Examining Gender Relations among South Asian Immigrant Women Living with HIV in the Greater Toronto Area: Theoretical Implications

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Abstract

This paper focuses on South Asian immigrant women living with HIV in Toronto. Our community-based research affirmed the benefits of augmenting R.W. Connell's social theory of gender with a focus on the local. We explored how multiple relations of domination and subordination affect women living with HIV. A general inductive approach identified four themes pursuant to women's perceptions of gender relations, and how they affect their risk of HIV: power, emotional attachment, gendered division of labour, and social norms. Richer understandings of how power operates between genders paves the way for theory refinement, and innovative, refocused research.

Résumé

Cet article est basé sur une recherche de doctorat achevée en 2011. L'objectif principal de cette étude est d'explorer comment le pouvoir masculin dans les communautés sud-asiatiques, légitimé par la masculinité hégémonique, contribue au risque d'infection par le VIH chez les femmes sud-asiatiques. Les histoires racontées par ces femmes révèlent des relations de pouvoir durant leur enfance et leur vie adulte, caractérisées par un déséquilibre de pouvoir et une domination du mâle. La compréhension des réalités des immigrantes sud-asiatiques selon une optique anti-oppressive est offerte comme un moyen de réduire le sentiment d'impuissance acquise, sans essentialiser la culture.

Introduction

There is a shortage of research focusing on HIV in the South Asian community in North America. Similarly, there is a dearth of published research on HIV/AIDS-related issues among South Asian women in Canada in general and in the Greater Toronto Area (GTA) in particular. Scholars engaged with this issue agree that there is an overall stigma attached to HIV/AIDS in the South Asian community, which has resulted in an overall denial of HIV/AIDS as a disease affecting community members (Abraham, Chakkappan, and Park 2005; Alliance for South Asian AIDS Prevention [ASAAP] 1999; Gagnon et al. 2010; Leonard et al. 2007; Raj and Tuller 2003; Singer et al. 1996; Vlassoff and Ali 2011). Although these studies have identified patriarchy, immigration, poverty, and discrimination as structural factors affecting South Asian women's risk for HIV, they fail to explain *how* these structural factors affected women's behaviour. This paper addresses this gap by examining how structural factors interact with the unique individual experiences of South Asian women, using Raewyn W. Connell's (1987, 1995) social theory of gender (see also Connell and Pearse 2009).

Theoretical Framework

By providing a clear picture of gender as a "structure of social practice" (Connell 1995, 71), Connell's social theory of gender explains how power operates between genders (1987; Connell and Pearse 2009). It emphasizes the relations of power between men and women while asserting that gender is structured relationally and hierarchically and consists of multiple masculine and feminine defined roles. According to Connell (1995), gender is affected by both the impersonal power of institutions and by more intimate and inter-personal connections. By acknowledging power relations as socially derived, Connell opens up new ways of understanding gender and gender relations.

An important aspect of Connell's (1987) social theory of gender is the recognition of race, class, and gender as structures that contribute to women's oppression. In light of these factors, it becomes imperative that scholars use an anti-oppressive lens to examine South Asian immigrant women's vulnerability to HIV. This lens acknowledges these women as racialized immigrants who are currently living in an imperialist nation where there is a deep tension between (a) a purported love of difference; and (b) the exploitation of those differences for its own ends. The focus of the paper is on the theoretical contributions by filling a gap in Connell's social theory of gender. I am weaving the anti-oppressive lens into the text.

Although Connell's (1987; Connell and Pearse 2009) theory is useful, some aspects of the theory have yet to be thoroughly examined. The first includes the particular local context in which hegemonic masculinity is performed. Although gender is enacted at local, regional, and global levels, the application of Connell's theory to local contexts is underdeveloped. According to Sarah Rosenfield (2012), "Gender conceptions and practices consist of the division of labor between men and women in and outside the home, the power relations between men and women, and differences in the self" (1793). These relational approaches conceptualize gender as dynamic and situational, sensitive to the local context (Sharman and Johnson 2012). Typically, changes in a local setting, such as the institution of the family, occur more rapidly than do societal changes (Connell 2002). Theoretically, Connell stipulated the significance of context in a general fashion and through the work of qualitative investigations of masculinities. Even though Connell has examined context in their more recent work (2005; Connell and Pearse 2009), the explanation of the local social context could be analyzed further. To that end, there is still a need to delve in greater depth into the daily transactions of individuals to explain personal context.

