-McNabb's (2006) study among Aboriginal women living with HIV, many of the women described needing to relate HIV to their traditional understanding of health and healing before they could move forward with their personal acceptance of their new HIV-positive identity. This finding was echoed in other studies, which documented how participants found their connection to their Aboriginal spirituality helpful in accepting their diagnosis. Some women described their HIV diagnosis as a catalyst for renewing their interest in Aboriginal cultural and healing traditions. However, it should be noted that not all of the women included in these studies felt connected to these aspects of their Aboriginal heritage.

For some, there was a strong feeling that they had become HIV positive for a reason (Mill et al., 2000). Karen (not her real name), although not specifically referring to the Creator, believed that she had become HIV positive because she was a strong person and would be able to learn from her illness. She describes her insights this way: "I have a positive attitude with it and I feel now that if it wasn't for that I probably wouldn't be sober right now. You know it's actually made me realize that what I'm going through is okay, it's part of me ..." (Mill et al., 2000).

Despite these examples of alternative views, biomedical approaches to HIV remains focused on individual risk behaviours and the empowerment of women in isolation from broader political, economic and structural factors. In fact, some women included in the studies conceptualized HIV as payment for past mistakes, exemplifying a sense of individual fatalism and discrediting the influence of social issues. Some women expressed their belief that they deserved to be HIV positive on the basis of their previous behavior. One woman said: "like I did it, I deserved it." Some women presented fatalistic views about their illness, believing that they had always known they would become HIV positive (Mill et al., 2000).



A focus on treatment of existing symptoms rather than prevention of risks or social factors that mitigate risk behaviours stymies HIV prevention efforts. In terms of programming, the expressed Aboriginal belief that a disease must exhibit physical symptoms of illness before treatment is sought may contribute to Aboriginal women being diagnosed later and having poorer HIV treatment outcomes. HIV prevention strategies, especially the promotion of HIV testing, must consider this and its interaction with the dominant biomedical approach in an effort to address HIV prevention for Aboriginal women through education for individuals, communities and health practitioners. The need for more holistic approaches to health and HIV that value culture, context, health promotion and disease prevention is evident. Involvement of community leaders, fathers and family members was also put forth.

For example, Aboriginal leaders identified the importance of including fathers and family members in prenatal care. Prenatal classes that were geared towards married couples and the nuclear family did not deal with issues and concerns of single parents and failed to meet the emotional, physical and spiritual needs of Aboriginal women (Bucharski et al., 1999). Aboriginal leaders also called for the involvement of Elders in the delivery of services. In one study Aboriginal staff were viewed as being beneficial for building trust with some clients, while others thought that working with non-Aboriginal staff would not be a major concern for many clients, particularly if service providers were both open-minded and non-judgmental (Wardman et al., 2006). However, the degree to which community is involved may vary from individual to individual. As such, health professionals must remain open to the degree to which a population may adhere to traditional values and beliefs (Mill et al., 2000).

The legacy of colonialism and residential schools

on HIV vulnerability. Mill (1997) describes Aboriginal women's HIV risk as being shaped by their relationships, formative years, self-esteem and need to engage in survival strategies. These themes are repeated in much of the literature on the impact of gender and HIV risk. Women, especially women from cultural minority groups, may be at higher risk of HIV due to social, economic and political marginalization. The reality that Aboriginal women in Canada are experiencing higher rates of HIV than non-Aboriginal women speaks to the cumulative impact of culture and gender on HIV vulnerability. Many of the studies included in this synthesis relayed stories of women's understanding of how their community and culture was detrimentally impacted by colonialism and specifically, residential schools. Some Aboriginal women attributed the high prevalence of sexual abuse to the loss of the traditional role of Aboriginal men as protectors of women, resulting from colonization, the socialization experiences in residential schools, and other assimilation practices. It is therefore not surprising that these experiences profoundly affected women's mental health (Bucharski et al., 2006).

Understanding how HIV risk and HIV infection affect Aboriginal populations necessarily raises the issues of the legacy of disadvantage which continues to impact negatively on the physical, mental/emotional, social, and spiritual health of Aboriginal peoples, families, and communities. Residential schooling, multi-generational abuse, and forced assimilation in tandem with widespread poverty, racism, sexism, loss of culture, values, and traditional ways of life have given rise to a range of pressing social problems that include alcoholism, substance abuse, high suicide rates, violence against women, and family violence (Ship & Norton 2001). These issues point to the need for a gender based analysis of HIV risk. However, it must be noted that gender alone cannot fully account for the higher infection rates in young Aboriginal women (or young men). A response to the HIV/AIDS epidemic in Aboriginal communities must begin with an understanding of the unique social, cultural, and economic issues facing Aboriginal peoples.

Embedded in the narratives are common themes that run from childhood to adulthood, including an absence and loss of love, security, esteem, family, friends, home, and education. Aboriginal women's experiences were layered on individual and community histories characterized by trauma, turbulent childhoods, violence and abuse and physical relocation (Mill et al., 2008; McKeown et al., 2003; Ship et al., 2001). The life histories of these women revealed many common characteristics such as unstable family situations, moving frequently, and experiencing strained interfamilial relationships (Mill, 1997). Many reported physical violence in childhood which resulted in running away from their home situation, citing sexual abuse as the main reason (McKeown et al., 2003).

An acknowledgement of how the legacy of colonialism intersects with current racism and sexism to marginalize and negatively impact Aboriginal women's health is crucial in providing culturally competent, accessible, safe and supportive environments within which HIV prevention work can occur. However, it is essential that culture and gender are not only presented as challenges to health, but also seen as sources of strength that can inform HIV prevention strategies. It is important to note that although many felt they were raised in a "white man's world," some of the Aboriginal beliefs that they had learned as children persisted and were evident in their adult worldview (Mill, 2000). These participants were often unaware that their beliefs were grounded in their Aboriginal culture. A focus on community assets and resiliency is an understudied area, with most studies adopting a deficit model.

The influence of stigma and racism. Several articles discussed how the primary source of information on HIV within Aboriginal communities is based on seroprevalence research, which fails to situate HIV rates and risks in the context of the broader social determinants of health. In a joint study, Health Canada and the University of Manitoba (1998) warned that HIV research that focuses solely on the increasing infection rates in Aboriginal communities can reinforce negative stereotypes and discrimination against Aboriginal people both within their community and among non-Aboriginal Canadians. In addition, there is also a risk of supporting stereotypes, perpetuating 'othering' and adding to the stigma and discrimination already disproportionately experienced by Aboriginal Canadians (Larkin et al., 2007).

In the study by Larkin et al., (2007), youth tended to associate contracting HIV with poor (and/or unlucky) decision-making and resisted the idea that social processes had any bearing on the construction of individual risk. Whether talking about "people in Africa," "poor people," "city" or "urban" dwellers, young people often perceived HIV to be something that happens to people elsewhere. (Larkin et al., 2007). In contrast, Aboriginal youth worried more about HIV/AIDS, which they recognized as a real and persistent problem in their community (Larkin et al., 2007). Many

youth also talked about the powerful contribution of intercommunity stigma to HIV risk and silence. Others talked about how the stigma is "contagious" and as a result, entire families can be treated as outcasts (Flicker et al., 2008).



In a study by Travers & Paoletti, 1999, denial was a particular concern to young lesbians. While reflecting on her presentation to a coming-out group for lesbian youth, one young woman revealed how denial experienced by young people who are HIV-positive is mirrored in the attitudes toward HIV risk among lesbians (Travers & Paoletti, 1999). The denial and invisibility of HIV among young lesbians raised heightened concerns about romantic or sexual partners. Young gay men were more likely to eventually encounter other HIV-positive peers, while young HIV-positive lesbians (given the low sero-prevalence among young lesbians) were more likely to experience longer-term isolation and marginalization within their peer group. This was evident in the comment from one young woman who worried about the inability of lesbians to accept that HIV is a reality in their community (Travers & Paoletti, 1999).



Larkin et al., (2007) and Flicker et al., (2008) interviewed youth to explore how they understand HIV/AIDS risk. Many of the Aboriginal youth in these studies spoke of colonialism, racism and the over-representation of their community in the HIV epidemic. Unlike their non-Aboriginal peers, many of these youth saw HIV as a real issue that directly affects their community, a genuine threat and as a death sentence. While some of the Aboriginal youth spoke of colonialism and its relationship to substance abuse and sexual abuse, others held their community responsible for the high prevalence of HIV without relating HIV to the determinants of health. Larkin et al., (2007) perceived the youth's discourse of self-blame as a possible reflection of the negative portrayals of Aboriginal populations in mainstream society. Despite the existence of internalized racism expressed by some youth, the majority of the youth described gaining an important sense of identity and support through their connection to their culture and community and felt that culturally-specific HIV resources and services were greatly needed. Many youth felt that it was important for Elders in their communities to learn more about HIV/AIDS so that they could take a leadership role in alleviating stigma. Some youth suggested the need for an intergenerational connection where Elders and youth could learn together and work together to fight this problem in their communities (Flicker et al., 2008). Further, youth engagement in stigma reduction and public education around HIV prevention are needed to help lessen the impact of racism and discrimination and to shift the focus to comprehensive prevention.

Insufficient, inappropriate and/or inaccessible services.

Many Aboriginal women expressed a desire for integrated health care services that respected traditional Aboriginal approaches to health and that also offered opportunities for input into service planning and delivery. Some of the common barriers to HIV-related services and other formal health care services described in these studies included: a lack of culturally-appropriate available services; fear of HIV testing and a lack of knowledge regarding testing and treatment options; non-existent or inconsistent HIV-related services in rural or remote locations; past negative experiences interacting with health practitioners; a lack of confidentiality when accessing health services in small communities or if the service was Aboriginal-specific or HIV-specific there was a fear associated with people in their community knowing that they were accessing HIV-related services; and lastly, many women found that services were not always open to family members, which was especially problematic for women with children.

Limited HIV-related services in small or remote communities as well as a lack of culturally-specific health services in urban communities represent significant barriers to HIV prevention, education, care, treatment and support for Aboriginal women. For some HIV positive women, living in urban and metropolitan centres, far from their home communities, was necessary to help ensure anonymity and because of the perception that there is greater acceptance of HIV-positive women in larger cities (Ship & Norton, 2001). The lack of sustainable infrastructure and financial resources for women-specific prevention has been linked to a general lack of support for sustainable community-based authority and governance in HIV/AIDS in Canada (Canadian HIV/AIDS Legal Network, 2005).



Many Aboriginal people also reported “feeling helpless” and “weary” of trusting health care providers based on their own or other Aboriginal people’s negative experiences with mainstream, non-Aboriginal-specific policies which

resulted in discriminatory treatment

(Bucharski et al., 2006). Many also expressed a desire for female physicians, due in part to the high rate of family violence, physical and sexual abuse issues, and risk behaviours in their earlier or current lives (Benoit et al., 2003). In this same study, participants were in search of culturally appropriate services that: (1) offered support and safe refuge from the urban decay around them; (2) provided staff who understood Aboriginal women’s historical wounds and were aware of the lingering racism and sexism that continue to negatively affect their health, language, identities and self-respect; (3) endorsed a philosophy that promoted preventive health and incorporated traditional Aboriginal medicine into modern health care practices; and (4) opened its doors to Aboriginal women’s families, especially their children (Benoit et al., 2003). Women also identified the value of peer support and appreciated the opportunity to meet with other mothers who shared similar life situations (Benoit et al., 2003).

A number of approaches to addressing these issues emerged including: partnering to create integrated health and social services in an effort to better address women-specific health and well-being needs and assuage women’s concerns about accessing HIV-specific services for fear of lack of confidentiality; more public education to reduce stigma and potentially improve testing and treatment uptake; inclusion of traditional healers and Elders in the development and delivery of HIV-related strategies and programmes; provide health service models that are open to family members; and consideration of on-reserve and off-reserve issues and the unique barriers experienced by people living in rural or remote communities.

