EXPLORING THE EXPERIENCE AND IMPACT OF INCARCERATION FOR WOMEN LIVING WITH HIV IN METRO VANCOUVER, CANADA

by

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Abstract

Background: Women living with HIV are disproportionately criminalized and overrepresented within correctional facilities. Incarceration is linked to gendered impacts on HIV health, including sub-optimal HIV outcomes for women. Despite this, there is a paucity of evidence on the unique needs and experiences of women living with HIV who face incarceration. This dissertation explores and investigates the social and structural factors that shape incarceration experiences and HIV health outcomes for women living with HIV both during and post-release from incarceration.

Methods: This dissertation draws on a mixed methods approach, using qualitative and quantitative data from the SHAWNA (Sexual Health and HIV/AIDS: Women's Longitudinal Needs Assessment) Project, a community-based research project with over 350 self-identified women living with HIV across Metro Vancouver, Canada. Drawing on in-depth interviews with participants who had experienced a recent incarceration, and interviews with service providers, qualitative analysis explored experiences of incarceration trajectories among women living with HIV. Using longitudinal cohort data, path analysis was conducted to investigate pathways from recent incarceration to optimal antiretroviral therapy (ART) adherence.

Results: Qualitative analysis revealed how HIV-related stigma within correctional facilities, reinforced by institutional processes that hinder privacy and confidentiality, was linked to isolation and discrimination, and compromised HIV care for women during incarceration. Findings highlighted heightened vulnerability following release, and elucidated key intersecting structural barriers including limited pre-release planning, a lack of immediate supports, and challenges securing safe housing and addiction services. This perpetuated re-incarceration, and undermined the continuity of HIV care. In path analysis, homelessness, experiences of gender-based violence,

and criminalized substance use were identified as key factors that fully mediated the relationship between incarceration and optimal ART adherence for women living with HIV in the post-release period.

Conclusion: This dissertation extends the limited body of research concerning the lived experiences and impacts of incarceration for women living with HIV by highlighting the complex ways in which social and structural factors shape unique experiences along incarceration trajectories and perpetuate harms. Findings elucidate specific considerations for interventions and policy reforms designed to improve HIV health outcomes, support overall well-being, and redress rates of incarceration for women living with HIV.

Lay Summary

Globally and within Canada, women living with HIV face disproportionate criminalization and incarceration and experience sub-optimal HIV health outcomes along incarceration trajectories. This dissertation explores and investigates the social and structural factors that shape incarceration experiences and HIV health outcomes for women living with HIV in Metro Vancouver, Canada, both during incarceration and following release. Findings revealed that during incarceration, HIV-related stigma, along with a lack of privacy and confidentiality, contributed to isolation and discrimination among women, and compromised their HIV care. Release from incarceration was characterized by heightened vulnerability due to a lack of pre-release planning and limited supports upon release. Challenges securing safe housing and addiction treatment, and experiences of gender-based violence, perpetuated re-incarceration and undermined continued HIV care. This research highlights opportunities for interventions and policy reforms designed to improve HIV health outcomes, support overall well-being, and redress rates of incarceration for women living with HIV.

Preface

This statement certifies that Margaret Erickson (ME) conceived, conducted, wrote, and disseminated the work presented in this dissertation. All research in this dissertation received ethical approval from the University of British Columbia/Providence Health Care Research Ethics Board (H14-01073/H19-03442). Manuscript co-authors are as follows: Andrea Krüsi (AK), Ruth Elwood Martin (REM), Jane Buxton (JB), Kathleen Deering (KD), Flo Ranville (FR), Kate Shannon (KS), Sherri Pooyak (SP), Terry Howard (TH), Bronwyn McBride (BM), Neora Pick (NP), Brittany Bingham (BB), Pam Young (PM), Mo Korchinski (MK), Melissa Braschel (MB), and Candice Norris (CN). All co-authors contributed only as is commensurate with supervisory committee, collegial, or co-author duties. AK and KD are the principal investigators of the research program from which the studies were derived (SHAWNA) and take full responsibility for the integrity of the results and data accuracy.

Outlined below are the specific contributions of the authors. All dissertation chapters were prepared, written, and edited by ME. *Chapters 1 & 5* are original, unpublished intellectual products of ME, with substantive guidance and input from co-supervisors (AK and REM) and committee members (JB and KD). With guidance from AK, REM, and committee members, ME designed the studies that appear in *Chapters 2–4.* ME conducted the qualitative analyses in *Chapters 2 & 3* with guidance from AK. MB conducted the statistical analysis in *Chapter 4* in collaboration with ME and with guidance from KD.

AK, REM, KS, FR, SP, TH, BM, and NP provided contextual and scientific input for the study presented in *Chapter 2* and approved the version submitted for peer review publication. AK, REM,

JB, KD, FR, BB, PY, MK, and KS provided contextual and scientific input for the study presented in *Chapter 3* and approved the version submitted for peer review publication. AK, REM, JB, KD, KS, MB, and CN provided contextual and scientific input for the study presented in *Chapter 4* and approved the version submitted for peer review publication. AK, REM, JB, and KD provided final feedback and approval on *Chapters 2–4* as they appear in this dissertation.

Final empirical chapter drafts were prepared following inclusion of material based on comments and feedback from all co-authors (*Chapter 2–4*), along with journal editors and external peer reviewers (*Chapter 2*). The analysis presented in *Chapter 2* has been published; the analyses presented in *Chapter 3* and *Chapter 4* are currently under review[1].

Chapter 2: **Erickson M**, Shannon K, Ranville F, Pooyak S, Howard T, McBride B, Elwood Martin R, Krüsi A. "They look at you like you're contaminated": How HIV-related stigma shapes access to care for incarcerated women living with HIV in a Canadian setting. Canadian Journal of Public Health. 2021. Published online first.

Chapter 3: **Erickson M**, Deering K, Ranville R, Bingham B, Young P, Korchinski M, Buxton J, Elwood Martin R, Shannon K, Krüsi A. "They give you a bus ticket and they kick you loose": A qualitative analysis of post-release experiences among recently incarcerated women living with HIV in Metro Vancouver, Canada. (*Under review).*

[1] The study titles presented here reflect the titles as they appeared for submission to their respective peer reviewed journal, titles of each empirical chapter have been edited slightly for consistency throughout the dissertation.