Second, the details in the interactions among individual, structural, and normative factors could also be expanded to more diverse contexts, especially a precise account of how they are interdependent in people's lives. Connell (2012) made a strong case for the link between gender roles, relationships, and health. She posited that gender is "multidimensional: embracing at the same time economic relations, power relations, affective relations and symbolic relations; and operating simultaneously at intrapersonal, interpersonal, institutional and society-wide levels" (1677). Viewing gender as multidimensional opens the door for the inclusion of the local as proposed in our study. It creates a space for examining the influence of individual, structural, and normative dimensions of gender.

Finally, Connell's (1987; Connell and Pearse 2009) theory tends to operate at the macro level. New knowledge may be created by directing more attention to a micro lens where these mutual dependencies and interactions are explained. By recognizing people as social actors, and specifically examining how structural, individual, and normative factors interact to legitimize hegemonic masculinity, the significance of Connell's theory at a micro-level in diverse populations may be more evident.

Research Objectives

This paper focuses on South Asian[1] immigrant women[2] living with HIV in the Greater Toronto Area (GTA) in order to improve our understanding of the factors that increase women's vulnerability to HIV infection. The main objective of this study was to investigate the macrostructural assertions of Connell's (1987; Connell and Pearse 2009) social theory of gender, which is primarily concerned with demonstrating the relational and hierarchical nature of gender. Because her theory has a global emphasis, this study attempted to examine gender relations using a local lens by focusing on the daily interactions of South Asian women living with HIV. Considering the local in more detail is quite imperative because hierarchies are formulated in a particular local context. South Asian women in the GTA were chosen as representative of a specific local context and a site of gender construction and contestation where hegemonic masculinity can be enacted.

Second, this study also aimed to gain a deeper understanding of the detailed interdependencies between structural, individual, and normative influences in the lives of South Asian immigrant women living with HIV. This investigation examined Connell's theory in order to explain *how* social norms interact with both personal beliefs and social structures (e.g., power relations, cathexis [emotional attachment], and gendered division of labour) to generate different constraints that influence South Asian immigrant women's risk for HIV. This strategy has helped to further investigate the interdependencies of social structures, individual-level factors, and social norms of behaviour.

Method

This qualitative study, based on community-based and feminist research principles, involved a general inductive approach and a thematic analysis of one-on-one interview data. Participants were obtained using a non-probability, purposive sampling strategy.

Community-Based, Feminist Research

This study followed the principles of community-based research (CBR) by developing a collaborative relationship with the ASAAP, a community-based organization serving South Asians living with HIV in the GTA. The research strategy emphasized the significance of collaboration, participation, and social justice wherein the focus was not only on individual South Asian women, but on the South Asian community as a whole. Informed by feminist research methods, we aimed to create a research atmosphere that fostered an egalitarian relationship between the researcher and the participant (Hamberg and Johansson 1999; Kirby and McKenna 1989). Additionally, a female researcher conducted all of the interviews (i.e., the first author), an approach recommended when research involves female participants and issues related to health, sexuality, or both (Hamberg and Johansson 1999).

Qualitative Methods

This study is based on the narratives of South Asian immigrant women living with HIV and residing in the GTA. Qualitative methods were deemed most suitable for developing an understanding of the personal experiences, feelings, perceptions, and values that underlie and influence behaviour (Patton 2002). Data were collected through in-depth one-on-one interviews, judged to be the most useful technique for gathering study participants' personal narratives, experiences, and histories (Creswell 2003; Marshall and Rossman 1995). This approach also allowed the interviewer to probe more deeply into the local context that is identified (but underdeveloped) in Connell's (1987) social theory of gender. Confidential, one-on-one interviews were deemed especially appropriate given the highly personal nature of the subject matter and the likelihood that many of the participants may have experienced some form of HIV-related stigma.

Sampling Strategy

For the purpose of this study, a non-probability, purposive sampling strategy was used. Originally, the study participants were to be limited to women who

accessed services at ASAAP. However, because many South Asian women living with HIV do not access AIDS Service Organizations (ASOs), due to the stigma of the disease, snowballing techniques were used to recruit additional South Asian women living with HIV (Morgan 2008). An infectious disease specialist also referred additional participants.

Data Collection

A semi-structured interview schedule (guide) was developed based on the objectives of the research and on Connell's social theory of gender (Connell and Pearse 2009). The one-on-one interviews averaged between one and a half and two hours. Basic sociodemographic questions were asked at the beginning of the interview, including date of birth, country of origin, year of immigration, date of diagnosis, and languages spoken. The interview guide was used to facilitate the flow of the interviews, which took a conversational format and very quickly turned into storytelling as the women felt safe to share their stories. Using the open ended-questions and probes (e.g., how much have you kept from the South Asian traditions over the years? What about values related to female sexuality? Male sexuality?) provided a safe space for the women to tell their life stories. The open-ended questions and probes allowed for additional inquiry into participants' responses and identified specific areas and topics to be explored. The use of the guide provided a certain degree of consistency among all interviews (Barriball and While 1994).