African and Caribbean Women

A lack of focus on African and Caribbean women's HIV-related needs. Despite the fact that Black women in Canada represent a significant group affected by the HIV epidemic, researchers and policy makers have largely ignored their unique needs (Tharao & Massaquoi, 2001). Fewer Black women access prevention, treatment, support and care services for HIV in Canada than other women. However, they are overrepresented in recent epidemiological statistics, especially among women being diagnosed during prenatal testing. There are very few prevention programs and educational resources targeted specifically to Black women. This suggests that many Black women may have limited knowledge of HIV/AIDS, modes of transmission and how it can be prevented. Most significantly, this may result in a lack of understanding of their own risk of infection (Tharao & Massaquoi, 2001). Findings indicate the need for greater sensitivity on the part of service providers and also the need for more services delivered by and for African and Caribbean communities (Gardezi et al., 2008).

A layering of various forms of marginalization. Increasing rates of HIV infection among African and Caribbean women in Canada have been attributed to the layering of various forms of marginalization. Several examples of marginalization emerged: fewer economic opportunities for visible minorities and discrimination related to the unequal transferability of accredited skills and education results in women being more likely to be financially dependent on men; the effects of racism on employment, housing, education and other opportunities; the detrimental impact of diagnosis on immigration status and/or ability to sponsor family members making individuals unwilling to find out their status; and lastly, barriers to receiving medical coverage (Tharao & Massaquoi, 2001; Newman et al., 2008; Mitra et al., 2006).



African and Caribbean women's economic disadvantage and the increased risk for HIV infection remains a significant prevention issue. Due to the economic marginalization of African and Caribbean women, a positive HIV test result may be regarded as yet another issue in the long list of daily hurdles faced, with many individuals preferring not to know their HIV status (Tharao & Massaquoi, 2001). Focus group participants indicated that, compared to HIV, other issues seem to be more important for Black Canadians on a daily basis, including intergenerational conflict, problems encountered by Black youth in the school system, unemployment, racism and immigration and settlement issues (Gardezi et al., 2008).

Community-based sexual norms. All of the studies included in this synthesis on African and Caribbean women's HIV-related needs discussed existing sexual norms that perpetuate male control in sexual relationships and create an environment conducive to possible gender-based violence (Gardezi et al., 2008; Mitra et al., 2006; Newman et al., 2008; Omorodion, Gbadebo & Ishak, 2007; Tharao & Massaquoi, 2001). These norms were described as being culturally reinforced social roles, leading to sexualized and gendered identities for African and Caribbean women. Specifically, Gardezi et al., (2008) and Omorodion, Gbadebo & Ishak (2007) described how sex, sexuality, physical and psychological health are generally not discussed in homes or communities within many African and Caribbean communities. Additionally, there was a noted lack of information or concern regarding HIV or STIs among the women interviewed in the two aforementioned studies. This situation was attributed to limited education opportunities leading to misinformation about the epidemic. Traditional cultural practices that increase risk of infection, such as genital mutilation and vaginal cleansing, were also discussed by women as contributing to HIV risk.

Lack of culturally and linguistically-appropriate resources and services. Many of the African and Caribbean women included in these studies expressed that their needs were not met by the North American systems of healthcare delivery, which are based primarily on a bio-medical, mono-cultural model, creating cultural, linguistic, racial, gender and class barriers embedded within these systems. For example, Tharao & Massaquoi (2001) and Newman et al. (2008) describe how policy on HIV testing in pregnancy was announced without culturally-appropriate and language-specific resources for Black women. Additionally, services often do not have the funds to provide culturally and linguistically appropriate resources. African and Caribbean women also spoke of the mistrust of HIV prevention services.

Among Black African participants, there was strong evidence that discussions of sex, sexuality, physical and psychological health issues were not part of their everyday experience (Gardezi et al., 2008). This silence and secrecy can result in a tendency, noted particularly among men, not to seek medical care until a health condition is acute and as a result, likely to yield worse health outcomes. It also impedes access to information about HIV or sexual health, discourages people from seeking treatment and contributes to ongoing denial of HIV as affecting African and Caribbean communities in Canada (Gardezi et al., 2008).



While HIV prevention strategies focused on women's experiences are clearly important, men are an undeniable component of Black women's vulnerability to HIV infection (as well as being vulnerable themselves). Men can play a significant role in lowering Black women's HIV risk (Newman et al., 2008). An HIV prevention discourse dominated by messages for men (especially, men who have sex with men) was also implicated in a disconnect between Black women and prevention messages. Cultural disconnects were also attributed to what was seen as the prevailing discourse around risk groups, particularly gay men and drug users, which led many Black women to exempt themselves from current HIV prevention messages (Newman et al., 2008).

A more nuanced understanding of socio-cultural issues that increase the risk of infection for Black women is needed in order to address the multiple challenges in developing appropriate prevention approaches. Some of the challenges include a lack of understanding of the cultural values, beliefs, and practices of Black women. To accurately assess the risk of HIV infection for African and Caribbean women, an understanding of these practices is essential (Tharao & Massaquoi, 2001). Many Black women emphasized the need for "spokespersons"

such as celebrities or religious leaders to draw attention to HIV in their communities and also emphasized the need for community development measures to provide venues for discussion and action. Further, it was noted that information about HIV may not be reaching their communities, perhaps because the distribution channels, language, images and cultural appropriateness of the messages are not geared to the needs of diverse Black Canadian audiences (Gardezi et al., 2008).

Confidentiality and stigma. Concerns about confidentiality extended to a fear of using a translator or interpreter from their own community to help with accessing health services (Newman et al., 2008). A ‘politics of blame’ was described to explain the stigma, denial, discrimination and HIV fear that women felt existed in their community. Fear of not being treated with respect when seeking or receiving HIV information as well as multiple intersecting forms of discrimination emerged as powerful contexts for understanding HIV risk and prevention among Black women (Newman et al., 2008). Reluctance to access health services for fear of encountering a racist perception that African or Caribbean people are carriers of HIV and other disease remains problematic in HIV prevention approaches (Gardezi et al., 2008). Commonly believed images, stereotypes, and attitudes about the disease itself, compounded by constant anxiety about what others think or feel about them may determine whether people seek and/or access services (Tharao & Massaquoi, 2001).

Fear of stigmatization for the community as a whole, as opposed to personal stigma, was a deterrent for testing. HIV prevention strategies traditionally address issues of personal safety, personal choice, and individual rights. For women who are raised in communally-oriented societies, the wellbeing of the family and the community may trump the rights of the individual. Successful strategies and programs for many communities must be adjusted in order to address this reality. Individual strategies should be complemented with community level strategies in order to modify cultural values, beliefs, norms, and practices that may increase risk of HIV infection (Tharao & Massaquoi, 2001).

The suggestion that it would be “better not to know” one’s HIV status because the stress of knowing would lead to physical decline needs to be attended to in subsequent HIV prevention strategies. The association of HIV with rapid decline and death is strong, with terms such as “dead and walking” used to describe community perceptions of HIV-positive people. This also makes it difficult for HIV-positive individuals to disclose to families back home that they are not able to see and reassure that they are healthy (Gardezi et al., 2008).

HIV prevention opportunities were identified in strategies that capitalize on existing community institutions and strengths. The church was regarded as a powerful cultural institution that could be tremendously effective in supporting HIV prevention. The widespread reach of the church was regarded as an important resource for disseminating HIV/AIDS information (Newman et al., 2008).

Asian Women (Youth-Focused)

Our document-scoping review resulted in only one article specific to Asian women’s HIV-related needs in Canada. The article by Kwong-Lai Poon and Trung-Thu Ho (2002) consisted of a qualitative analysis of the cultural and social vulnerabilities to HIV infection among gay, lesbian, and bisexual Asian youth. This study identified the following themes as creating vulnerabilities to HIV for Asian youth living in Canada: 1) the lack of sex education at home, 2) homophobia in Asian families, 3) unresponsive health and social service providers, 4) lack of social support, 5) negative stereotypes, 6) ideal standards of beauty, and 7) negative perceptions of safer sex practices among Asian lesbian and bisexual women.

Youth

The predominant theme to emerge from the research based on young women and HIV prevention was that young women are ill equipped to discuss sex and safety with their sexual partners (Cleary et al., 2002; DiCenso et al., 2001; Beazley et al., 1996). The primary recommendation from the reviewed literature was to teach youth how to discuss and negotiate safer sex. Providing youth with accurate, practical information about sex from informed, non-judgmental teachers and service providers was seen as a necessary step to curb misinformation and lack of information regarding available services. Additional recommendations included ensuring accessible anonymous testing and counselling are available to youth and actively involving both genders in HIV prevention discussions and initiatives.

Youth also talked about difficulty accessing appropriate sexual health services. Both males and females indicated barriers such as clinic locations, hours of operation or insufficient time for appointments. In rural communities, the issue of location provided additional challenges. Transportation to and from clinics was a barrier, given that many students had no access to a car or public transportation (DiCenso et al., 2001). In rural communities both male and female students expressed concern about confidentiality when using any of the sexual health services given the high risk of being seen in the local drug store or sexual health clinic (DiCenso et al., 2001).



In some cases, physicians' offices were not seen as the most appropriate venue to receive information. For example, a few young women commented that physicians had not fully informed them about contraceptives, an omission which left them with misunderstandings about the proper use and possible side effects of birth control pills (Beazley et al., 1996). In other instances doctors would not share information unless a parent was present.

It is important to note that even the most articulate, educated, skilled young women were not able to have discussions with partners who were unwilling to engage. Participants reported that partners who inhibited the communication process did not want to talk about sexual health issues, sexual histories and/or to sexually self-disclose (Cleary et al., 2002).

Assumptions were also used to avoid discussions about condom use, and the potential awkwardness. In the study by Clearly et al., (2002) instead of initiating conversations related to condom use, young women assumed that their partners would know that they needed to use a condom. In other cases, the men seemed to assume that the women would be taking care of the contraception. It was evident that many of the participants did not think that there were any substantive risks involved in having a sexual relationship with their partner. Most used unfounded assumptions in making their own decisions on condom use and contraception. Under these circumstances, they felt quite safe (Cleary et al., 2002).

Students explained that sex education classes did not provide them with information they found useful. Little was taught beyond the basic “plumbing” of sexual health and that the focus was on the negative consequences of unhealthy sexual decisions (DiCenso et al., 2001). Although most students had been taught the various forms of birth control, very few could identify forms of birth control other than the pill and condoms. Students didn’t consider teachers to be the best sexual health educators and they often feared that teachers would tell their parents or give them poor grades if they learned they were sexually active (DiCenso et al., 2001). Both male and female adolescents said they would like to be able to talk to their parents about sex (DiCenso et al., 2001). Youth also talked about being bored with traditional sexual health education approaches and thought the current strategies were out dated and unrealistic (Flicker et al., 2008; DiCenso et al., 2001).



Sexual Orientation and Identity

Very limited research has explored the HIV/AIDS-related information and prevention service needs of lesbian, bisexual and transgendered women. The existing androcentric health system assumes that women who are not having sex with men are not at risk of acquiring HIV. Health care providers should be aware of how lesbian, bisexual and transgendered women’s health care needs may differ from heterosexual women’s needs (i.e. safe sex needs, pregnancy planning issues, hormone therapy) and how these differences may impact their access to culturally-sensitive and appropriate HIV prevention services and information.