Chapter 4: **Erickson M**, Krüsi A, Shannon K, Braschel M, Norris C, Buxton J, Elwood Martin R, Deering, K. Pathways from recent incarceration to ART adherence: Opportunities for interventions to support women living with HIV post-release from correctional facilities. (*Under review).*

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List of Abbreviations

AESHA	An Evaluation of Sex Workers' Health Access
ACCW	Alouette Correctional Centre for Women
ART	Antiretroviral Therapy
BC	British Columbia
CBPR	Community-Based Participatory Research
CFI	Comparative Fit Index
CGSHE	Centre for Gender and Sexual Health Equity
CIHI	Canadian Institute for Health Information
HIV	Human Immunodeficiency Virus
IQR	Interquartile Range
PHSA	Provincial Health Services Authority
RMSEA	Root Mean Square Error of Approximation
SHAWNA	Sexual Health and HIV/AIDS: Women's Longitudinal Needs Assessment
TRC	Truth and Reconciliation Commission of Canada
UBC	University of British Columbia
US	United States

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My deepest gratitude first and foremost to the SHAWNA participants who contributed to this research through participation in the SHAWNA cohort, qualitative interviews, and incarceration-focused Positive Advisory Working Group. Thank you for sharing your stories, perspectives, time, and collective wisdom—it has been an honour to learn from you. Thank you also to the service providers who participated in qualitative interviews and shared their views and experiences so candidly. I am forever grateful to the entire SHAWNA team, especially the Peer Research Associates and Community Engagement Associates, and to the wider CGSHE staff, trainees, and faculty who have supported me in various ways since first joining CGSHE in 2014—this work is collective on so many levels. A special thank you to the colleagues who provided care and friendship along the way.

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well to Yolanda and Anika at *Drawing it Out* for bringing their creative vision to the animated video process, and to Patrick Geraghty for his careful proofreading.

Completing a PhD in the height of a global pandemic was at times an overwhelming experience, but it also centered important conversations in a mainstream and accessible (virtual) way that helped frame this research on many levels. I want to recognize the amazing organizers and facilitators (who will never read this) for pouring their labour and time into webinars and panels concerning transformative justice, prison abolition, defunding the police, mutual aid, etc. These past two years have been fundamental in my own growth and development surrounding these topics and I feel immensely privileged for all the opportunities to listen and learn that have been graciously offered throughout this otherwise challenging and complicated time.

Last, thank you to my family and friends for always encouraging me in my academic pursuits, and for showering me with love and encouragement over the last four years. To Guillaume, my partner, thank you for your unwavering support, love, and patience. Every day spent with you is a gift.

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This research took place on the unceded traditional territory of the Coast Salish Peoples, including the territories of xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and Səl̓ílwətaɬ (Tsleil-

Waututh) Nations. As a descendent of immigrants from Finland, Scotland, and Sweden, I had the immense privilege of growing up by the ocean on traditional and unceded, Semiahmoo, Kwantlen, and Coast Salish territories. My involvement in this research has prompted continued critical self-reflection in terms of my social location relative to this work and I am forever humbled and honoured to live and learn as a guest on these lands. It is not possible to speak about the carceral system in Canada without acknowledging the detrimental impacts of ongoing colonial violence perpetuated against Indigenous peoples. Meaningful and dedicated action is needed to end the systematic overrepresentation of Indigenous people who are—and continue to be—incarcerated with impunity.

A Note on Language

As language is ever changing and evolving, I have strived to use terminology throughout this dissertation that reflects current and respectful language as identified by the respective communities that are most impacted. I acknowledge that over time the language used in this dissertation will become dated and may even elicit negative or harmful reactions. This is likely to be especially true concerning language around identity (i.e., gender, sexuality, race, Indigeneity, etc.), along with the way we talk about HIV and other health disparities and inequities and language that encompasses people who are involved in the criminal justice system. As this dissertation ages, my hope is that readers will bear in mind that myself and others involved in this work would have wanted the language to be updated and adapted appropriately to be respectful to all.

Dedication

For the SHAWNA participants, Peer Research Associates, and Community Engagement Associates who shared their experiences and supported this research.

Chapter 1: Introduction

1.1 Background

1.1.1 Women and Incarceration

More women are incarcerated globally than ever before (1). The World Health Organization indicates that over the course of the last 20 years, the number of women incarcerated worldwide has increased by 50%, growing 16% in the last 6 years (2). Similar trends can be observed in Canada; in the decade between 2005 and 2015, the number of women incarcerated federally[2] increased by 50% (3). This number has continued to rise, while the overall proportion of men who are incarcerated has declined (4). In the United States (US)—the country that incarcerates the most women worldwide—the number of women incarcerated between 1980 and 2019 increased by more than 700% (5). Findings and reports from the US suggest that the significant growth in rates of incarceration and re-incarceration among women can be linked to an increased emphasis on law enforcement efforts, more repressive laws, and increased sentences around criminalized[3] substances (i.e., the war on drugs), along with barriers following release that impact women in unique ways, and perpetuate re-incarceration (5,6).

[2] Federal facilities in Canada (commonly referred to as federal intuitions) house individuals who are sentenced to 2 or more years, while provincial/territorial facilities house individuals on remand (i.e., awaiting trial, or individuals with sentences of less than two years). The distinction is described in detail later.

[3] For the purpose of this dissertation I use the term criminalized substance use to emphasize how drug policy and laws surrounding the personal use of illicit substances are harmful and further perpetuate the cycle of criminalization for marginalized populations (279,281).