Analysis

The general inductive approach was employed in this study. It is a technique used to analyze qualitative data where the analysis is directed by both explicit research objectives and the data (Creswell 2003). We followed an iterative process to allow the research findings and directions to materialize from the frequent, prevailing, or central themes built in the raw data (Thomas 2006). The use of an inductive approach was intended to aid in understanding the data through the formulation of summary themes and categories. All interview transcripts were subjected to preliminary thematic analysis, which involves the clustering or coding of research findings into groups of closely-related themes so as to provide a more manageable view of the data (Strauss 1987).

Findings

Sample

The study sample consisted of twelve women living with HIV who self-identified as first-generation immigrant women of South Asian descent with the exception of Juhi, a second generation immigrant who identified as South Asian. The women reported origins in India, some parts of Africa, the Caribbean, and South East Asia. They all resided in the GTA and ranged in age between twenty eight and fifty years. They were all fluent in English so there was no need for translation; however, one of the women did have her husband present during the interview because she did not feel her English was strong enough to be interviewed on her own.

Thematic Findings

The study findings are presented according to the four primary themes emergent from the analysis related to HIV risk in women: 1) *power relations; 2) emotional attachment; 3) gendered division of labour;* and *4) social norms* (see Figure 1). The theoretical implications of these themes are presented in the Discussion section. The participants' quotes included in the presentation of each theme illustrate the interactions between and among the themes. However, despite the themes being interdependent, they are discussed separately for analytical purposes. The findings from the in-depth interviews, which were designed to investigate the experiences and interactions of the participants within their families and their immediate community, are described. Through the interviews, we were able to examine in some detail the women's perceptions of gender relations and how these relations affected their risk of HIV.

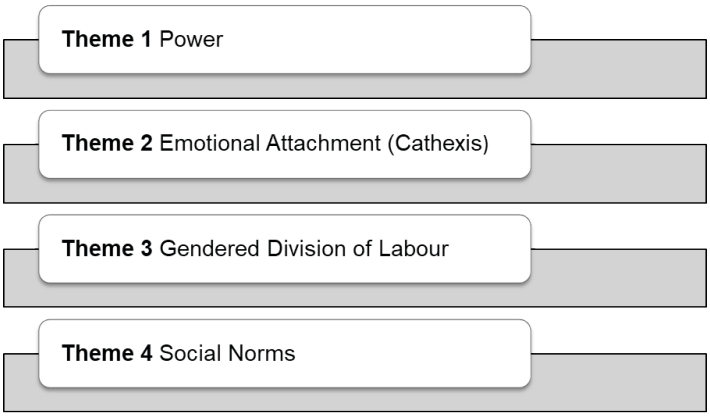

Figure 1. Four main themes

Theme 1: Power

The women's stories highlighted power relations during their childhood and in their adult lives, characterized by power imbalance and male dominance as evidenced by patriarchal authority. The women said they were expected to be less assertive and more submissive than the males in their families. All of the participants described their fathers as the *head of the household* and talked about the power exerted by their fathers, brothers, and husbands as an accepted reality in their world.

Examining social power as understood by these women shed some light on its complexity. Force was only one component the women reported experiencing, which seemed to indicate the male figures in their lives were trying to establish and maintain dominance. Although physical abuse was not often used as a way of exercising control over the women, the majority of them said they experienced ongoing emotional and psychological abuse as well as unequal access to household and workplace resources. Sutra said that, although her husband was controlling and she had experienced one incident of physical abuse, she claimed that he was supportive because he encouraged her and paid for her to attend college. She reported that he was controlling when they first arrived in Canada, which rendered her vulnerable to the eventual physical abuse. Sutra described the incident of physical abuse:

> It was really hard that time in particular just for controlling things. You know we went to the wedding and he wanted to leave early and…And then he left me and he went home… Now when we got home, he started arguing with me and then we got into fight. Yeah, that's the only time when we got into a physical fight. Yeah, and after that he realized what he did and he said, 'Sorry.' Yeah, that's it. Yeah, but it's the only time I remember that we got into a real fight. Yeah, but usually it's verbal, verbal fight in the house.