Kwong-Lai Poon et al., (2002) interviewed 15 gay, lesbian and bisexual Asian youth to investigate cultural and social barriers to HIV prevention. They identified multiple barriers to sexual health education and resources related to unresponsive and/or homophobic family members and service providers. Travers & Paoletti (1999) found that age-specific, barrier-free, well-advertised services were urgently needed for HIV-positive lesbian, gay and bisexual youth to prevent social isolation and despair. Service providers can play a significant role in enhancing quality of life for these youth. First and foremost, services must be youth-specific and barrier-free. Misinformation, shame, self-blame, denial, social isolation, and fear can be reduced through individual and group counselling supports. Finally, there is an important role for community supports including peer-based programming (Travers & Paoletti, 1999). It is important for counsellors to consider that youth may have little, if any, life experience in coping with adverse life events, or the death of family members or friends. These factors may make the helplessness associated with fear of dying from AIDS particularly acute for HIV+ lesbian, gay and bisexual youth. Counselling supports should thus focus on building hope through assisting youth in sorting through residual conflicts or difficulties related to sexual identity formation, familiarization with current treatment methods, and provision of the requisite skills for living with HIV infection (Travers & Paoletti, 1999).

Drug Use

Six studies in our synthesis focused on the HIV prevention or care needs of women who use drugs (Shannon et al., 2008; Elwood-Martin et al., 2005; Jackson et al., 2002; Strike et al., 2002; Harvey et al., 1998; Ship et al., 2001). These studies contained a wealth of information regarding the contexts within which women who use drugs must navigate in their HIV prevention efforts. The authors described the need for harm reduction initiatives (i.e., needle exchange programs) to be complimented and supported by larger policy shifts (i.e., harm reduction services in prisons) and revised drug laws based on human rights principals and evidence-based evaluation data (Elwood-Martin et al., 2005; Strike et al., 2002; Harvey et al., 1998). Jackson et al., (2002) described individual behavioural level issues that impact HIV risk, such as women being less likely to use condoms with regular sexual partners and uncovered the important contribution that peers can make in promoting healthy behavioural choices. Shannon et al. (2008) explored how addiction, interpersonal relationships, violence, local policing and sex work all influence one another in relation to HIV risk within Vancouver's Downtown Eastside (DTES). HIV prevention strategies that move beyond an individual, behavioural focus to include structural and environmental interventions are recommended as a way to create environments that will enable and sustain effective HIV prevention (Harvey et al., 1998).

Many of the respondents who indicated that they have in the recent past shared needles spoke of how this occurred when they ran out of needles and the needle exchange was closed, or they had some unexpected access to drugs and were without a needle. Several spoke of sharing needles while incarcerated (Jackson et al., 2002). In the study by Ship et al. (2001), all of the Inuit women interviewed were aware of the risks of HIV from unprotected sex and sharing needles. The notion of negotiated risk, particularly in resource-limited settings, offers an important insight into the provision of HIV prevention within a harm reduction framework.

Participants offered several recommendations to enhance the profile and availability of harm reduction. The key component of these recommendations was focused around augmenting education to all sectors of the community to make them more aware of the need for these services. It was felt that there is a general lack of awareness regarding how harm reduction services can fit with existing philosophies and treatments of addictions (Wardman et al., 2006). Participants suggested that educational efforts should be offered in a participatory manner in order to capture the experiences of those who would be affected by the integration of harm reduction services. In addition, it was suggested that combining harm reduction education with other health promotion initiatives might provide an easier point of entry for HIV prevention strategies. Participants also strongly emphasized the diversity of groups in need of prevention education campaigns (Wardman et al., 2006).

The value of community leaders must not be underestimated, as their support is crucial for delivering harm reduction services. In addition to elected leadership, gaining the support and trust of community Elders can also play a key role in advocating for these services (Wardman et al., 2006). Changing community members' attitudes and beliefs around harm reduction was seen as vital in gaining widespread acceptance of harm reduction approaches to service provision. Community education efforts could be facilitated by existing media, which are often used for communication in First Nations communities (Wardman et al., 2006).



Living With HIV/AIDS

Five articles included in our synthesis explored the HIV-related needs of women living with HIV/AIDS. The primary focus of these articles was to discuss the social and psychological impact of HIV on women's lives and their care, treatment and support needs. The primary themes discussed were parenting challenges, the significance of the diagnosis event, and barriers to support service use (McKeown et al., 2003; Antle et al., 2001; Heath et al., 1999; Metcalfe et al., 1998). According to Metcalfe et al., (1998) women disclosed an interest in support groups or peer meetings, integrated care with other social and health services and the need for female-friendly environments where children were welcome. Heath et al., (1999) discussed how larger social structural issues such as unemployment, lack of housing, poverty, childcare, lack of information and lack of support contributed to HIV-positive women's isolation and inability to access local resources for support. Recommendations included peer-based support, woman-friendly services, female staff, childcare and education for communities and service providers.

Participants across diverse populations and cultures indicated experiencing various levels of social isolation. For mothers living with HIV/AIDS, a lack of emotional and social support was reported. In addition, as a consequence of multiple forms of stigma and barriers to services, First Nations women living with HIV/AIDS and their children, have little, if any, emotional and social support. Daily struggles for most positive women who are unable to provide for basic needs include food, clothing, shelter and transportation for themselves and for their children. Unable to afford expensive treatments, difficult choices are often made between purchasing medications for themselves and basics for their families (Ship et al., 2001).



For the women in Vancouver's Downtown Eastside (DTES), there are very few places where Aboriginal women feel comfortable to go and sit with their children in a safe, nonjudgmental environment. There are even fewer support systems

available for children to learn how to cope with the fact that their mothers are living with HIV or AIDS (Benoit et al., 2003).

Families worry about discrimination, particularly towards their children, should they disclose their HIV status (Antle et al., 2001). It is important that allied health professionals understand the complex dynamics in families living with HIV/AIDS (Antle et al., 2001). For example, social workers in a range of settings could become more proactive in reaching out to families living with HIV. Those working with adults who are HIV-positive need to include a child and family focus, inquiring about potential children, helping to evaluate the impact of HIV/AIDS on these children, and addressing the extra demands of parenting (Antle et al., 2001). Families need to know that they are not alone. Social workers need to recognize and prepare for the ways in which HIV/ AIDS touches their lives, their clients' lives, and their clients' families and children (Antle et al., 2001).

Many women live in secrecy due to the multiple forms of stigma associated with HIV/AIDS but they also suffer from gender discrimination because as women they carry the additional stigma of being branded “promiscuous,” “a bad mother,” and “deserving of HIV/ AIDS.” (Ship et al., 2001). Reluctance to disclose the seropositive status of a loved one is also related to fear of rejection, fear of emotional and physical harm to children, fear of discrimination and/or simply needing time to come to terms with the reality of living with HIV/AIDS (Ship et al., 2001).

Isolation of caregivers is a consequence of the continuing stigma attached to HIV/AIDS in Aboriginal communities and the resulting dilemmas of disclosure. Lack of services, counselling and supports for the caregiver, the loved one living with HIV/AIDS and in some cases the family, serves to reinforce their isolation (Ship et al., 2001). Counselling and support for caregivers are almost nonexistent. Many caregivers find it difficult to accept the diagnosis of HIV of a loved one. Caregivers require time and support in working through their complex and often, contradictory feelings.

Participants also stated that they experienced a lack of acceptance of people living with HIV/AIDS not only from society-at-large, but more painfully, from their family members and from members of their communities. The shame, stigma, and discrimination associated with the disease leads to the perception among some women that an HIV diagnosis is something they would be better off not knowing. This in turn can serve to limit access to and uptake of HIV testing services, timely diagnosis, and early access to treatment for those who are found to be infected. This may also be an important issue in relation to secondary prevention of HIV where those who are living with HIV but unaware of their HIV status, may see no need to take precautions to prevent the onwards transmission of the virus.

While some participants have endured hardships and persevered and have begun to develop their new identities as women living with HIV/AIDS, others continue to struggle to cope with the factors that are a part of their everyday lives. According to McKay-McNabb et al. (2006), it is important to understand that Aboriginal women affected by HIV/AIDS go through developing new identities as shaped by HIV/AIDS. Each of the Aboriginal women interviewed shared experiences unique to their lives and their individual stages of identity that revealed what it was like to walk along the path to healing with HIV/AIDS (McKay-McNabb et al., 2006).

Several HIV-positive women indicated encountering problems with male partners after an HIV diagnosis. Women described verbal, psychological or physical abuse, which either followed or was aggravated by disclosure of their HIV status to their partners. Women also described difficulties accessing HIV-related support services because of opposition from their partners. It was found that heterosexual men are more prone to denying their own or their partner’s HIV status than women (Gardezi et al., 2008).

Lesbians with HIV continue to be a hidden and isolated population, and despite attempts to include greater numbers of HIV-positive lesbians in research, they are reluctant to come forward. Those who did, however, spoke poignantly about HIV-related stigma and the resulting social marginalization and isolation. It is likely that because lesbians primarily contract HIV from sharing needles or from sex with men, social stigma is further intensified adding to their sense of isolation (Travers & Paoletti, 1999).



Almost all of the participants mentioned the importance of a strong support system to assist HIV-positive individuals to adapt to and accept their diagnosis. Many expressed a need to become involved in a support group exclusively for HIV positive women. It was felt that involvement in a women's support group would provide an opportunity to express their feelings more openly (Metcalf et al., 1998). Several were surprised by the amount of support that was available once they knew where to find it and were able to ask for it. Women differed in the type of support they found most comfortable. Some preferred individual support while others attended support groups. For the most part, women found it very helpful to talk with other Aboriginal men and women who were HIV positive. Most had at least one family member, such as a parent or sibling, who provided support following their diagnosis; however greater support from their families was needed at the time of, and following, their diagnosis (Mill et al., 2008).

HIV/AIDS Service Providers/Testing/Counseling

Several articles included in our synthesis looked at issues related to providing HIV prevention education, testing, counseling, care, treatment and/or support to women from the perspective of service providers (Worthington et al., 2003; Strike et al., 2002; Beazley et al., 1996; Spittal et al., 2003; Hilton et al., 2001; Mitra et al., 2006; Beazley et al., 1996).

These studies illustrate a number of key issues that arise between service providers and service users which can serve as barriers or facilitators to HIV prevention for women. Worthington et al. (2003) suggested how patient-provider power dynamics during HIV testing as being potentially stigmatizing and disempowering. Spittal et al. (2003) described how a group of needle exchange workers had to 'bend' inefficient service delivery policies to better meet the needs of their clients. Hilton et al. (2001) described the specialized education and support needs of outpost nurses who engage, retain and treat marginalized women who are at high risk of acquiring HIV and other health and safety issues. Hilton et al. (2001) also described the challenges of connecting marginalized women to the mainstream health care system and influencing colleagues to be responsive to their unique needs. Olivier & Dykeman (2003) discussed the commonalities between the HIV prevention work completed by nurses and social workers and suggested the need for greater collaboration in areas of service delivery, policy development, advocacy and professional development.

Many practitioners linked decisional conflict to HIV-related stigma that women feared from their social network. There is the fear of the negative consequences of testing: fear of alienation and ostracism, fear that their partners may leave if they find out they tested, and fear of being isolated from the community. Others linked HIV stigma to institutional discrimination, noting the specific populations of women fear how their test results will affect their immigration status or being able to afford all required medications and related treatments if they do not have a health plan (Mitra et al., 2006).

Despite varying levels of distrust of the health system, health care providers were seen by some as important resources for providing HIV prevention information. Health care providers were specifically acknowledged as important sources for HIV information to Black youth, particularly immigrant youth, who were described as vulnerable due to lack of exposure to HIV education and being protected by their families (Newman et al., 2008). However, in the study by Beazley et al., (1996), physicians were not the preferred source of reproductive health information. It was felt that physicians either did not take enough time to fully inform them or used inaccessible medical terminology. As such, women interviewed in this study offered two key suggestions for physicians. First, within their offices and communities, they must provide accurate and nonjudgmental information in language that is accessible to young women. Second, they must do so before potential adverse outcomes of sexual intercourse are experienced (Beazley et al., 1996). Several other considerations were raised in relation to physicians, including the need to switch to a new physician once a patient is found to be HIV-positive, and paternalistic attitudes of some physicians in dictating what patients ought to do about their HIV status rather than discussing options with patients (Newman et al., 2008).