1.1.1.1 Carceral settings and the gender binary

Globally, the criminal justice system operates on a gender binary; individuals are most commonly housed in the institution that corresponds to their sex assigned at birth[4], not their gender identity (7). The specific Canadian context is discussed below in Section 1.4.1.1; however, on a global scale, there is limited data on the rates of incarceration among transgender (trans), Two-Spirit[5], and gender diverse people (8), let alone research that documents their unique experiences or needs. This dissertation focuses on the experience of self-identified women and lacks analysis[6] to address the experiences of trans, Two-Spirit, and gender diverse people who experience incarceration. Nevertheless, in the context of researching the specific experiences of women, I wish to highlight the complexities of carceral settings [7] being embedded in the gender binary. In the US, trans people are incarcerated at twice the rate of the general population, with Black trans women incarcerated at approximately 10 times the rate of the general population (9). These statistics highlight the structural vulnerability and overcriminalization of trans and gender diverse people. Correctional facilities are settings of distinct and amplified trauma for trans people due to a lack of recognition on the basis of gender (e.g., misgendering, restricted access to gender-appropriate clothing and gender-affirming care), alongside maltreatment and violence by correctional staff and other people who are incarcerated (8). For trans people and especially racialized trans people, incarceration is associated with increased marginalization within a context of racism and transphobia, resulting in

[4] These policies also reflect male versus female sex, and do not account for intersex people.
[5] Two-Spirit is an identity among people Indigenous to Turtle Island (otherwise known as North America) who identify as having both a masculine and a feminine spirit, and may be used to describe any or all of sexual, gender, and/or spiritual identity; however, this depends on the individual and context (311).
[6] The study samples of the empirical chapters presented in this dissertation include only a small number of participants who identified as a gender minority (discussed further in the Limitations section).
[7] I use the term carceral settings as an overarching term to refer to formal institutions of confinement.

disproportionate rates of social, mental, and physical health disparities (10). Of critical human rights concern, trans people face extremely high rates of physical and sexual assault within correctional facilities, with trans women housed in men's facilities being especially vulnerable. A 2015 report from the US Bureau of Justice Statistics indicates that within a period of 1 year, a third of trans people held in prisons or local jails experienced one or more incidents of sexual victimization by correctional staff or other people who were incarcerated (11). Data from the US also indicates that, compared to other people who are incarcerated, trans people are over five times more likely to be sexually assaulted by correctional staff, and over nine times more likely to be sexually assaulted by other people who are incarcerated (9). Research from Canada indicates that as a result of their heightened vulnerability and exposure to victimization and violence, trans individuals are often placed in solitary confinement or are otherwise isolated (12). Increased attention to this issue is imperative, along with protection for the rights and safety of trans people who are incarcerated globally.

The experiences of trans, Two-Spirit, and gender diverse people involved in the criminal justice system are effectively erased as a result of the way corrections statistics are reported. This is further perpetuated in most of the research within the field; overwhelmingly, criminal justice–based research uses language consistent with the gender binary. In the context of this dissertation, when referring to correctional facilities for men and women, I recognize and acknowledge that many individuals who are incarcerated are not incarcerated at a facility that affirms their gender, and that people of all gender identities are incarcerated within both types of facilities; however, much of the research cited throughout this dissertation concerning women who experience incarceration is

limited and generalized to cisgender (cis) women[8]. This is a significant limitation of the research in this field, which is discussed further in *Chapter 5*.

1.1.2 Incarceration as a Marker of Gendered Inequities

Involvement in the criminal justice system is inherently gendered. Women who experience incarceration are commonly low-income, have low levels of education and sporadic employment histories, and are often the primary caretaker for children (6). As such, imprisonment for women is closely related to poverty (13), and is a marker of marginalization[9] (14–16). As will be detailed in the following sections, women follow different pathways to incarceration compared to men (17), with women mostly incarcerated for non-violent and survival-based crimes (13,18,19). Crimes committed by women are overwhelmingly driven by economic factors, including motivated by poverty, and are often closely linked to alcohol and drug use (6).

1.1.2.1 Criminalized substance use and mental health conditions

Correctional Service Canada indicates that three-quarters of women who are incarcerated federally in Canada report a lifetime or current mental health disorder, and at least two-thirds report symptoms consistent with a co-occurring alcohol or substance use disorder (20). Across high-income settings, women who experience incarceration also have a higher prevalence of substance use disorders relative to men (21). Compared to men who are incarcerated in Canada, women are twice as likely to have a serious mental health diagnosis (22), and are more likely to have co-occurring mental health and substance use disorders (23). In 2015, 77% of women and 69% of

[8] Research that includes trans women is distinguished and highlighted whenever possible.
[9] As defined by the National Collaborating Centre for Determinants of Health: "Marginalized populations are groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions" (312).

men who were incarcerated federally reported having "issues with substance use" (24)[10]. At first glance the discrepancy is evident but not drastic; however, the breakdown of types of substance use reported by gender provides important context. This data (provided by Correctional Service Canada) highlights that in the year prior to arrest, women reported cocaine or crack (36%) as their most commonly used drug, followed by opioids (25%) and marijuana (19%), whereas men reported marijuana as their most commonly used drug (50%), followed by cocaine or crack (22%) and opioids (14%). Compared to men, women were also more likely to indicate a history of injection drug use (30% vs. 21%) (24)[11]. This data indicates that the substance use profile of women involved in the Canadian criminal justice system differ from men, which may in turn influence the types of crimes committed by women, especially related to criminalized substance use. The criminalized nature of substance use is an important driver of incarceration rates among marginalized women—including women living with HIV—and the relationship between criminalized substance use and incarceration among women has been well documented (25–28). Importantly, data from the US has shown that women are more than twice as likely as men to be incarcerated for a drug related offense (26% vs. 13%) (5).

Given the nature of crimes committed by women, they also spend less time incarcerated on average compared to men. In Canada, women are often incarcerated for less than 1 month at a time (29). Even within the Canadian federal system (sentences of 2 or more years, described later), the majority of women (62%) serve sentences of less than 5 years (30). Shorter stays are highly

[10] This is data gathered upon admission to federal facilities via the Computerized Assessment of Substance Abuse and the Women's Computerized Assessment of Substance Abuse (24).

[11] Methamphetamine was not included in this report; however, research published in 2021 drawing on intake screening data from BC provincial correctional facilities indicates that prevalence of methamphetamine use disorder among people who are incarcerated has increased nearly fivefold since 2009 (313).

disruptive to peoples lives and well-being, and have an inevitable impact on discharge planning and access to and availability of services in the post-release period, especially concerning housing (31).