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

The women internalized gendered behaviours from early childhood and carried them into their intimate relationships with men. They described practices in their families of origin that resulted in them being, for the most part, passive in their acceptance of marital partners chosen for them. This passivity subsequently remained in their relationships with their husbands. By speaking of men as superior and women as inferior and controlled by men, the women highlighted the power imbalances in their marriages. Examples of these dynamics were expressed clearly through the recounting of experiences related to their relationships throughout their lives. For example, Haifa described the expectations for females growing up simply as: "*No, we were not allowed to date*." In some households, double standards for dating were openly exercised and enforced. Several of the women spoke about males in the household, usually brothers, being allowed to date whereas they, as female children, were explicitly told that dating was not an option for them. Sutra shared her experience of this double standard in her family: "*But my dad wouldn't talk to his son, saying that, 'You can't do this.' But he would talk to me. You know, even if he knew my brother had girlfriends.*"

The participants' individual beliefs in male superiority, and their widely accepted beliefs and norms supportive of male dominance, are interdependent and representative of *power relations* as a social structure (per Connell's theory). Without this interdependence, there would be no basis for the hierarchical relations of power between the women and their partners. Power relations, supported by strongly adhered-to social norms that position the women's role in the home, remain the structure most resistant to change and the most influential in sustaining the legitimacy of male power. Although the presence of abuse suggests a failure of legitimacy, it is not valid to infer that its mere absence constitutes legitimacy of male power. For this reason, we propose that, in addition to power relations, emotional attachment plays a central role in validating and legitimizing male power.

Theme 2: Emotional Attachment (Cathexis)

This theme focuses on the social structure of *emotional attachment* and its interaction with the structure of *power relations*. Exploring this theme allows for a better understanding of the factors that put this sample of immigrant women at increased risk for HIV. The interaction between power relations and emotional attachment was clear as power imbalances could only be sustained if the women had emotionally invested in and endorsed them. At the relational level, emotional attachment influences how one may approach a power imbalance. For example, without an emotional attachment, one may decide to simply leave a relationship that does not foster equal power and opportunity. With emotional attachment, however, leaving may become much more difficult as fear of losing a partner could shape how one communicates. Further, the interdependency of power relations and emotional attachment also intersected with social structural factors, the women's personal values and beliefs, and the social norms illustrated by their shared understandings of traditions and practices. These interdependent factors played a role in how these women constructed male superiority in their lives and how hegemonic masculinity was legitimized.

The interdependence of power and emotional attachment is perhaps best illustrated by the women's reactions and responses to their husband's extramarital affairs. Many of the women reported that they were aware of their husband's infidelity. Despite not approving of this behaviour, they did not feel there was anything that could be done. Shreya talked about the shared idea that when a woman is married, she requires nothing else in life but her husband. Even if she briefly thinks about sex, she will only think about it in relation to her husband. She remarked of sex:

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

Shreya added that women will not go outside the marriage for sex because they know that is not in their best interest. In other words, if a woman does engage in this behaviour, her life could be destroyed: "*It's not something…It's not that she's not allowed to, but it's not something an Indian woman would do…oh yeah, to us the men can go and sleep with fifty women. Nobody will say anything. But the woman goes and sleeps with just one man, that's it. Yeah, that's the end. I mean her entire life is ruined.*"

According to Deepa, to ensure their own self-preservation, women will choose not to have sex outside the marriage, accepting instead that men sometimes do and that the woman's role is to acquiesce. She also talked about women's fears of being sent to prison or being tortured if they were to engage in these behaviours, which contributed to their decision not to do so:

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

The interdependence of social norms, power relations, and emotional attachment is also clearly illustrated in the women's stories regarding sexual roles and marital relationships. For the majority of these women, husbands or partners asserted their power by dictating the terms of their sexual relationships, including whether or not condoms were used. Within this sexually intimate realm of living, most of the participants reported that men do not use condoms with their wives nor would they do so if asked. Most women agreed that it was usually the man who had a problem with using a condom. For Minu, it was simply a matter of men's preference: "*It is you know, sometimes the man wouldn't want to use it*." The most frequently reported reason for not asking one's husband to use a condom was the fear that if a woman did so, her husband would assume she was being unfaithful to him. This fear contributed to women's submissiveness to their husbands. They did not want to put their relationship

(and thus emotional attachment) in jeopardy. This fear legitimized male power in the lives of these women and was especially evident in Deepa's quote above.

Some of the women's narratives also provided evidence of the interdependence of individual beliefs and social norms. Because some believed that male infidelity was widely accepted in the community, these women accepted male power (in the form of a double standard with respect to sexual autonomy) as part of their own reality. Strong social norms, and the emotional buy-in from the women, provided legitimacy for male power. Ultimately, the power dynamics in these situations contributed to the women condoning the extramarital affairs and leaving them in a position where they were still at risk of HIV. They were aware of the affairs, but they still did not want to lose their relationship, leaving them submissive to their husband's wishes.