Overall, physicians must make their practices more accessible and female friendly. Specifically, young women will benefit more when their doctors: (a) provide office environments that encourage frank, clear, and confidential discussions; (b) listen actively to their young female patients; (c) present caring, accurate, and nonjudgmental messages; and (d) discuss societal influences which negatively affect their adolescent patients. More gender sensitive practice could help young women gain confidence in their own sexual decision-making skills, have better control over their sexual behaviours, and become proficient in the use of various options for the prevention of pregnancy and STIs (Beazley et al., 1996).

Although the key principles of the ideal HIV testing situation constitute the groundwork for culturally-appropriate testing, additional strategies that relate specifically to their Aboriginal culture were noted. In addition to incorporating and respecting cultural practices, programs must also respect both age and literacy levels of clients. For instance, youth tend to prefer messages that are blunt and that use appropriate, accessible language (Wardman et al., 2006). Key informants offered specific suggestions for mainstreaming HIV prevention education and testing information into general health education programs that would allow for a greater integration of HIV/AIDS into existing health discourse of women's health. This could include discussions of HIV testing within the context of a general health check-up (Newman et al., 2008).



DISCUSSION

Overarching Themes and Gaps

One of the key messages that emerged from this synthesis was the importance of women's day-to-day realities, including the social and structural contexts that shape their individual and collective HIV risk. The importance of tailored programming and policy cannot be overstated and was reflected to some degree in each article included in this synthesis. When women are regarded and treated as a homogeneous group with identical HIV prevention needs, the ensuing prevention interventions lack the specificity to address the unique determinants of health among the diverse populations of women in Canada. More research, funding and support are needed to allow for tailored policy and programming responses that can address the impact of overlapping and intersecting determinants of health on HIV risk.

HIV-related service providers, specifically nurses, frontline AIDS service organization workers, harm reduction workers, peer support workers and social workers, need to be valued and supported in their roles to avoid burnout and promote ongoing training and collaboration (Gardezi et al., 2008; Hilton et al., 2001; Antle et al., 2001). Integrated care holds promise for improving accessibility to, and knowledge of, existing resources for HIV prevention among the diverse populations of women in Canada. Confidential programs and services, including anonymous HIV testing and counseling, must be made accessible to all. Community-wide education to promote available services, increase general knowledge regarding HIV/AIDS and decrease social stigma continues to be the primary recommendations to emerge from the literature.

A major limitation found in this body of literature was the varying level of descriptive detail provided in the articles. For example, several studies included both male and female participants, but did not provide gender-based analysis or sex-disaggregated information in their results or discussion sections. Without this information, we are unable to ascertain how gendered issues surrounding HIV prevention differ for men and women. Other studies did not report on the age, ethnicity or physical location of participants. Several articles which focused on Aboriginal women, took a pan-Aboriginal approach, without discussing diversity among Aboriginal women in Canada. Without detailed information on participant characteristics, we are unable to garner relevant information for priority setting, fund allocation and policy or program decision-making.

A second limitation was a lack of positioning of individual study findings within a larger structural, macro-level view of HIV prevention for the purpose of making connections between studies. One of the strengths to be derived from contextualized HIV prevention research is the insight that can come from creating links between macro-level factors and micro-level factors and thereby shifting the discourse from individual risk behaviours to risk environments. Few articles discussed how larger social issues such as sexism, housing, poverty, racism and settlement issues impact HIV prevention for women. Lastly, it is important to note that many of the articles did not specifically or solely set out to address HIV prevention.

Given the long history of strained researcher/community relations, particularly within many Indigenous communities, there may be resistance to disseminating HIV prevention information through mainstream 'peer review' processes. In our search strategy, studies were limited to those in English and published in peer-reviewed journals. This may be problematic for cultures that might resist 'writing down' in sharing Indigenous knowledge. As such, the written record of the Western academy may not provide the full picture of these lessons.

Recognizing that not all of the most promising HIV prevention approaches are disseminated through peer review channels, the research team contacted experts in the field for suggestions and recommendations for other types of documents, specifically program reports, agency evaluations and other forms of community-based or government reports that would help us learn more about effective strategies and approaches for HIV prevention with both Aboriginal and non-Aboriginal women in Canada. However, the information gathered did not meet our literature search inclusion criteria and were removed from our analysis and discussion. It is important to take these limitations into consideration in subsequent reviews in order to identify what is currently being implemented by community-level HIV/AIDS organizations and to help identify best or wise practices in HIV prevention efforts in Canada beyond what is housed in academic, peer-reviewed journals.



Recommendations

Shifting the discourse away from a biomedical focus largely concerned with individual HIV risk behaviours to 'risk contexts' acknowledges the complexity of the social, political and economic determinants of

HIV prevention. This in turn may create a robust understanding of the intersecting contexts of HIV risk, resulting in a more comprehensive approach to HIV prevention for women. We argue this approach needs to be more widely adopted as a framework for government-led and community-based HIV prevention programming and policy in Canada.

It is clear from this synthesis that problems arise when trying to translate a determinants of health framework into effective HIV prevention programs and policies. The Public Health Agency of Canada's *Federal Initiative (2004)* and the *Blueprint for Action on Women and Girls and HIV (2006)* have identified women among the most vulnerable to HIV in Canada. Both have expressed the need for a national HIV/AIDS response that addresses human rights, determinants of health and gendered dimensions of the epidemic. Despite widely accepted endorsements of the importance of these approaches in shaping HIV prevention policies and programs, more needs to be done to address and lessen the burden of HIV among women in Canada, specifically minority women.

The themes in this synthesis provide knowledge relevant to HIV prevention programming and policy, particularly in relation to the diverse populations and communities of women in Canada. The valuing of cultural identity and traditions, requires being open and reflexive to the impact of, for example, language, culture and ethnicity in our HIV prevention efforts. More specifically, HIV prevention for women requires enhancing public education about HIV, eliminating barriers to testing, improving the quality of HIV-care, ensuring community-based governance of HIV prevention services, developing culturally-specific prevention programming, and partnering with local and existing services to create integrated health resources and to reduce HIV stigma. Additionally, HIV prevention services must provide support and safe spaces for women by ensuring health service providers understand the impact of the social determinants of health, such



as culture, gender and poverty, on women's HIV-related prevention realities. Women's experiential knowledge must be integrated into programming and policy to improve the fit, quality and longevity of interventions. Existing HIV prevention programs and policies that

apply biomedical approaches to HIV without exploring and addressing the root causes and social determinants of HIV need to be challenged and revised. The federal government should consistently require gender-based analysis as mandatory in research and programming grants and provide adequate funding and support for gender-focused strategies. Lastly, Canadian women must be included in all stages of research investigating their HIV-related needs, from priority setting and planning to evaluation and dissemination in order to ensure that the research remains in line with their lived experiences and evolving needs.

Future Directions for Research on HIV Prevention for Women in Canada

Drawing parallels and identifying successes and challenges is necessary in order to move this important work forward with implications on HIV prevention policy, practice and programming. The results of this synthesis suggest there are a number of significant gaps in need of further consideration in future research and programming efforts. The following sections briefly outlines areas that warrant further attention as specified by the findings of the synthesis. It should be noted that some of these issues may have been addressed in other research studies not included in this synthesis.

Cultural norms. The cultural norms and expectations that serve to regulate and inform sexual behaviors and practices of women require additional consideration. Research with different populations, such as women living on reserves that are not HIV-positive, may be necessary to further explore this question. For the women interviewed in the Mill et al., (1997) study, it was critical to explore their life histories in order to develop a greater understanding of the factors that influenced their HIV infection.

Parenting. Links between HIV prevention, HIV/AIDS care and reproductive health, including fertility options for people living with HIV requires additional attention by health care providers. The desire for parenthood among people living with HIV, access to fertility services and coverage policies are important issues for future investigation and care initiatives.

Parenting issues for women, both HIV+ women wishing to become pregnant as well as those wishing to become pregnant where the serostatus of their partners may be unknown, requires additional attention. As well, parenting of infected and affected children within the same family and the differential approaches and challenges this may cause is an important area which has been largely overlooked (Antle et al., 2001).



HIV counseling and testing.

Despite the availability of HIV testing, barriers to testing differ in urban and rural areas (Bucharski et al., 2006). Obtaining both recipient and provider perspectives would provide a more complete understanding of how potentially differing views may influence the dynamics of care in the HIV counselling and testing situations (Bucharski et al., 2006). Further, there are numerous Canadian studies that identify discrimination as a key barrier for Aboriginal women seeking health care services in general (Bucharski et al., 2006). Further information on HIV counselling techniques that can allow for more effective approaches to addressing perceptions of safety in monogamy and HIV immunity may assist in reducing misinformation about risk (Ryder et al., 2005).

Although the national guidelines for HIV counseling and testing in Canada are being revised, focusing on HIV testing for women through prenatal care overlooks HIV testing for both heterosexual male partners and women who fall outside reproductive age. In addition, post-test counselling will continue to result in missed prevention opportunities if removed from the revised guidelines (Ryder et al., 2005). It is noteworthy that pre-test assessment of HIV risk behaviours was not seen as a significant barrier to testing and was rarely mentioned in the literature (Bucharski et al., 2006).

Stigma and discrimination. To the extent that stigma and discrimination are significant components of the experience of Aboriginal people with HIV/AIDS, further community-based intervention research is needed to address these concerns (Clarke et al., 2005).

Health protective sexual communication (HPSC).

Men and women may have different gender-based experiences and attitudes in relation to health protective sexual communication. Additional clarity on how can one engage in health protective sexual communication with a partner without sacrificing the relationship or one's sexual health may be warranted (Cleary et al., 2002).

Macro-level systemic factors. It is clear from the synthesis that further efforts are needed to address systemic inequities in HIV prevention education and stigma reduction at the macro-structural level (Flicker et al., 2008).

Determinants of HIV risk. Future research may be needed to understand the particular social determinants of HIV risk of Aboriginal youth in diverse situations, including on-reserve youth and youth who migrate between cities and reserves (Larkin et al., 2007). In future research in treatment settings, there is a need to take into account how addictions issues may be used as an important defence mechanism in buffering against the reality of HIV/AIDS (Nadeau et al., 2000).

Lesbian and bisexual women. Health care providers need to be aware of how lesbians' needs differ from those of heterosexual women in the area of reproductive health, including HIV prevention approaches. As well, acknowledging and addressing the barriers faced by lesbian/bisexual women in accessing basic services is crucial (Mathieson et al., 2002). Lesbians living with HIV remain a hidden and isolated population and are often unwilling to come forward as research participants. Further research with lesbian and bisexual populations, particularly from diverse youth populations, is required to attain a broader understanding of their needs (Travers & Paoletti, 1999). Further, understanding the regional differences in health care uptake patterns among lesbian and bisexual women may yield important HIV prevention outcomes (Mathieson et al., 2002).

Treatment and care. The decision when to begin HIV treatment may be problematic among certain populations who are more likely to be in care at a much later stage of illness. This may raise ethical issues regarding the basis of the knowledge that early treatment of HIV disease can prolong life. Further debate and discussion on this complex issue is necessary to ensure that treatment options that are congruent with an individual's or community's beliefs and values are available and accessible (Mill et al., 2000).

Lived Experience of Women with HIV. Clearly there is a dire need to expand our knowledge of the lived experiences of women affected by HIV – both in terms of primary and secondary prevention, particularly as women are living longer with HIV.

Black women. The historical absence of Black women in the HIV prevention and in terms of accessing prevention, treatment, support, and care initiatives is especially evident. Although Black women and Aboriginal women make up a small proportion of the Canadian population, they are vastly overrepresented among those infected. The current HIV infection rates indicate an urgent need for further research with, by and for populations of Black women to contextualize results obtained by statistical modeling and to better understand the psychosocial, cultural and structural determinants of HIV risk (Tharao & Massaquoi, 2001).