1.1.2.2 Experiences of trauma among women involved in the criminal justice system

Correctional Service Canada acknowledges the inherent connection between experiences of trauma among women who face incarceration—especially post-traumatic stress disorder—and substance use as a coping mechanism (32). Research consistently points to high rates of lifetime and ongoing experiences of trauma, including gender-based violence, among women with a history of incarceration (33–37). Furthermore, women who are incarcerated have experienced disproportionate rates of childhood abuse relative to the general population, as well as relative to men who are incarcerated (6). A systematic review from 2019 indicated that between 56% to 75% of women involved in the Canadian criminal justice system had experienced some type of childhood abuse (38).

1.1.2.3 Disproportionate criminalization and incarceration of Indigenous and Black women in Canada

Involvement in the Canadian criminal justice system is inherently racialized. A 2021 report from the British Columbia (BC) Human Rights Commission—highlighting historical and ongoing systemic racism within BC provincial policing practices—showed that Indigenous[12] and Black people are significantly overrepresented in arrest statistics throughout the province (39). The report also points to the gross overrepresentation of Indigenous women among people who are arrested,

[12] In Canada, Indigenous refers to First Nations, Métis and Inuit peoples.

which in many jurisdictions exceeds the arrest rate of white men (39). The subsequent disproportionate incarceration of Indigenous and Black women in Canadian correctional facilities[13] further highlights systemic racism within the criminal justice system (4,40,41) rooted in colonialism and white supremacy (42,43).

Data from 2021 indicates that Indigenous women now account for nearly 50% of all federally incarcerated women (41), despite accounting for only 4% of adult women in Canada (44). In the prairie provinces of Manitoba and Saskatchewan, 75% of people who are incarcerated are Indigenous (29)[14]. Overall, the significant overrepresentation of Indigenous women within Canadian correctional facilities must be understood in the context the ongoing harms of colonial violence, including through the historical and ongoing displacement of Indigenous peoples from their land, the residential school system, and long-term effects of intergenerational trauma (45). The final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls highlights that Indigenous women who experience incarceration are overwhelmingly survivors of residential schools, or have family members who experienced severe trauma from residential schools, and that this has had a direct impact on their lives (42). The report also points to the fact that the majority (64%) of Indigenous women who are incarcerated are single mothers, which often results in the institutionalization of their children at an early age by way of the foster care system (42). Overall, the criminal justice system exacerbates and perpetuates structural inequities for

[13] Data on incarceration rates for other racialized groups (excluding Black and Indigenous people) across Canada is limited, and dated; however, from existing reports and research, other racialized groups, including women belonging to these groups, are not overrepresented in correctional facilities compared to the general population (314,315).
[14] This data is not available based on gender.

Indigenous women, effectively ignoring their lived realities of systemic injustices, colonial violence, and dispossession (42).

Black women are also overrepresented within Canadian correctional facilities. Black lives continue to be over-surveilled, over-policed, and over-incarcerated, stemming from a history of state violence, white supremacy, racism, anti-Blackness, and discrimination perpetuated against Black people in Canada (46). Although dated, a 2013 case study reported that the number of Black women incarcerated in Canada is rising quickly, and concentrated largely in the provinces of Ontario, Quebec, and Nova Scotia (47). Black people who are incarcerated federally in Canada account for 9% of the total incarcerated population, yet Black people only account for 3% of the Canadian population, meaning that the incarceration rate for Black people in Canada is three times their representation rate in the general society (3). Although a breakdown by gender is lacking on a national level, research published in 2010 exploring data from provincial correctional facilities in Ontario indicate that Black women are almost three times more likely to be incarcerated compared to white women (48).

1.1.3 Incarceration and HIV

Living with HIV is another marker of inequity and structural vulnerability that is linked to being criminalized and over-policed. People living with HIV are disproportionately represented among people who are incarcerated globally (49,50), with the global HIV burden among people who are incarcerated estimated to be between 2 and 10 times that of the general adult population (51). As the number of women who are incarcerated across the globe continues to rise (52), women living with HIV are increasingly overrepresented within correctional facilities (52,53).

Up to date data is urgently needed concerning the prevalence of HIV among people who are incarcerated in Canada. The most recent and publicly available national data dates back to 2007, indicating an overrepresentation of women living with HIV within correctional facilities across the country, with more women living with HIV compared to men (7.9% vs. 4.5%) (54). The same report indicated that Indigenous women were twice as likely to be living with HIV in federal correctional facilities compared to non-Indigenous women (54), further highlighting the intersecting structural inequities that Indigenous women living with HIV experience. Findings from a 2016 systematic review of the health statuses of people incarcerated in Canada highlight that between 1%–9% of women in correctional facilities are living with HIV, compared to 1%–2% of men (55). Overall, research with women living with HIV in Canada and the US has shown significantly high levels of incarceration amongst this population (36,56–58).

1.1.3.1 The criminalization and marginalization of women living with HIV

Women living with HIV face high rates of poverty, unstable housing, criminalized substance use (59,60), and depression (61). Compared to the general population, women living with HIV face a heightened risk of gender-based violence and trauma (62,63). Experiences of violence against women living with HIV are exacerbated in the context of the criminalization of HIV non-disclosure[15], specifically in a Canadian setting (64). Further, Indigenous women and other racialized women, specifically Black women, are vastly overrepresented among people living with

[15] Summarized by the Canadian HIV/AIDS Legal Network, people living with HIV in Canada have a legal obligation to disclose their HIV status to a sexual partner before sexual activity where there is a "realistic possibility of transmission". There is no obligation to disclose when having vaginal or anal sex if a condom is used and if the person living with HIV has a "low" viral load. Prosecutions and convictions around non-disclosure also continue to evolve, and continue to be challenged on the basis of human rights violations (285).

HIV in Canada (65). As such, racialized women living with HIV face unique experiences of intersectional stigma on the basis of race and gender (66).