For some of the women, trust in their husbands and a misplaced faith that the relationship was monogamous led to risk of HIV. Those who suspected that their husbands were involved in some kind of extramarital relationship, either while they were together or during a separation, described themselves as being a person who would not have considered that her partner was having sex outside the relationship. For instance, despite Anandi's devastation upon receiving the call from public health that revealed her partner's infidelity at the same time they were trying to conceive and in spite of a doctor recommending she not continue her relationship with him, Anandi accommodated his infidelity and went on to conceive her second child with him.

The women's risk of acquiring HIV was heightened by a complex myriad of factors, including their (a) underlying desire for trust and fidelity in their relationships; (b) emotional dependence on their partners; (c) trust in their partners to not put them at risk; and (d) lack of awareness of HIV, paired with their inability to negotiate or enforce condom use regardless. The confluence of these factors demonstrates the interdependency of emotional attachment, personal values and beliefs, power, and social norms. For instance, Chandra reported that she trusted her husband to be monogamous or at least to protect himself by using condoms if he did engage in extramarital affairs. She recalled her neighbour's words, warning her about the possibility that her husband would cheat on her during her absence: "*You have left your husband for 2 1/2 years, and at that time, he was a single guy. For sure, he's been fooling around*." Nevertheless, Chandra felt strongly that she could trust her husband to do the right thing: "*I didn't know much, I don't know much about the virus. I had so much trust that I thought maybe he fooled around, but he was protecting himself. I had trust*."

Again, the interdependency of the women's individual experiences and their perception of social norms is clearly illustrated in their narratives. According to Anjali, most women assume that there is trust and fidelity in their marital relationships, a trust that results in a false sense of security. Anjali described her perception of women's desire for trust in their marital relationships: "*In terms of women, their husband is the man that they will marry, so they don't think of any worry. But, however, they don't know where those husbands have been and what they're doing. And they come back home after they've been elsewhere.*"

Theme 3: Gendered Division of Labour

The third theme to emerge from the study was the *gendered division of labour*, which is a social structure in Connell's (1987, 1995; Connell and Pearse 2009) social theory of gender. The gendered division of labour is not just about the allocation of work, but about the nature and organization of that work. It is impossible to separate either from the distribution of the by-products of work; that is, the distribution of services and income. The gendered division of labour must be seen as part of a larger pattern, a structured system of production, consumption, and distribution. When developing this theme, we focused on the social structure of the *gendered division of labour* and its interaction with the structures of *power relations* and *emotional attachment* in relation to HIV-risk. As per intersectionality, we examined the overlap of these social structures and highlighted examples that also connect to the women's personal values and beliefs. Understanding the interdependence of these factors contributes to an understanding of the construction of male superiority and the legitimization of masculine hegemony in these women's lives.

The women's narratives illustrated that their households were constituted by a division of labour that defines the work of women as domestic and unpaid and the work of men as public and paid. The

gendered division of labour reflects ideas about a "woman's place." From their accounts, the division of labour in their families were partly a consequence of their husbands' power to define their wives' situation. Childcare and other care-giving duties were basic to the division of labour in these women's families. Because their husbands were in control of the division of labour in the family, these men made the decision as to whether or not to help with childcare, reflecting their dominance and power. Many men refused to participate in childcare, reflecting the social norm that this is women's work and thus of lesser value. This practice had a particular prominence in the domestic division of labour in that it represented a large portion of these women's daily domestic duties. In Noor's case, the in-laws assisted with childcare. However, according to Noor, it is not uncommon for women to have to look after aging in-laws as well as their children: "*Yeah, she [mother-in-law] is cook and she is look after my daughter. Before she is live with me and now she is ah lives with my brother-in-law. Well mostly men earn, earn money and women stay at home. Women look after in-laws as well.*" The gendered division of labour inside the home limits the women's ability to do paid work outside the domestic realm, which in turn translates into less power in their relationships.

The economic hardships faced by most of the women translated into economic dependence on their partners, which increased men's control over finances, ultimately increasing their power in the marriage. Most of the women in the study reported limited economic control in their lives. Men were charged with making decisions about the large expenditures, such as a house, car, or major appliance, whereas women, as the subordinate party, had authority over what men consider to be menial purchases such as groceries or children's items. Despite the fact that he shared in the daily chores including housework and childcare, Doyel still felt the economic control exercised by her husband. She was in charge of purchasing small items such as groceries and things for the children:

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

Doyel's account highlights that, even though some situations were suggestive of equal roles in the relationship (e.g., shared household duties), there was still a dependent relationship with regards to money and purchasing power. In this situation, there was still a clear divide between men's and women's abilities to make major decisions that could impact both persons in the relationship. This is a nuanced example of how power inequities between husband and wife contribute to HIV risk for South Asian women in the GTA.