Youth. HIV prevention for young women in Canada is characterized by significant barriers to HIV testing and access to treatments and as such this remains an area in need of further research (Travers & Paoletti, 1999). Young heterosexual men need to be included in HIV prevention intervention development and further research with male youth in this regarded as necessary for ensuring gender-inclusive approaches.

Relationship with health professionals. The relationships women have with health care professionals can serve as an important conduit to timely access to prevention interventions, HIV testing, and treatment. However, interacting with health care providers can be a significant source of anxiety which has both policy and practice implications. Such anxiety is often related to service and social context issues, in addition to “anxious apprehension” about HIV test results. This is also the case with existing understandings of the power dynamic between clients and service providers, where the control exerted over the professional interaction by the client has been investigated only tangentially. More research is required in these areas (Worthington et al., 2003).

AIDS widowhood. Women whose husbands or partners have died of AIDS are of particular significance. This was described as “two in the one” which acknowledges the dual process of caring for a dying husband or partner while learning of and trying to adjust to their own diagnosis. This population appears to have some unique support needs that have, until now, been overlooked but which merit further examination (Heath et al., 1999).



Next Steps: The Way Forward

The shift away from focusing solely on individual level factors and recognizing the need to attend to the broader structural factors in HIV transmission has resulted in a more complex analysis of the biopsychosocial issues that, collectively, increase the likelihood of becoming HIV positive. This is particularly relevant to women as we regard gender as a key determinant of health and where gender-related expectations regarding sexuality serve to shape and impact our HIV prevention efforts. The predominant message that emerged from the synthesis was the importance of women's day-to-day realities and the social and structural realities that shape their HIV risk contexts.



Shifting the discourse away from a biomedical focus on individual HIV risk to 'risk environments' or contexts acknowledges the interaction of social, political and economic determinants of HIV risk. We argue this approach needs to be widely adopted as a framework for government-led and community-based HIV programming and policy in Canada.

While this synthesis recognizes the long history of HIV prevention efforts in Canada, it also recognizes the lack of integration of findings. This lack of integration has important implications for our future research knowledge generation, as well as informing our policy responses and programming efforts. Clearly HIV research, policy and programming responses for, by and with diverse populations and communities of women requires an augmented response across health, educating social and legal sectors to ensure our efforts are meeting both the primary and secondary HIV prevention needs of all women in Canada.

REFERENCES

- Antle, B., Wells, L., Goldie, S., DeMatteo, D., & King, S. M. (2001). Challenges of parenting for families living with HIV/AIDS. *Social Work, 46*(2), 159-169.
- Arber, S., & Khlat, M. (2002). Introduction to social and economic patterning of women's health in a changing world. *Social Science and Medicine, 54*, 643-647.
- Barnsley, J., & Ellis, D. (1992). *Research for change: Participatory action research for community groups*. Vancouver, BC: Women's Research Centre.
- Beadnell, B., Baker, S., Knox, K., Stielstra, S., Morrison, D. M., DeGooyer, E., Wickizer, L., Doyle, A., & Oxford, M. (2003). The influence of psychosocial difficulties on women's attrition in an HIV/STD prevention program. *AIDS Care, 15*(6), 807-820.
- Beasley, C. (2005). *Gender and sexuality: Critical theories, critical thinkers*. London: Sage Publications.
- Beazley, R. P., & Schmidt, K. M. (1996). Physicians as providers of reproductive health information to young women. *The Canadian Journal of Human Sexuality, 5*(1), 1-6.
- Benoit, C., Carroll, D., & Chaudhry, M. (2003). In search of a Healing Place: Aboriginal women in Vancouver's Downtown Eastside. *Social Science and Medicine, 56*, 821-833.
- Blueprint for Action on Women & Girls and HIV/AIDS. (2006). *Blueprint for action on women and girls and HIV/AIDS: Blueprint manifesto*. Retrieved from http://www.athenanetwork.org/docs/Blueprint_Manifesto_2006_EN.pdf
- Bucharski, D., Brockman, L., & Lambert, D. (1999). Developing culturally appropriate prenatal care models for Aboriginal women. *The Canadian Journal of Human Sexuality, 8*(2), 48-54.
- Bucharski, D., Reutter, L. I., & Ogilvie, L. D. (2006). You need to know where we're coming from: Canadian Aboriginal women's perspectives on culturally appropriate HIV counseling and testing. *Health Care Women International, 27*(8), 723-747.
- Canadian HIV/AIDS Legal Network. (2005). *Aboriginal People and HIV/AIDS: Legal Issues*. Retrieved from <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=1>
- Canadian Institutes of Health Research. (2007). Knowledge translation strategy 2004-2009: Innovation in action. Retrieved May 29, 2007 from <http://www.cihr.ca/e/26574.yhtml>
- Clarke, J. N., Friedman, D. B., & Hoffman-Goetz, L. (2005). Canadian Aboriginal people's experiences with HIV/AIDS as portrayed in select English language media. *Social Science and Medicine, 60*(10), 2169-2180.
- Cleary, J., Barman, R., MacCormack, T., & Herold, E. (2002). Discussing sexual health with a partner: A qualitative study with young women. *The Canadian Journal of Human Sexuality, 11*(3), 117-132.
- Commonwealth Secretariat & Atlantic Centre for Excellence in Women's Health. (2002). *Gender mainstreaming in HIV/AIDS: Taking a multisectoral approach*. London, UK: Commonwealth Secretariat.
- Corneil, T. A., Kuyper, L. M., Shoveller, J., Hogg, R. S., & Li, K. (2006). Unstable housing, associated risk behaviour, and increased risk for HIV infection among injection drug users. *Health and Place, 12*, 79-85.
- DiCenso, A., Borthwick, V., Busca, C., Creatura, C., Holmes, J. A., Kalagian, W. F., & Partington, B. M. (2001). Completing the picture: Adolescents talk about what's missing in sexual health. *Canadian Journal of Public Health, 91*(1), 35-38.

- Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., Bonas, S., Booth, A., & Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: A quantitative and qualitative comparison of three methods. *Journal of Health Services Research and Policy, 12*(1), 42-47.
- Doyle, L. (2007). Synthesis through meta-ethnography: Paradoxes, enhancements, and possibilities. *Qualitative Research, 3*(3), 321-344.
- Elliot, R. (1999). *After Cuerrier: Canadian criminal law and the non-disclosure of HIV-positive status*. Montreal, QC: Canadian HIV/AIDS Legal Network.
- Elwood-Martin, R., Gold, F., Murphy, W., Remple, V., Berkowitz, J., & Money, D. (2005). Drug use and risk of bloodborne infections: a survey of female prisoners in British Columbia. *Canadian Journal of Public Health, 96*(2), 97-101.
- Evans-Campbell, T., Lindhorst, T., Huang, B., & Walters, K. L. (2006). Interpersonal violence in the lives of urban American Indian and Alaska Native women: Implications for health, mental health, and help-seeking. *American Journal of Public Health, 96*(8), 1415-1422.
- Flicker, S., Larkin, J., Smilie-Adjarkwa, C., Restoule, J-P., Barlow, K., Dagnini, M., & Mitchell, C. (2008). "It's hard to change something when you don't know where to start": Unpacking HIV vulnerability with Aboriginal Youth in Canada. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 55*(2), 175-200.
- Gardezi, F., Calzavara, L., Husbands, W., Tharao, W., Lawson, E., Myers, T., Panchum, A., George, C., Remis, R., Wilms, D., McGee, F., & Adebajo, S. (2008). Experiences of and responses to HIV among African and Caribbean communities in Toronto, Canada. *AIDS Care, 20*(6), 718-725.
- Goldstone, I., Albert, R., Churchill, K., Schilder, A., Perry, T., Makowski, S., & McLeod, W., A. (2000). HIV and injection drug use among First Nations in Vancouver: Outcomes of care and neglect. *Native Social Work Journal, Special Edition on HIV/AIDS: Issues Within Aboriginal Populations, 3*(1), 145-163.
- Gupta, G. R. (2000). *Gender, Sexuality and HIV/AIDS: The What, the Why, and the How*. Plenary Address to the XIII International AIDS Conference, Durban.
- Harvey, E., Strathdee, S. A., Patrick, D. M., et al. (1998). A qualitative investigation into an HIV outbreak among injection drug users in Vancouver, British Columbia. *AIDS Care, 10*(3), 313-321.
- Health Canada. (2007). *HIV/AIDS pandemic*. Ottawa, ON: Author.
- Health Canada & University of Manitoba. (1998). *Research on HIV/AIDS in Aboriginal people: A background paper*. Winnipeg, MB.
- Heath, J., & Rodway, M. R. (1999). Psychosocial needs of women infected with HIV. *Social Work in Health Care, 29*(3), 43-57.
- Hilton, B., Thompson, R., Moore-Dempsey, L., & Hutchinson, K. (2001). Urban outpost nursing: The nature of the nurses' work in the AIDS prevention street nurse program. *Public Health Nursing, 18*(4), 273-280.
- Jackson, L., Bailey, D., Fraser, J., Johnson, J. K., Currie, A., & Babineau, D. D. (2002). Safer and unsafe injection drug use and sex practices among injection drug users. *Canadian Journal of Public Health, 93*(3), 219-222.
- Jackson, R., Cain, R., Collins, E., Mill, J., & Barlow, K. (2006a). *Formal and informal responses to depression among Aboriginal people living with HIV/AIDS*. Unpublished poster presentation. XVI International AIDS Conference. Toronto, Ontario. Available via the World Wide Web at http://www.caan.ca/pdf/formal_and_informal_responses_to_depression.pdf.

- Jackson, R., MacLean, L., Leonard, L., Mill, J., Reintjes, F., Austin, W., Dumont-Smith, C., & Edwards, N. (2006b). Time to make health services safe from stigma: Voices of Canadian Aboriginal people living with HIV/AIDS and health care providers. Unpublished oral presentation. XVI International AIDS Conference. Toronto, Ontario. Available via the World Wide Web at http://www.caan.ca/pdf/time_to_make_health_services_safe_from_stigma.pdf.
- Jackson, R., & Reimer, G. (2005). *Canadian Aboriginal people living with HIV/AIDS: Care, treatment and support issues*. Ottawa, Ontario: Canadian Aboriginal AIDS Network.
- Jenkins, S. R. (2000). Toward theory development and measure evolution for studying women's relationships and HIV infection. *Sex Roles*, 42(7/8), 751-780.
- Jurgens, R. (2004). *Deadly Public Policy: HIV/AIDS and Government (In)action*. Arthur Kroeger College Annual Lecture in Public Affairs and Civic Society, Carleton University. Ottawa, ON: Canadian HIV/AIDS Legal Network.
- Kemmis, S., & McTaggart, R. (2000). Participatory action research: Communicative action and the public sphere. *The sage handbook of qualitative research* (3rd edition). Thousand Oaks, CA: Sage Publications Ltd.
- Kwong-Lai Poon, M., & Trung-Thu Ho, P. (2002). A qualitative analysis of cultural and social vulnerabilities to HIV infection among gay, lesbian, and bisexual Asian youth. *Journal of Gay and Lesbian Social Services*, 14(3), 43-78.
- Larkin, J., Flicker, S., Koleszar-Green, R., Mintz, S., Dagnino, M., & Mitchell, C. (2007). HIV risk, systemic inequities, and Aboriginal youth: Widening the circle for HIV prevention programming. *Canadian Journal of Public Health*, 98(3), 179-183.
- Lavallee, B., & Clearsky, L. (2006). From woundedness to resilience: A critical review from an Aboriginal perspective. *Journal of Aboriginal Health*, 3(1): 4-5.
- Marshall, C., & Rossman, G. (1995). *Designing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Mathieson, C., Bailey, N., & Gurevich, M. (2002). Health care services for lesbian and bisexual women: Some Canadian data. *Health Care for Women International* 23, 185-196.
- Mays, N., Pope, C., & Popay, J. (n.d.). *Details of approaches to synthesis*. A methodological appendix to the paper: Systematically reviewing qualitative and quantitative evidence to inform management and policy making in the health field.
- McKay-McNabb, K. (2006). Life experiences of Aboriginal women living with HIV/AIDS. *Canadian Journal of Aboriginal Community-Based HIV/AIDS Research*, 1, 5-16.
- McKeown, I., Reid, S., & Orr, P (2003). Experiences of sexual violence and relocation in the lives of HIV infected Canadian women. *Circumpolar Health*, 63, 399-404.
- Metcalf, K. A., Langstaff, J., Evans, S., Paterson, H. M., & Reid, J. L. (1998). Meeting the needs of women living with HIV. *Public Health Nursing*, 15(1), 30-34.
- Mill, J. E. (1997). HIV risk behaviors become survival techniques for Aboriginal women. *Western Journal of Nursing Research*, 19(4), 466-489.
- Mill, J. E. (2000). Describing an explanatory model of HIV illness among Aboriginal women. *Culture and Caring*, 15(1), 42-56.
- Mill, J. E., & Anarfi, J. K. (2002). HIV risk environment for Ghanaian women: Challenges to prevention. *Soc. Sci. Med. Feb.*, 54(3): 325-37.