Research with women living with HIV across Canada—including published findings from the research project that this dissertation draws on—highlights that incarceration is experienced alongside homelessness and unstable housing, criminalized substance use (36,56), and gender-based violence (36). Findings from the US demonstrate that among people living with HIV, women are significantly more likely to report both homelessness and criminalized substance use following incarceration relative to men (67), factors that are also associated with increased rates of recidivism (68). Research has shown that housing insecurity or homelessness (69–72) and criminalized substance use (72–78) can create barriers to optimal HIV health, including impacts on sub-optimal antiretroviral therapy (ART) adherence and unsuppressed HIV viral load.

1.1.3.2 Gendered impacts of incarceration on HIV health and treatment outcomes

In Canada as well as the US, women living with HIV are more likely to experience sub-optimal HIV treatment outcomes compared to men, including lower ART initiation and adherence, and are more likely to face structural vulnerabilities that increase obstacles to receiving high-quality healthcare (60,79). Correctional facilities are often presented as important sites to engage and re-engage people living with HIV in care. However, systematic reviews consistently demonstrate that achieving optimal treatment outcomes along the HIV continuum of care—which includes timely HIV testing and diagnosis, treatment initiation, support and retention in care, optimal adherence, and sustained viral suppression (80)—remains a challenge to people who are incarcerated (81,82). Although knowledge is limited with regards to how specific institutional processes within correctional facilities might facilitate or hinder continuity of care, research from Canada and the

US points to HIV-related stigma in correctional facilities as one barrier to engagement and retention in HIV care during incarceration (83–85). Incarceration as a point of disruption in care has been further evidenced by studies highlighting sub-optimal HIV health outcomes for people living with HIV with a recent history of incarceration (73,86–90). In other words, evidence suggests attrition from the HIV care continuum post-release from incarceration.

In Canada, findings from the SHAWNA (Sexual Health and HIV/AIDS: Women's Longitudinal Needs Assessment) Project have demonstrated a significant relationship between recent incarceration and unsuppressed HIV viral load among women living with HIV in Metro Vancouver (91). These findings are echoed by a 2019 national study by the Canadian HIV Women's Sexual and Reproductive Health Cohort Study that linked recent incarceration to sub-optimal ART adherence among women across Canada (56).

Moreover, involvement in the criminal justice system is linked to gendered impacts on HIV health outcomes. Findings from a 2019 systematic review, which I led, examining the impacts of incarceration on HIV outcomes for women living with HIV demonstrated that along incarceration trajectories (i.e., before, during, and following incarceration), women experience sub-optimal engagement in HIV care compared to their male counterparts (92). These discrepancies are increasingly exacerbated in the post-release period, where women face substantial barriers staying connected to HIV care, alongside challenges with adherence and maintaining HIV viral suppression (92). Across the studies (which were mainly conducted in the US) – compared to men, women were less likely to have optimal ART adherence, less likely to achieve viral suppression, and less likely to be retained in HIV care in the months following release from correctional facilities (92). The differences in HIV outcomes within the literature are quite pronounced; for

example, multicenter data from the US has highlighted that 6-months post-release from incarceration women are half as likely to achieve viral suppression compared to men (67).

Indicators of sub-optimal HIV health outcomes for women following release from incarceration must be contextualized within the broader criminalization and marginalization of women living with HIV, and situated in the lack of social supports for marginalized women that would otherwise help to support optimal health. Overall, it is necessary to further understand the needs of marginalized women living with HIV who experience incarceration in order to improve supports for this population.

1.1.3.3 Gender-based research gaps for post-release interventions

As outlined above, despite unique pathways to incarceration among women, and sub-optimal HIV health outcomes for women in the post-release period compared to men, there is a paucity of evidence surrounding gender-specific[16] interventions designed to improve HIV health outcomes for women living with HIV following release from correctional facilities. When I systematically reviewed the published literature on interventions and programs designed to improve HIV outcomes for women living with HIV post-release from incarceration, I found that studies focusing solely on interventions among women were scarce. Additionally, most studies paid limited attention to gender and did not stratify results based on gender, making it challenging to deduct any clear inferences concerning intervention effectiveness or potential differences based on gender. Building on this work, I co-authored a 2021 systematic review of controlled trial

[16] As defined by the World Health Organization Gender Responsive Assessment Scale, gender-specific programs and policies consider gender-specific needs, and are intentional in designing programs that benefit a specific group of women or men to meet those needs (316).

interventions for improving ART adherence and care linkages among people living with HIV post-release from correctional facilities. The systematic review identified only one published study in the last decade that reported on gender differences with regards to interventions among people living with HIV post-release (93).

When evaluating the effectiveness of post-release interventions, excluding or overlooking gender in study design and reporting constitutes a missed opportunity for research to inform innovative policy (94). Women living with HIV report different needs following release from incarceration compared to their male counterparts (95), and research has emphasized the need for gender-specific interventions that consider the unique needs and histories of women who experience incarceration (96). Outside the HIV research field, evidence suggests that interventions tailored to the needs of women involved in the criminal justice system can be instrumental in decreasing rates of recidivism (25). This should also extend to the need for reporting gender beyond the binary, in order to tailor interventions for trans, Two-Spirit, and gender diverse people. Beyond gender, study design and analysis that considers race, sexuality, socioeconomic status, and other social indicators also remains critical to guiding effective interventions (97). Together, these findings, considerations, and gaps in existing research provide context to the framing of this dissertation and emphasize the importance of ensuring that interventions are designed and tailored to meet the needs of all people living with HIV involved in the criminal justice system.

1.2 Study Rationale and Justification

In the context of the disproportionate criminalization of women living with HIV in Canada and globally and the structural vulnerabilities experienced by this population, investigation into the experiences of women living with HIV along incarceration trajectories is needed to inform policy

and practice. The carceral system was designed with men in mind (13), yet despite evidence of gendered disparities for women living with HIV who experience incarceration (as outlined above), research centering how incarceration shapes the specific needs and health outcomes of women (trans-inclusive) living with HIV involved in the criminal justice system remains sparse. There is a critical lack of understanding of the unique experiences of women living with HIV during and post-release from incarceration, including the mechanisms that shape HIV health outcomes. This gap in knowledge also remains starkly evident within a Canadian setting.