Theme 4: Social Norms

The fourth and final theme in this study, which has been discussed to some degree in the above sections, is *social norms*. Connell (1995) used the term *culture* to refer to the totality of social norms. According to her, culture is communicated through norms and related behaviours, with norms defined as "individual perceptions about the generally held attitudes of others in the system. Individuals derive beliefs about what is valued within the social system by their perceptions of attitudes generally held by others, especially when they need to negotiate norms and behaviours with others in public" (33). Social norms do not form an individual's attitudes, but they impact them and are impacted by them.

The three interdependent but distinct social structures discussed above (i.e., individual, structural, and normative influences) interacted with the women's individual attitudes and the social norms they adhered to, thus influencing their sexual practices and their risk of HIV. The interactions of the social structures and individual attitudes with *social norms* will now be discussed.

We found that individual beliefs were not always consistent with social norms. Four of the women in the study contested male power by resisting their upbringing, which dictated a form of asexuality for females with the exception of procreation with their husbands. These particular women wanted to "experiment" in what seemed at the time to be a safe venue. But, they

contested male power secretly because of their fear of the severe repercussions that may have resulted if they had opposed a socially sanctioned norm in public; in this case, female virginity. For example, despite growing up in Canada, Anjali described her upbringing as "*very traditional*." Nonetheless, she reported that when she was much older and in university, she indulged in sexual activities which she kept secret from everyone in her family. The man involved eventually became her husband: "*Until university came, a little bit of experimentation and that was hidden. It was never, even in university, it was hidden. It was never brought up and I, I, I did have sex before marriage, but they didn't know it.*"

In this study, social norms were the most important factor in legitimizing male power and keeping order in these women's lives. Many general accounts of patriarchy give the impression that it is a simple, orderly structure. However, these women's stories showed that, behind the facade, exists a mass of disorder and anomalies. As illustrated by these women's narratives, the perceived ideal of purity, modesty, and obedience may never have existed in their lives. Anandi, Juhi, and Anjali engaged in premarital sex with their boyfriends who they later married. Haifa also engaged in premarital sex, but with a boyfriend whom she never married. Haifa and Anjali both dated and had sex with a man following the demise of their marriages. Haifa described having a clandestine premarital sexual relationship with a boy when she was fifteen or sixteen years old: "*Yeah, we dated, yeah. Mm, no, I can't remember how many years. Maybe 3, 4 years.*" When asked whether she used condoms while having sex, Haifa responded, "*Oh, we don't use that*." The interaction of norms with the women's individual practices and the social structures of power relations and emotional relations is clearly illustrated here. A socially and religiously sanctioned norm of modesty for girls (i.e., premarital sex was forbidden) was inconsistent with their experiences. They resisted this social norm at great risk.

On a different level, power relations, as exemplified by the power imbalances described in their marriages, reinforced the psychosocial dynamic of male superiority and female submission. This, in turn, allowed the men to determine and reinforce behavioural norms, including sexual norms. The women were emotionally and economically dependent on their husbands with most of the women subjected to ongoing emotional or psychological abuse in their marriages. For these reasons, they were not in a position to resist; that is, to require that their husbands use condoms even if they knew that their husbands were engaging in sex outside the marriage. Further, regardless of their life experiences, whether it was domestic violence or HIV infection, the women, encouraged by their religious beliefs, accepted their experiences as their fate and did not protest in either word or deed.

This intractable situation was exacerbated by the stigma attached to divorce in their cultural community, reinforcing their lack of power and heightened risk of HIV. For example, despite hardships in her marriage, Sutra's extended family became involved in the relationship to ensure it remained intact:

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

Further, strongly endorsed norms likely contributed to most of the women staying in their marriages, especially those norms that value family honour and condemn those who bring shame to their families. As evidenced by the quotes above, the women's words exemplify the rather complex interactions that legitimize male power. Despite the fact that individual women's attitudes were not always consistent with social norms (i.e., some of them pushed back), most of them still, for the most part, lived according to the norms of their cultural community. Staying in their marriages, in some cases despite warning signs, and bowing to social norms and male power increased the susceptibility of the women to HIV infection.