- Mill, J. E., Lambert, D. T., Larkin, K., Ward, K., & Harrowing, J. N. (2008). Challenging lifestyles: Aboriginal men and women living with HIV. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 5(2), 151-187.
- Milton Keynes Primary Care Trust. (2002). *10 questions to help you make sense of qualitative research: Critical appraisal skills programme*. Retrieved from http://www.phru.nhs.uk/learning/casp_qualitative_tool.pdf
- Mitra, D., Jacobsen, J. J., O'Connor, A., Pottie, K., & Tugwell, P. (2006). Assessment of the decision support needs of women from HIV endemic countries regarding voluntary HIV testing in Canada. *Patient Education & Counseling*, 63(3), 292-300.
- Nadeau, L., Truchon, M., & Biron, C. (2000). High-risk sexual behaviors in a context of substance abuse: A focus group approach. *Journal of Substance Abuse Treatment*, 19(4), 319-328.
- Newman, P., Williams, C., Massaquoi, N., Brown, M., & Logie, C. (2008). HIV prevention for Black Women: Structural barriers and opportunities. *Journal of Health Care for the Poor and Underserved*, 19(3), 829-841.
- Noblit, G. W., & Dwight Hare, R. R. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Newbury Park, CA: Sage Publications.
- Olivier, C., & Dykeman, M. (2003). Challenges to HIV service provision: The commonalities for nurses and social workers. *AIDS Care*, 15(5), 649-63.
- Omorodion, F., Gbadebo, K., & Ishak, P. (2007). HIV vulnerability and sexual risk among African youth in Windsor, Canada. *Culture, Health and Sexuality*, 6(4), 429-437.
- Public Health Agency of Canada. (2001). *What determines health?* Retrieved from <http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php>
- Public Health Agency of Canada. (2003). *Gender Based Analysis*. Ottawa, ON: Minister of Health.
- Public Health Agency of Canada. (2004). *Federal initiative to address HIV/AIDS in Canada*. Retrieved from <http://www.phac-aspc.gc.ca/aids-sida/fi-if/index.html>
- Public Health Agency of Canada. (2010). *HIV/AIDS Epi Update 2010*. Ottawa, ON: Author.
- Ryder, K., Haubrich, D. J., Calla, D., Myers, T., Burchell, A. N., & Calzavara, L. (2005). Psychosocial impact of repeat HIV-negative testing: A follow-up study. *AIDS and Behavior*, 9(4), 459-54.
- Sandelowski, M., & Barroso, J. (2007). *Handbook for synthesizing qualitative research*. New York, NY: Springer Publishing.
- Shannon, K., Kerr, T., Allinott, S., Chettair, J., Shoveller, J., & Tyndall, M. W. (2008). Social and structural violence and power relations in mitigating HIV risk of drug-using women in survival sex work. *Social Science and Medicine*, 66(4), 911-921.
- Ship, S. J., & Norton, L. (2001). HIV/AIDS and Aboriginal women in Canada. *Canadian Woman Studies*, 21(2), 25-31.
- Sledjeski, E. M., Delahanty, D. L., & Bogart, L. M. (2005). Incidence and impact of posttraumatic stress disorder and comorbid depression on adherence to HAART and CD4+ counts in people living with HIV. *AIDS Patient Care*, 19(11), 728-736.
- Spittal, P. M., Small, W., Wood, E., Johnston, C., Charette, J., Laliberte, N., O'Shaughnessy, M. V., & Schechter, M. T. (2003). How otherwise dedicated AIDS prevention workers come to support state-sponsored shortage of clean syringes in Vancouver, Canada. *International Journal of Drug Policy*, 15, 36-45.

- Status of Women Canada (1998). Gender-based analysis: A guide for policy-making. (Revised edition). Ottawa, Ontario: Author. Accessed via the World Wide Web on May 20, 2007 from http://www.swc-cfc.gc.ca/pubs/gbguide_e.html.
- Strike, C., Challacombe, L., Myers, T., & Millson, M. (2002). Needle exchange programs: Delivery and access issues. *Canadian Journal of Public Health, 93*(5), 339-343.
- Tharao, E., & Massaquoi, N. (2001). Black women and HIV/AIDS: Contextualizing their realities, their silence and proposing solutions. *Canadian Woman Studies, 21*(2), 72-82.
- Travers, R., & Paoletti, D. (1999). Responding to the support needs of HIV positive lesbian, gay and bisexual youth. *The Canadian Journal of Human Sexuality, 8*(4), 271-283.
- Tuhiwai Smith, L. (1999). *Decolonizing methodologies: Research and Indigenous people*. New York, New York: St. Martin's Press.
- Wardman, D., & Quarts, D. (2006). Harm reduction services for British Columbia's First Nation population: A qualitative inquiry into opportunities and barriers for injection drug Users. *Harm Reduction Journal, 3*, 30.
- Worthington, C., & Myers, T. (2003). Factors underlying anxiety in HIV testing: Risk perceptions, stigma, and the patient provider power dynamic. *Qualitative Health Research, 13*(5), 636-655.

APPENDIXES

Appendix One: Meta-Ethnography: Qualitative Critical Appraisal Screening Questions

Rigour, credibility and relevance were considered when appraising the qualitative research:

The following ten questions were designed to help the research team think critically about the articles identified:

- Was there a clear statement of the aims of the research?
- Is a qualitative methodology appropriate?
- Was the research design appropriate to address the aims of the research?
- Was the recruitment strategy appropriate to the aims of the research?
- Were the data collected in a way that addressed the research issue?
- Has the relationship between researcher and participants been adequately considered?
- Have ethical issues been taken into consideration?
- Was the data analysis sufficiently rigorous?
- Is there a clear statement of findings?

Appendix Two: Key Themes

- 1. Determinants of Health:** Aboriginal status, Age, Culture, Income/poverty (and its distribution), Early life (child development), Education, Employment and working conditions (incl. Security), Gender, Food security, Health care services, Housing, Historical trauma, Location (urban, rural, remote), Sex, Social safety net, Social exclusion and Racism.
- 2. Risk Settings (lack appropriate, available & accessible services):** CBOs/ASOs, Living situation, Formal health care settings (primary, secondary, tertiary), Prison/incarceration, Legal environment, Street involvement (homelessness, sex work)
- 3. Perception/Attitudes/Knowledge:** Perceptions of individuals (lack of awareness of need for services), Perceptions of service providers (lack of awareness related to racism, prejudice), policy domain, research domain, programming domain, Perceptions re: stigma/discrimination.
- 4. HIV Transmission:** Unprotected sex, Sharing needles (and other equipment), Vertical transmission.
- 5. HIV Risk,** Marginalization/isolation (lack of social support), Abuse (physical, sexual, emotional), Substance use, Mental health (untreated, undiagnosed), Sex work, Community/peer influences.
- 6. Targeted Approaches:** Sex work, Street involvement, IDU, Gender, Cultural, LGBTQIT, Pregnancy (incl. families), Immigrants, Youth, Men, Gender-based.
- 7. Ethnocultural Populations:** Aboriginal, White/mixed, African Caribbean, Asian (includes South Asian).
- 8. Programming Implications/ Prevention:** Formal health care (primary, secondary, tertiary), CBO/ASO, Testing (anonymous, nominal), Harm reduction, Referrals (social services, etc.), Gender sensitive/appropriate, Culturally sensitive/appropriate, Challenges (incl. political climate), Facilitators.
- 9. Policy Implications/ Prevention:** Formal health care (primary, secondary, tertiary), CBO/ASO Testing (anonymous, nominal), Harm reduction, Referrals (social services, etc.), Gender sensitive/appropriate, Culturally sensitive/appropriate, Challenges (incl. political climate), Facilitators.
- 10. Living with HIV: Support and Barriers:** Peers, Family, Faith/Spirituality/Church, Stigma/discrimination, Confidentiality/disclosure, Invisibility/silence, Treatments (incl. biomedical i.e. ARVs and alternative treatments i.e. supplements, etc.), Self-Care (that do not require professional or medical involvement), Emotional/Affective Domain (positive or negative, such as fatalism or hopefulness about the future), Financial Issues.

Appendix Three: HIV/AIDS Organizations Contacted (Grey Literature N=97)

Aboriginal Canada Portal	AIDS Support Committee of Sarnia-Lambton
Aboriginal Healing Foundation	AIDS Vancouver
Aboriginal Health Association of BC	AIDS Vancouver Island
Aboriginal Nurses Association of Canada	Alberta Community Council on HIV
Access AIDS Network	Assembly of First Nations
AIDS Calgary	Atlantic First Nations AIDS Task Force
AIDS Coalition of Cape Breton	BC Women's Hospital and Health Centre
AIDS Coalition of Nova Scotia	BC Centre for Excellence in HIV/AIDS
AIDS Committee of Guelph & Wellington County	BC Persons With AIDS Society (BCPWA)
AIDS Committee of London	Canadian Aboriginal AIDS Network
AIDS Moncton	Canadian AIDS Society
AIDS New Brunswick	Canadian Association of Nurses in AIDS Care (CANAC)
AIDS Committee of Newfoundland and Labrador	Canadian AIDS Treatment Information Exchange
AIDS Committee of Simcoe County	Canadian HIV/AIDS Information Gateway
AIDS Committee of Toronto	Canadian HIV Trials Network (CTN)
AIDS Committee of Windsor	Canadian HIV/AIDS Legal Network
AIDS Community Care Montreal	Canadian HIV Research Inventory
AIDS Network Kootenay Boundary Outreach and Support Society	Canadian Nurses Association
AIDS Niagara	Canadian Nurses Foundation
AIDS PEI	Canadian Treatment Action Council (CTAC)
AIDS Programs South Saskatchewan	Centre for Aboriginal Health Research
AIDS Saint John	Centre for Rural and Northern Health Research
AIDS St. John Inc.	Chiefs of Ontario
	Congress of Aboriginal Peoples

Government of Nova Scotia	Positive Youth
HALCO	Prisoner's HIV/AIDS Support Action Network (PASAN)
Halifax Sexual Health Centre	Public Health Agency of Canada
Health Canada - First Nations, Inuit and Aboriginal Health	Purpose Society - HIV Program
Healing Our Spirit BC Aboriginal HIV/AIDS Society	Canadian Red Cross
HIV Community-Based Research Network	Regina and Area Drug Strategy
Interagency Coalition on AIDS and Development (ICAD)	Southern Alberta Clinic
Indian and Northern Affairs Canada	The Centre for AIDS Services of Montreal (Women)
Indigenous Physicians Association of Canada	The Red Road HIV/AIDS Network Society
Institute of Aboriginal Peoples Health	The Vancouver Friends For Life Society
Live positive	The Wabano Centre for Aboriginal Health
Oak Tree Clinic	Tillicum Haus Native Friendship Centre
Okanagan Aboriginal AIDS Society (OAAS)	Toronto Hospital Immunodeficiency Clinic
Ontario AIDS Network	Toronto People With AIDS Foundation
Ontario HIV Treatment Network	University of Toronto
Métis National Council	Urban Society for Aboriginal Youth
National Aboriginal Health Association	Vancouver Island PWA Society
National Indian & Inuit Community Health Representatives Organization (NIICHO)	Vancouver Native Health Society
Nova Scotia Department of Health	Victoria AIDS Resource & Community Service Society
Pacific AIDS Network	Voices of Positive Women
Pauktuutit Inuit Women's Association	Women's Health in Women's Hands
Peel HIV/AIDS Network	Windspeaker AIDS/HIV
Positive Living North	Yekooche First Nation
Positive Living Northwest	YouthCo AIDS Society
Positive Women's Network	YOUTHLINK

Appendix Four: Summary Table of Academic Literature (N=38)

Antle et al., (2001)

“Challenges of parenting for families living with HIV/AIDS”.