The 2017 transfer in healthcare leadership within BC provincial correctional facilities (described below in Section 1.4) provides a unique opportunity for the findings of this dissertation to inform programmatic and policy changes that can improve efforts to address the health of marginalized women along incarceration trajectories within BC. Furthermore, amidst a call to action to improve interventions for people living with HIV who are incarcerated globally (98), the findings of this dissertation have important implications for jurisdictions both locally and across Canada, as well as on a global scale. This dissertation aims to address a critical gap in knowledge through the below objectives.

1.3 Study Objectives

The overall aim of this dissertation is to explore and investigate the intersecting social and structural factors that shape experiences and HIV health outcomes for women living with HIV both during incarceration and throughout post-release trajectories. This dissertation addresses the following objectives:

1. **To explore how HIV-related stigma within correctional facilities shapes access and retention to HIV care and overall well-being for women living with HIV during incarceration,** *Chapter 2* draws on qualitative analysis of semi-structured interview data with women living with HIV who have experienced a recent incarceration.
2. **To explore barriers to care and challenges faced by women living with HIV during the period of transition from correctional facilities to community, including how structural inequities may inhibit or advance HIV health outcomes,** *Chapter 3* draws again on qualitative analysis of semi-structured interview data with women living with HIV who have experienced a recent incarceration, alongside qualitative interviews with service providers who support women living with HIV along incarceration trajectories.
3. **To investigate pathways from recent incarceration to engagement in the HIV care continuum via social and structural factors, and elucidate specific considerations for interventions to support women living with HIV along post-incarceration trajectories,** *Chapter 4* uses path analysis and draws on longitudinal epidemiological cohort data (2010–2019) with over 350 women living with HIV.

1.4 Study Context

1.4.1 Canadian Correctional Facilities

In Canada, there are two main types of adult correctional facilities. Federal correctional facilities are managed by Correctional Service Canada—a branch within the Canadian Government—and are designated for individuals serving sentences of 2 or more years (99). There are 43 federal facilities across Canada (100), including five facilities designated for women, located in the provinces of BC, Alberta, Ontario, Quebec, and Nova Scotia (30). Included in the 43 federal

institutions are four Indigenous healing lodges that aim to "foster a traditional healing environment" that supports "reintegration" of Indigenous people back into the community (100). One healing lodge is dedicated to Indigenous women and is located on the Nekaneet First Nation, in Saskatchewan (101). The latest published data (2019) indicates that between 2018 and 2019 there were 693 women incarcerated at federal facilities, accounting for 6% of the total number of people who were federally incarcerated at that time (30).

Provincial and territorial facilities house individuals who are serving sentences of less than 2 years, or individuals remanded to custody while awaiting sentencing or trial, although on average the majority of individuals in these facilities are incarcerated for less than 30 days, with shorter stays experienced by women (29). Provincial and territorial facilities in Canada operate under the jurisdiction of each provincial or territorial government. In BC, the 10 provincial facilities are managed by BC Corrections (102). Alouette Correctional Centre for Women (ACCW), located in Maple Ridge (approx. 1 hour east of Vancouver), is the only facility dedicated solely to women; a small number of spaces exist for women in facilities located in the interior (Okanagan Correctional Centre), and northern region (Prince George Regional Correctional Centre) of the province. The consequence of limited institutions that accommodate women means that most are incarcerated at significant distances from their communities and families. Across Canada, 14% of people admitted to provincial or territorial facilities between 2018 and 2019 were women, and of these women who were incarcerated, 42% were Indigenous (29). The 2021 BC provincial corrections profile indicates that 6% of people in BC provincial custody are women (102).

1.4.1.1 Trans and gender diverse people incarcerated in Canada

With regards to the gender binary within Canadian correctional facilities, reports on the number of trans, Two-Spirit, and gender diverse individuals incarcerated across Canada are not available. Policies that allow for individuals to be housed at facilities that affirm their gender (regardless of their assigned sex at birth) have been referenced at the federal (103,104) as well as BC provincial level (12); however, both publicly available policies[17] indicate that individuals can only be considered for a transfer to a facility that affirms their gender if they have completed (105) or are in the process of (106) gender-affirming surgery[18]. Overall, the way that policies are currently outlined in provincial and federal facilities implies that correctional officials have discretionary power over the placement and treatment of trans, Two-Spirit, and gender diverse individuals who are incarcerated (12). Research indicates that many trans people who are incarcerated in Canada endure ongoing barriers to accessing adequate and non-judgmental healthcare (12).

1.4.2 Healthcare Delivery in Canadian Correctional Facilities

Access to healthcare during incarceration is a human right: the United Nations Minimum Standards for the Treatment of Prisoners, known as the Nelson Mandela rules, maintains that people who are incarcerated have the right to the same health services—free from discrimination—as individuals who are not incarcerated (107). In Canada, reports and research maintain that the standard of healthcare provided within correctional facilities remains inadequate (108–110).

[17] The 2015 and 2018 policy amendments and 2018 guidelines for the treatment of transgender and gender diverse individuals incarcerated within BC provincial facilities are not published publicly, but are available via the BC freedom of information website. For this dissertation, the 2015 and 2018 provincial policy amendments were accessed upon request through the BC Ministry of Public Safety and Solicitor General.

[18] In this case, gender-affirming surgery refers specifically to surgery on primary sex characteristics.

The delivery of healthcare within correctional facilities is determined by the type of governing institution. On a national level, Correctional Service Canada oversees healthcare within federal facilities. The Corrections and Conditional Release Act mandates that Correctional Service Canada provide every individual who is incarcerated with essential healthcare that conforms to "professionally accepted standards" (111). At the provincial and territorial level, each respective government ministry responsible for corrections oversees healthcare delivery. Therefore, correctional healthcare delivery can be contracted out to an independent healthcare company. However, operating healthcare in a siloed fashion distinct from community care can present challenges. In an effort to improve best practice standards of community equivalence, support integration with community healthcare services, and enhance post-release continuity of care, calls have been made to shift the delivery of healthcare in corrections to the respective provincial or territorial health authorities or ministries (112–114). Several Canadian provinces have already made the transfer of leadership for correctional healthcare delivery to their respective health authorities; in 2001 the province of Nova Scotia became the first province to do so, followed by Alberta in 2010 (115). A transfer within Quebec's facilities has been ongoing since 2016 (116), while Ontario and Newfoundland and Labrador are also currently exploring a transfer (117).