Gender equality is another dimension of the social norm theme. Gender inequality arises from differences in socially constructed gender roles (i.e., the actions or activities assigned to or required of a person). Inequality refers to unequal treatment or perceptions of individuals based on their gender. Connell's (1987)

theory assumes that gender inequality is reproduced through the processes of institutionalization and legitimization. As such, it is built into the social structures of power relations, emotional attachment, and the gendered division of labour via the everyday routines that sustain them. Indeed, we found complex interactions between social norms and the social structures of gendered division of labour, power relations, and emotional attachments. The women identified themselves as belonging to communities with strong social and gender norms that supported a clearly defined gendered division of labour (and, by association, increased risk of HIV).

Most women in the study confirmed that they socialized primarily with others in Canada who were from their ethnic or cultural community. As Noor remarked, "*but mostly our friends, who come and visit and you go and visit are mostly East Indian*." Also, the women's experiences of social and workplace discrimination further influenced their decision to work at home and assume childcare responsibilities. The resultant division of labour increased the women's economic dependence on their husbands, resulting in an increase in the women's submission and emotional attachment to their husbands, which in turn strengthened male power in the relationship. Thus, attachment to the community influenced the women's behaviours in such a way as to increase their risk of acquiring HIV from their husbands, representing the convoluted complexity of their situations.

This relationship becomes even more complex because attachment to the community can paradoxically provide support for the women while also exposing them to HIV risk. Some women came to Canada when they were young wives and the only person they knew was their husband. Some of these women were not even that familiar with their husband. These women reported that isolation amplified the challenges of adjusting to a new country and the new role of wife. While Doyel discussed who she and her husband socialized with when they first came to Canada, she confirmed that most of her contacts were with "*South Asians…we were involved in the South Asian community*." Chandra also socialized strictly with families from her own community despite working in a culturally diverse organization. It was important for her and her own family to be around others from her own community: "*It's hard…I'm a working person, but I'm mostly a family person. So if I had time I would have company so that we all are family and kids grow up together…I still keep my culture*." Ironically, her cultural norms were inadvertently exposing her to risk of HIV infection and hence the paradox.

Discussion

With this analysis, we aimed to investigate the connections between the macro- and micro-structural assertions of Connell's (1987) (see Connell and Pearse 2009) social theory of gender by examining the local context of South Asian women living with HIV in the GTA. We also aimed to examine the interdependencies between structural, individual, and normative influences (per later work by Connell 2012; Hankivsky 2012) in the lives of South Asian immigrant women living with HIV. Four themes were identified as relevant to Connell's social theory of gender and as significant to the women in this study: power relations, emotional attachment, gendered division of labour, and social norms. Through their stories, the women in the study demonstrated how they constructed male superiority in their lives through these four social constructs, thus revealing how they participated in the legitimization of hegemonic masculinity. The importance of the findings is discussed below with particular attention paid to how the findings highlight the significance of examining micro-level, local structures in the context of Connell's social theory of gender.

Power relations emerged as a major theme in this study. In Connell's social theory of gender (1987, 1995; Connell and Pearse 2009), power is a structure in gendered relations referred to as the sexual division of power. Among other things, it is maintained in relationships through hegemonic masculinity (Connell and Messerschmidt 2005). The women's narratives suggested that they believe in male superiority and these beliefs are widely accepted in their community. Given these assertions, we propose that individual and societal beliefs are interdependent with power relations as a social structure and that, without this interdependency, there is no basis for the hierarchical relations of power between the women and the men in their lives. We also propose that this interdependence influenced the women's sexual practices, thus contributing to their risk for HIV.

Both the emotional and psychological abuse

perpetrated by the participants' husbands appeared to reinforce the subordinate status of the women in the study. Possessiveness and combativeness (i.e., emotional and psychological abuse) were commonly reported forms of abuse with physical violence mentioned by five women in the sample. Although abuse is an indication of the illegitimacy of male power, its use suggested it was maintaining the status quo; that is, it appeared to force the women to abide by widely accepted social norms as reported by the women (especially in regards to women's asexuality and division of labour). Some of the women suffered from abuse when they first immigrated and were isolated and more vulnerable to their husbands' control. This finding of abuse is consistent with previous studies that examined the experiences of South Asian-sponsored brides in Canada. In these studies, women indicated that they were exposed to harsh physical and emotional mistreatment by their husbands (Cote, Kerisit, and Cote 2001; Husaini 2001; Merali 2009).