Objective: To explore the parenting needs of Canadian Parents Living with HIV

Location: Specific cities not specified

Results: Eight themes were identified: managing chronic sorrow, stress and burden; normalization; stigma secrecy and disclosure; family time as precious time; focused parenting; the parenting preparation needs of fathers; efforts to parent affected and infected children

Conclusion: Parenting found to be a source of joy and an additional challenge in an already complicated life; more attention is needed on this topic by researchers and clinicians to provide essential support; more training for social workers needed

Beazley et al., (1996)

“Physicians as providers of reproductive health information to young women”.

Objective: To comment on physicians as a source of information about preventing pregnancy and sexually transmitted disease

Location: Nova Scotia

Results: 15 of the young women had not received prevention-oriented messages from physicians; 24 had received information from physicians, but these interventions had been insufficient to prevent pregnancy or STD

Conclusion: Physicians need to be trained to play a larger role in the prevention of unplanned pregnancies and STDs; physicians were found to be reluctant to bring up topics; power differential makes it difficult for youth to ask about sex; the belief that young women should not be sexually active still influences behaviours; anonymity

Benoit et al., (2003)

“In search of a Healing Place: Aboriginal women in Vancouver’s Downtown”.

Objective: To address the gap in social science literature on how the health care concerns of Aboriginal women are being met by Urban Aboriginal Health Centres

Location: British Columbia

Results: Aboriginal women’s health and social concerns have not been sufficiently studied and articulated in policy and programming

Conclusion: Women desire integrated services that are culturally tailored and allow for their involvement in active decision-making roles

Bucharski et al., (1999)

“Developing culturally appropriate prenatal care models for Aboriginal women”.

Objective: To review available information about HIV-positive women and their children; to identify existing culturally based supports for pregnant aboriginal women; to develop culturally appropriate prenatal care models that would support and promote prenatal HIV screening; to identify sites and develop resources for the implementation of the prevention model for the targeted risk group

Location: Alberta

Results: Prenatal classes were geared towards married couples and the nuclear family; classes did not deal with concerns of single parents and were not culturally-tailored; fathers should be included

Conclusion: Need to revisit and expand prenatal classes; need for culturally tailored programs; counselling on HIV and STDs should be included

Bucharski et al., (2006)

“You need to know where we’re coming from: Canadian Aboriginal women’s perspectives on culturally appropriate HIV counselling and testing”.

Objective: To determine women’s perspectives on culturally appropriate HIV counselling and testing

Location: Alberta

Results: Four themes emerged: influence of life experiences; barriers to testing; and characteristics of culturally appropriate HIV testing

Conclusion: There is a fear of being judged by both the Aboriginal and non-Aboriginal communities and a need for sensitivity to the historical and current context of Aboriginal women’s lives

Clarke et al., (2005)

“Canadian Aboriginal people’s experiences with HIV/AIDS as portrayed in selected English language Aboriginal media (1996-2000)”.

Objective: To explore the portrayal of HIV/AIDS in Aboriginal publications

Location: Across Canada

Results: Women and youth are underrepresented as persons with HIV/AIDS; frequent references to Aboriginal culture and the political and economic position of Aboriginal Canadians; found expressions of stigma and fear surrounding the disease

Conclusion: HIV is more contextualized by culture, identity, spirituality and political-economic issues in Aboriginal specific publications

Cleary et al., (2002)

“Discussing sexual health with a partner: a qualitative study with young women”.

Objective: To determine whether young women engage in health protective sexual communication with a recent sexual partner before intercourse; to discuss barriers and facilitators; to determine strategies used to initiate discussions between partners

Location: Ontario

Results: Ten themes were identified: education, responsibility for sexual health, importance of feeling comfortable, feelings of fear, the use of assumptions, peer influences, experience, relationship expectations and commitment, personal characteristics, partner influences

Conclusion: Typically, very little, if any, discussion occurred prior to first intercourse; most young women did not have the communications skills necessary to initiate such discussion

DiCenso et al., (2001)

“Completing the Picture: Adolescents talk about what’s missing in sexual health services”.

Objective: To learn adolescents’ opinions about sexual health services and strategies to improve their delivery

Location: Ontario

Results: Sexual education focused too much on ‘plumbing’ and was often provided by teachers with whom they felt uncomfortable discussing sexual topics; peers and media were the primary sources of information; participants had limited knowledge of services available; comments reflected traditional gender differences; peers, and for females, parents and partners influenced sexual decision making

Conclusion: Recommendations are provided for confidentiality, public relations, education and sexual health services; sexual health educators need to be better trained and selected based on comfort discussing material; resources need to be developed by youth committee and updated regularly; more openly discussed in community; sensitivity training around confidentiality needed

Elwood-Martin et al., (2005)

“Drug use and risk of bloodborne infections: A survey of female prisoners in British Columbia”.

Objective: To determine the characteristics of women who do and do not report illicit drug use in prison; patterns of drug use inside prison; factors associated with illicit drug use that might contribute to bloodborne transmission inside prison.

Location: British Columbia.

Results: 77 reported being in prison on drug-related charges; 26 participants identified as Aboriginal; 37 reported illicit drug use in prison; 22 reported injecting in prison; 54 were HCV positive and 8 were HIV positive; 19/22 who reported injecting, also reported sharing equipment.

Conclusion: The majority of women reporting prison injection drug use also reported hepatitis C sero-positivity and shared needle use; harm reduction needed in the prison system.

Flicker et al., (2008)

“It’s hard to change something when you don’t know where to start”: unpacking HIV vulnerability with Aboriginal youth in Canada”.

Objective: To uncover new possibilities for HIV prevention with Aboriginal youth that account for systematic inequities

Location: Ontario and Quebec

Results: Youth described the links between: colonialism, traditional knowledge, and HIV risk in relation to gender inequities, stigma, and involving multiple stakeholders

Conclusion: New prevention approaches relating HIV risk to colonial legacies are necessary-need for an analysis of systemic inequities in HIV prevention education, stigma reduction, wide-spread community support, diversity across Aboriginal peoples, increasing active engagement (peer) with youth

Gardezi et al., (2008)

“Experiences of and responses to HIV among African and Caribbean communities in Toronto, Canada”.

Objective: to understand HIV-related stigma, discrimination, denial and fear and the effects of multiple intersecting factors that influence responses to the disease, prevention practices and access to treatment and support services

Location: Ontario

Results: Themes: Canada vs. back home, community gossip, cultural silences, perception that HIV is a ‘gay disease’, religious beliefs and norms, issues of race and racism, social determinants of health, immigration, gender issues

Conclusion: need for greater sensitivity and knowledge on the part of health care providers; more culturally specific support services; community development; greater community awareness; expanded efforts to tackle housing, poverty, racism and settlement issues

Harvey et al., (1998)

“A qualitative investigation into an HIV outbreak among injection drug users in Vancouver, British Columbia”.

Objective: this was the first step in a case control investigation aimed at identifying risk factors associated with seroconversion in the DTES

Location: British Columbia

Results: Three dominant themes emerged: addiction, prevention and social determinants

Conclusion: Risk determined by social context; Prevention efforts such as the availability of clean needles and condoms are not adequate to combat the complex social determinants of addiction

Heath et al., (1999)

“Psychosocial needs of women infected with HIV”.

Objective: To examine the psychosocial needs of HIV positive Caucasian women

Location: Alberta

Results: Needs identified: information and support (especially at time of diagnosis); assistance from health care professionals and friends; planning for present and future care of children; financial assistance; adjustment to the loss of employment; finding accommodations

Conclusion: Older widows of husbands who died of AIDS had unique issues; most wanted increased contact with peers; more counselling and services specific to women and specific to mothers were requested

Hilton et al., (2001)

“Urban outpost nursing: the nature of the nurses’ work in the AIDS prevention street nurse program”.

Objective: A large evaluation project that included interviews and document analysis

Location: British Columbia

Results: themes included: reaching marginalized high-risk populations for HIV/STDs; building and maintaining trust, respect and acceptance; doing HIV/AIDS prevention, early detection and treatment work; helping clients connect with and negotiate the health care system; influencing colleagues and the system to be responsive

Conclusion: street nursing requires specialized knowledge and clinical autonomy and judgment skills

Jackson et al., (2002)

“Safer and unsafe injection drug use and sex practices among injection drug users in Halifax, Nova Scotia”.

Objective: To explore the community and interpersonal influences affecting safer and unsafe injection drug use and sexual practices among injection drug users living in and around Halifax, NS.

Location: Nova Scotia

Results: There are key community and peer influences on drug use and sex practices; needle exchanges are not always open or accessible to clients; peers can assist in reducing sharing; peers also sometimes encourage condom use; condom use occurs less with regular partners

Conclusion: expanded prevention strategies are needed and must be supported; peer models should be used to encourage positive practices and discourage negative practices

Larkin et al., (2007)

“HIV Risk, Systemic Inequities and Aboriginal Youth: Widening the Circle for HIV Prevention Programming”.

Objective: To determine how Aboriginal youth in Toronto understand HIV/AIDS risk and the relevance of their comments for HIV prevention education.

Location: Ontario

Results: Aboriginal youth were more aware of HIV/AIDS and the structural inequities that contribute to risk than their non-Aboriginal counterparts; spoke of colonialism; were more fatalistic about their futures and blamed their community for its high HIV rates.

Conclusion: The legacy of colonialism must be included in HIV prevention programs for all youth to eradicate stigma and self-blame.

Mathieson et al., (2002)

“Health Care Services for Lesbian and Bisexual Women: Some Canadian Data”.

Objective: Women were asked to indicate whether a particular health care service was important to them

Location: A Maritime Province (not specified).

Results: the four most important services to these women were: general physical exam; pap smear; breast examination; and holistic medicine; HIV/AIDS information/screening and safer sex were judged as important by over half of the participants.

Conclusion: Health care providers need to be aware of how lesbian women’s health care needs differ from heterosexual women’s needs (i.e. – less likely to see doctor about birth control, lower rate of STDs, higher incidence of breast cancer related to never having been pregnant); physicians should not make assumptions about sexuality; misconception that lesbian/bisexual women are not at risk of STIs.

McKay-McNabb et al., (2006)

“Life experiences of Aboriginal women living with HIV/AIDS”.

Objective: To contribute qualitative data to our understanding of how Aboriginal women have experienced the impact of HIV/AIDS.

Location: Saskatchewan, British Columbia and Manitoba.

Results: Described healing as a process of integrating acceptance, risk factors and everyday challenges, support and developing new identities as Aboriginal women living with HIV/AIDS or as individuals affected by HIV.

Conclusion: Traditional Aboriginal models of health (i.e. the medicine wheel) were important to this group.

McKeown et al., (2003)

“Experiences of sexual violence and relocation in the lives of HIV infected Canadian women”.