Most recently, the delivery of BC's correctional healthcare transferred in October 2017 from being privately contracted under the BC Ministry of Public Safety and Solicitor General, to provision under the BC Ministry of Health through the Provincial Health Services Authority (PHSA) (118,119). The PHSA plays a key role in clinical policy and service delivery in the province, and works collaboratively with the BC Ministry of Health and regional and First Nations health authority partners to ensure specialized healthcare services across the province (120). The PHSA's

role overseeing correctional health services is focused on the unique and often complex health needs of people who experience incarceration (121), and a stated key aim of the transfer is to improve continuity of care between correctional facilities and the community (119). A focus of the shift in leadership has been on increased mental health and substance use supports among people who are incarcerated, including piloting the implementation of community transition teams aimed at improving linkages to care and other supports following release from corrections (122). Although formal evaluation of the transfer to leadership under the PHSA in BC has yet to take place, research examining the early impacts of the transfer has demonstrated a positive impact on job satisfaction among healthcare providers, including a sense of improvement in terms of the quality of care provided to clients (123). Initial findings with regards to health outcomes among people who experience incarceration are promising, showing increased access to substance use treatment (specifically opioid agonist therapy) during incarceration, and increased likelihood of accessing community healthcare services post-release (123).

1.5 Conceptual Framework and Approach

In the context of this dissertation, I conceptualize health, as well as experience with incarceration, as shaped by intersecting social and structural determinants. The relationship between incarceration, gendered disparities in HIV care outcomes, and the overrepresentation of marginalized women within the criminal justice system (e.g., Indigenous and Black women, women living with HIV, those who experience poverty, etc.[19]) is conceptualized as closely linked to the social (i.e., gendered power relations, racism, etc.), structural (i.e., laws, policing practices,

[19] Acknowledging that these identities and structural inequities are often not mutually exclusive.

etc.), and physical (e.g., correctional facilities) conditions that are maintained and reproduced within society. To inform the examination of the gendered impacts of incarceration experiences among women living with HIV, this dissertation is grounded in critical social science scholarship (124–127). Critical social theory addresses how relations of power influence the processes by which "groups are differently placed in specific political, social, and historic contexts characterized by injustice" (127), and highlights how individual behavioural conceptualizations of health are inherently connected to social, political, and institutional forces. The below sub-sections offer an introduction into the main concepts and frameworks that I draw on in this dissertation, which are also expanded upon in the subsequent chapters.

1.5.1 Structural Stigma

Within this dissertation, I draw on the concept of structural stigma, which brings attention to how societal-level conditions and institutional policies constrain the opportunities, health, and well-being of certain groups (128). Structural stigma theorizes HIV-related stigma and discrimination as social processes inherently linked to the production and reproduction of structural inequalities (126). Among people living with HIV, stigma is a key barrier to access and use of services (129), and yet often goes unrecognized as a determinant of health (130). Stigma is maintained through policies and laws (e.g., criminalization of HIV non-disclosure) and is reinforced when no action is taken to address policies that maintain structures of power and oppression (130). In *Chapter 2* specifically, I focus on the concept of structural stigma to explore how HIV-related stigma within correctional facilities shapes access and retention to HIV care and overall well-being for women living with HIV during incarceration.

1.5.2 Structural and Symbolic Violence

To better conceptualize the harms experienced by women involved in the criminal justice system, I also draw on the concepts of structural and symbolic violence (131,132). Structural violence extends beyond personal or direct violence to encompass "the social structures that perpetuate poverty, racism, gender inequities and other forms of systemic marginalization" (133). Structural violence highlights how unequal power shapes inequities (133), and how arrangements embedded in social structures or institutions prevent groups of people from meeting their basic needs and ultimately cause harm (134). Drawing on a structural violence perspective helps identify the violence within the criminal justice system and how it reproduces harms and consequences for those who experience incarceration (135).

Symbolic violence is closely linked to the concept of structural violence, and manifests when those who experience harms and inequities feel shame for their apparent weakness in the face of structural barriers (136). Symbolic violence is at the root of much suffering because it manifests blame inwards on an individual level, instead of towards the institutions and structural systems that maintain oppression (132). Using these more expansive definitions of violence provides an important framework central to this dissertation when it comes to analyzing and understanding the harms perpetuated over time among women living with HIV through their involvement in the criminal justice system. These concepts are further elaborated on in *Chapter 3* when I explore barriers to care and challenges faced by women living with HIV during the transition from correctional facilities to community.

1.5.3 Intersectionality

In this dissertation, I also draw broadly on principles of intersectionality as a guiding approach. Introduced by Black feminist scholar Kimberlé Crenshaw (137) intersectionality is a paradigm used to examine how various forces of oppression such as race, gender identity, class, and colonialism impact the experiences of marginalized and oppressed groups (138). Intersectionality also promotes the application of a critical lens to explore how "race and class systems of oppression work together in shaping the social determinants of health" (139). As such, intersectionality facilitates critical guidance for policy by providing "precise insights into *who* is affected and *how* in different settings", allowing for the development of more tailored and focused interventions that take into consideration multiple sources of disadvantage (140). In the context of this dissertation, I draw on principles of intersectionality when interpreting results, and in thinking through recommendations and tailored interventions to meet the specific needs of differently positioned women involved in the criminal justice system. Additionally, the concept of intersectionality has helped me to think critically through the limitations of this research, specifically concerning whose experiences might be excluded from the findings, as well as where future research and methodological innovation is needed.