In a qualitative study examining South Asian adolescent girls' experiences in Canada, Aziz Talbani and Parveen Hasanali (2000) found that the young women perceived "a high social cost attached to protest [and opposition]" (623); thus, they accepted the status quo. Through our analysis, we also identified some tensions between micro- and macro-systems, highlighting the significance of studying Connell's (1987) social theory of gender from the local context (see also Connell 2012). For the women in our study, and in Talbani and Hasanali's (2000), the local context appeared to have a strong impact on day-to-day living, especially when tensions between micro- and macro- systems existed. As Connell (2012) and Zena Sharman and Joy Johnson (2012) have proposed, conceptualizing gender and health in local contexts is an emerging imperative.

The effect of immigration on power relations has also been documented in other studies. Many South Asian immigrants in Canada reported feelings of being socially ostracized. As a result, their socialization is limited to others who are part of their cultural networks (Cote, Kerisit, and Cote 2001; Husaini 2001; Merali 2009) as was evident in our study. Further, social relations that result in gender disadvantages may actually be strengthened, rather than diminished, through the process of immigration. As was found in our study, this is possible because new diasporic identifications may reinforce existing patriarchal relations (Dwyer 2000). In such cases, changes in the macro-system may actually increase the vulnerabilities in the local context. As we assumed, examining the local contexts and the interdependencies between the micro- and macro-level structures detailed in Connell's theory may be worthy of further investigation.

The women in our study experienced social isolation at the local level, often due to racism and gender inequality. Sherene Razack (2005) maintains that the social isolation experienced by the women in her study could be illustrative of a "culture clash" (11). Culture clash constructs Canada's role as that of the rescuer and as an icon of tolerance that saves people, especially women, from patriarchal cultures that devalue them. Since the events of 9/11, Razack argues that a specific "geo-political terrain" (12) has been promoted worldwide, allowing undeniable racism to be expressed in the name of feminism. This racism needs to be attended to because the new geo-political terrain is characterized, in part, by a violent culture clash between the West (constructed as modern, good, civilized, secular, and democratic) and the Islamic world (depicted as the West's opposite: non-modern, evil, uncivilized, religious, and barbaric) (12).

In the sample of women we interviewed, this divisive terrain (Razack 2005) may have contributed to the local context by further isolating the South Asian women in the Canadian context and leaving them in a vulnerable position in a country where their social and familial networks are limited. Although the women's retreat to their own communities and religious institutions may not have always been a safe haven for them as it reinforced hegemonic masculinity, it provided them with acceptance and validation, which became a source of strength and resilience against the various oppressions in their lives despite the aforementioned paradox (see also Rosenfield 2012).

Some of the women in our study gingerly pushed back against male power and gendered violence, often risking their safety and lives and despite the fact that they still contracted HIV. This can be considered a form of agency. Veronica Magar (2003) examined gender-based violence and established a model of empowerment in which agency is a fundamental concept in women's emancipation and liberation. According to Magar, "agency is the individual's capacity to act on their life situation and make strategic life choices using

capabilities and resources such as knowledge and skills, critical consciousness, and gender awareness available to them" (520). Yasmin Jiwani, Nancy Janovicek, and Angela Cameron (2001) add a critical piece to this idea of agency in the context of a culturally divided terrain: when anti-immigrant sentiments are present and extreme, members of visible minority groups must constantly bend to societal norms and seek support from their own cultural communities. Further, they assert that the Canadian context represents a culture replete with increasingly complex relations that are challenging to navigate.

The women in our study said they experienced this navigational challenge, which they partially met by turning to their local communities, a move that inadvertently exposed them to heightened risk of HIV. This risk manifested because of the aforementioned convoluted interdependencies between power relations, emotional attachment, gendered division of labour, and social norms and the three structural, individual, and normative influences (see Hankivsky 2012).

Conclusions

Our analysis suggests that using Connell's social theory of gender to explore *how* social norms may interact with personal beliefs and social structures (i.e., power relations, emotional attachment, and gendered division of labour) offers new knowledge that can impact how we understand experiences; thus, how we can best support people who are situated in challenging social locations that threaten their health and well-being (Connell 2012).

Findings from this study clearly indicate that power, emotional attachment, gendered division of labour, and social norms *are* structures that contribute to some South Asian women's oppression and increased risk of HIV.

The major contributions of this research include the need to augment Connell's theory of gendered social relations with a focus on the local (balanced with an anti-oppressive lens) and to take into account the insights gained from the four themes emergent from this study: power, emotional attachment, gendered division of labour, and social norms. If gender differences are socially constructed, these social relations can be reconstructed, leading to more supportive and less hegemonic personal relations. Richer and nuanced understandings of how power operates between genders, especially for South-Asian women at risk of HIV, paves the way for theory refinement and innovative, refocused research.

Endnotes

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

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