Objective: To investigate the role, if any, that violence and physical relocation may play in the acquisition of HIV infection in Canadian women.

Location: Manitoba.

Results: All participants reported experiences of isolation and violence in childhood; half reported being afraid to disclose violent events to adults; the majority reported running away from home, involvement in sex trade and use of drugs; half reported previous incarceration; the majority reported looking to community social programs for guidance and support.

Conclusion: early intervention programs must be implemented in partnership with communities to reduce family violence and create support networks for children, youth and adults at risk.

Metcalfe et al., (1998)

“Meeting the needs of women living with HIV”.

Objective: To examine the feelings, concerns and needs of HIV infected women in a mid-sized Canadian city; -to determine whether a community agency for HIV positive persons was adequately supporting women.

Location: Ontario.

Results: Four areas of concern were identified: the impact of diagnosis on women and their children; need for supports specific to HIV positive women; differences in needs and supports available to men and women; lack of comfort with, or knowledge of available resources.

Conclusion: Recommendations include: education; gender-tailored; self-help groups for women; female-friendly environments; presence of female staff; peers; interagency cooperation; offsite support group.

Mill (1997)

“HIV risk behaviours become survival techniques for Aboriginal women”.

Objective: To explore the cultural factors that relate to the high HIV infection rate in these women.

Location: Alberta.

Results: A relationship between the women’s formative years, their self-esteem, and survival techniques they used prior to becoming HIV-positive emerged; traditionally passive roles in relationships with men, lack of power to negotiate safer sexual practices; reluctance by Aboriginal women to discuss reproductive health.

Conclusion: Specific survival techniques may have place women in situations that increased their risk of HIV infection.

Mill (2000)**“Describing an explanatory model of HIV illness among Aboriginal women”.**

Objective: To determine the women’s perspectives on the etiology, pathophysiology, symptomology, course of illness and methods of treatment for HIV.

Location: Alberta.

Results: Aboriginal traditions need to be valued. Cultural beliefs are reflected in Aboriginal women’s explanatory model of HIV illness. Overall health was important and seen as a success marker. Symptoms as a trigger for medication.

Conclusion: There is utility in knowing models of illness for health care professionals, particularly nurses. Models help direct and focus HIV/AIDS care.

Mill et al., (2008)**“Challenging lifestyles: Aboriginal men and women living with HIV”.**

Objective: To identify factors that limited or enhanced risky behaviours, and to develop and implement an intervention to promote healthier lifestyles for Aboriginal persons living with HIV/AIDS.

Location: Alberta.

Results: Receiving and adapting to a positive HIV diagnosis resulted in a number of harmful behaviours and painful emotions; ongoing challenges included: stigma and discrimination, coping with histories of abuse, and confidentiality concerns.

Conclusion: Some participants used drugs and alcohol as a coping mechanism; the authors stress the importance of the first year post-diagnosis for providing resources and care; focus on neutralizing risk environments versus focusing only on risk behaviours; use peers for support; move beyond ‘cultural sensitivity’ to cultural safety – which examines the broad social, political, historical and power-related factors that influence HIV infections and reveals traditional beliefs about the meaning of health and illness.

Mitra et al., (2006)**“Assessment of the decision support needs of women from HIV endemic countries regarding voluntary HIV testing in Canada”.**

Objective: to describe the decision support needs of immigrant and refugee women from HIV endemic countries regarding decision-making about voluntary counselling and testing for HIV in Canada; and the needs of practitioners who support these women in making this decision, in a culturally appropriate manner.

Location: Ontario.

Results: Practitioners identified women’s lack of knowledge about HIV transmission and prevention as a primary need; patients identified inadequate awareness of HIV screening and treatment services, and their benefits and harms; patients also perceived that women would not be aware of testing options.

Conclusion: Counselling strategies are needed to improve decision making around testing and follow up.

Nadeau et al., (2000)

“High-risk sexual behaviours in a context of substance abuse: A focus group approach”.

Objective: To better understand the dynamics of unsafe sexual practices among alcoholics or non-intravenous drug users.

Location: Quebec.

Results: Unsafe sexual practices attributed to three factors: intoxication; negative perceptions of condoms; cognitive distortions.

Conclusion: Alcohol and drug use the main factors leading to unsafe sexual practices; drug use differentially impacts general risk.

Newman et al., 2008

“HIV prevention for Black women: structural barriers and opportunities”.

Objective: to explore Black Canadian women’s perspectives on HIV risk and prevention.

Location: Ontario.

Results: Themes identified: stigma; cultural disconnect; lack of engagement of Black religious institutions; multiple intersecting forms of discrimination.

Conclusion: Recommendations include: engage Black church; mainstream topic with health care providers and ethno-specific agencies; focus on social and structural factors rather than behaviours.

Olivier et al., (2003)

“Challenges to HIV service provision: the commonalities for nurses and social workers”.

Objective: To explore the experiences of service providers in HIV service provision.

Location: New Brunswick.

Results: Fear of contracting HIV, feeling helpless, problems getting up to date information, grief and inadequate referral resources.

Conclusion: providers experiencing burn-out and lack of institutional support; nurses and social workers experience some of the same issues in working with people living with HIV and should learn from one another and collaborate.

Omorodion et al., (2007)

“HIV vulnerability and sexual risk among African youth in Windsor, Canada”.

Objective: to explore the sexual behaviour of youth Africans living in Windsor.

Location: Ontario.

Results: Themes: awareness and concerns about STIs/HIV; partner’s influence on negotiating sex or discussing sexual matters; effects of migration and availability of healthcare on perceptions of own risk and assumptions about HIV prevalence in Canada; discomfort talking about sex.

Conclusion: Findings highlight the influence of gender power in determining the nature of sexual activities and outcomes as well as risky activities; need for cultural sensitivity.

Kwong-Lai Poon et al., (2002)

“A qualitative analysis of cultural and social vulnerabilities to HIV infection among gay, lesbian, and bisexual Asian youth.”

Objective: To investigate cultural and social barriers that may increase HIV risk among gay, lesbian and bisexual Asian youth.

Location: Ontario.

Results: Lack of sex education at home; homophobia in Asian families; unresponsive health and social service providers; lack of social support; negative stereotypes; ideal standards of beauty negative perceptions of safer sex practices among Asian lesbian and bisexual women

Conclusion: Programs are culturally inappropriate or non-youth focused; self-empowering programs urged; redistribution of community resources is recommended, especially in funding crunch.

Ryder et al., (2005)

“Psychosocial impact of repeat HIV-negative testing: a follow-up study”.

Objective: To determine the impact of repeat negative testing for HIV.

Location: Ontario.

Results: Repeat HIV-negative testing results in confusion over what constitutes risk and occasionally thoughts of immunity; participants expressed beliefs that monogamy constitutes safety; psychosocial factors lead to risk; sexual risk reduction is unsustainable.

Conclusion: The repeat negative test experience for some neither clarifies risk behaviour nor reinforces sustained risk reduction.

Shannon et al., (2008)

“Social and structural violence and power relations in mitigating HIV risk of drug-using women in survival sex work”.

Objective: To explore the role of social and structural violence and power relations in shaping the HIV risk environment and prevention practices of women in survival sex work.

Location: British Columbia.

Results: The following factors were found to directly and indirectly affect women’s agency, access to resources and ability to practice HIV prevention and harm reduction: boyfriends as pimps and the everyday violence of bad dates (micro-level); lack of safe places to take dates and the adverse effects of local policing (meso-level); dope sickness and the need to sell sex for drugs (macro-level).

Conclusion: Highlights need for a renewed HIV prevention strategy that moves beyond a solely individual-level focus to structural and environmental interventions, including legal reforms.

Ship et al., (2001)

“HIV/AIDS and Aboriginal women in Canada”.

Objective: To examine how HIV differentially impacts Aboriginal women in Canada versus Aboriginal men.

Location: Quebec, British Columbia and Nova Scotia.

Results: Aboriginal women invisible in HIV/AIDS research and policy; face numerous barriers in accessing service; abuse major issue

Conclusion: Need culturally appropriate, gender specific resources; support and counselling to reduce risk and improve quality of life for women and their children and caregivers.

Spittal et al., (2003)

“How otherwise dedicated AIDS prevention workers come to support state-sponsored shortage of clean syringes in Vancouver, Canada”.

Objective: To examine the relationships and commitments the exchange agents develop with the using community; to observe their needle distribution patterns.

Location: British Columbia.

Results: Although a ‘one-for-one’ system exchange is ideal, a ‘loaner’ system developed out of agreements made between needle exchange clients and staff, to ensure clients weren’t turned away.

Conclusion: Detailed, contextualized accounts of the circumstances surrounding needle exchange procedures are necessary to fully evaluate their success and practices; alternative models to address issues of access must be considered with a primary focus on maximising access and secondary consideration given to disposal.

Strike et al., (2002)

“Needle exchange programs: Delivery and Access Issues”.

Objective: To examine the challenges of four service delivery models (i.e. fixed, mobile, satellite and home visits) and how service delivery may impact on needle exchange program HIV prevention efforts.

Location: Ontario.

Results: Effective NEP prevention efforts depend on client development and retention and service design. Fixed and satellite sites, home visits and mobile services provide various levels of temporal and spatial accessibility; combining modes of delivery can offset accessibility challenges.

Conclusion: Programs must be evaluated with an understanding that NEPs are most effective when they employ multiple modes of delivery, each serving a unique group of clients.

Tharao et al., (2001)

“Black women and HIV/AIDS: contextualizing their realities, their silence and proposing solutions”.

Objective: to document the experiences of African and Caribbean women in Canada as they relate to HIV/AIDS.

Location: Ontario.

Results: Lack of economic opportunities; deprivation of rights to autonomy and sexual control; cultural practices that increase risk of infection such as genital mutilation and vaginal cleansing; limited educational opportunities leading to misinformation; migration issues.

Conclusion: Economic marginalization; racism; fear of testing; religious beliefs; migration issues; parenting issues.

Travers et al., (1999)

“Responding to the support needs of HIV positive lesbian, gay and bisexual youth”.

Objective: To determine the challenges of living with HIV infection and barriers to HIV/AIDS and youth services for lesbian, bisexual and gay youth.

Location: Ontario.

Results: Themes: initial periods of denial, self-blame and shame, judgments by family and peers, issues around disclosure, social isolation and loneliness; participants also described barriers to accessing services.

Conclusion: Few youth spoke of hope and resiliency; social isolation, loneliness, anxiety, despair and often-inaccessible services; service need can be very urgent.

Wardman et al., (2006)

“Harm reduction services for British Columbia’s First Nation population: a qualitative inquiry into opportunities and barriers for injection drug users”.

Objective: To provide an overview of the availability and content of current harm reduction practices; to identify barriers and opportunities for implementing these services in First Nation communities.

Location: British Columbia.

Results: Barriers to services include: community size, limited service infrastructure, lack of financial resources, attitudes towards harm reduction services and cultural differences.

Conclusion: Community education efforts needed, followed by harm reduction services and the readiness of communities be assessed.

Worthington et al., (2003)

“Factors underlying anxiety in HIV testing: risk perceptions, stigma and the patient-provider power dynamics”.

Objective: To examine the situational and social factors underlying anxiety associated with HIV testing.

Location: Ontario.

Results: Four themes: perceptions of risk and responsibility for health; stigma associated with HIV; the patient-provider power dynamic; techniques used by test recipients to enhance control in their interactions with providers.

Conclusion: Service implications include modifications to information provision during the test session, attention to privacy and anonymity and sensitivity to patient-provider interactions.

For Information

For further information about this study
please contact:

Dr. Jacqueline Gahagan, PI

Professor of Health Promotion

Department of Health Promotion
School of Health & Human Performance
Dalhousie University
6230 South Street, Halifax, Nova Scotia
B3H 3J5 Canada

Tel 902.494.1155

fax 902.494.5120

email jacqueline.gahagan@dal.ca