1.5.4 Community-Based Participatory Research Approach

Finally, this dissertation is grounded in the principles of community-based participatory research (CBPR), an approach whereby community stakeholders and researchers are partnered along the research process, which involves collective and reflective inquiry (141). Through centering community voices and expertise, CBPR promotes collaborative efforts between academic researchers and community members in order to generate knowledge that meets a community-

identified need, supports appropriate knowledge dissemination, and operates with the underlying purpose of working towards social change and social justice (142,143). In brief, drawing on a CBPR approach in the context of this dissertation included having people with lived experience involved in all aspects of this work. Throughout this dissertation (and further expanded on in Section 1.7.1 below), I outline how I operationalized a CBPR approach.

1.6 Reflexivity, Positionality, and My Role as a Researcher

Reflecting on my positionality in the context of this dissertation has been a continuous and often conflicting process. As a student and researcher, I am fully aware of the inherent power imbalances that exist in academic settings, especially when research draws data from or "studies" oppressed communities. My understanding of the complex social issues and health inequities highlighted in this dissertation is shaped through witnessing and hearing firsthand the experiences of many individuals navigating the intersections of health and (in)justice, including through my roles in youth work and public health research surrounding HIV, Hepatitis C, criminalized substance use, drug policy, and prison health, along with involvement in various projects that allowed me to work closely with, and learn from, people with lived experience of incarceration. And yet, as a cis, white woman who has never been incarcerated or experienced the levels of oppression and discrimination faced by many marginalized groups, I lack the necessary perspective of lived experience to fully interpret and bring meaning to the complexities of these findings on my own. As such, working with, learning from, and centering the voices of women with lived experience (of HIV and incarceration) through the community-based approaches outlined in this dissertation is key to enhancing the credibility and validity of this research. I made efforts to ensure that I connected in meaningful ways with research participants and experiential SHAWNA staff when it

came to study design, interpretation of findings, and working collaboratively on knowledge translation and dissemination outputs. Still, despite efforts to conduct research "in a good way", I struggled with whether or not it was my place to be writing this dissertation in the first place. These feelings felt especially true given the overrepresentation of Indigenous women involved in—and impacted by—this research. As such, drawing on expertise through consultation with Indigenous academics and SHAWNA team members throughout this process, alongside constant self-reflection with regards to my social location relative to this research, was instrumental.

Finally, as mentioned in the *Acknowledgements* section at the start of this dissertation, in the wake of the COVID-19 pandemic and increased mainstream attention being paid to police brutality, systematic racism, and the harms of the criminal (in)justice system, an influx of options to attend workshops and webinars through online platforms became available in new and accessible ways. I was able to listen and learn from amazing facilitators and organizers on topics deeply connected to this research. However, I want to acknowledge that these organizers were overwhelmingly Black, Indigenous, and other people of colour (and predominantly women). Their efforts and labour resulted in my enhanced learning and understanding of prison abolition movements, alternatives to policing, and transformative justice frameworks - which has served as a fundamental underpinning of this dissertation. Although this research lends to recommendations tailored to improve the experiences and well-being of individuals during periods of incarceration, this dissertation is firmly grounded in the understanding that we need alternatives to incarceration and futures that include a focus on healing, community building, and mutual aid, rather than punishment and the perpetuation of harms and trauma by way of the criminal justice system as we know it.

1.7 Study Design and Methods

1.7.1 SHAWNA Project and Study Population

For this dissertation, I draw on qualitative and epidemiological data from an ongoing, longitudinal community-based research project of self-identified cis and trans women[20] living with HIV known as the SHAWNA (Sexual Health and HIV/AIDS: Women's Longitudinal Needs Assessment) Project. SHAWNA initiated recruitment in 2014 and involves over 350 women living with HIV aged 14 and older, who live and/or access HIV services in Metro Vancouver. SHAWNA launched following extensive community consultations with women living with HIV, HIV care providers, and policy experts on research priorities and gaps in services. Housed at the Centre for Gender and Sexual Health Equity (CGSHE), SHAWNA is a collaboration among a diverse team of academic researchers (including principal investigators Drs. Deering and Krüsi); community, legal, and policy experts; and women living with HIV, and is guided by a Positive Women's Advisory Board and a Community Stakeholder Advisory Board. SHAWNA includes both a community-based longitudinal cohort and a qualitative and arts-based research component. Recruitment for SHAWNA is ongoing and participants have been invited to enroll in the SHAWNA cohort through different means over the years. This has included outreach by a team of Peer Research Associates (women living with HIV), self-referrals, and referrals from HIV care providers, peer navigators, HIV/AIDS organizations, and clinical outreach, including close collaboration with the provincial referral centre for women living with HIV (Oak Tree Clinic, BC Women's Hospital).

[20] Recruitment/eligibility for the SHAWNA study includes cis and trans women (self-identified). Acknowledging that gender is fluid and can shift and change over time, during the course of the study, some participants have self-identified with other gender identities including non-binary and genderqueer, and Two-Spirit (for Indigenous participants). *Chapter 4* provides a descriptive breakdown for gender identity within SHAWNA.

In line with CBPR principles, the SHAWNA team has been committed from its inception to meaningful engagement with women living with HIV across all stages of the project, from integral members of the research team to participation on SHAWNA advisory boards and working groups. This dissertation is grounded in the continued involvement, input and guidance from women living with HIV, which is crucial to helping ensure that analyses and findings from this work remain relevant and reflective of the experiences of marginalized women. I had the privilege of working closely with women living with HIV through various aspects of this work—including the initial quantitative analyses exploring incarceration among SHAWNA participants developed prior to the start of my doctoral studies (36,91). Collaboration has involved formulation of research questions, development of semi-structured qualitative interview guides, interpretation of analysis, and dissemination of findings (through co-authorship of publications, and other knowledge translation activities described below in Sections 1.7.4 and 5.6).

1.7.2 Mixed Methods Approach

For this research I use a mixed methods approach to draw on the strengths of both qualitative and quantitative research methods that includes exploring lived experiences and meanings, and testing hypotheses by examining the statistical relationships among variables (144). In this dissertation, I conceptualize mixed methods research as involving the collection, analysis, and integration of two forms of data to answer an overarching research question. This supports inquiry that "yields additional insight beyond the information provided by either quantitative or the qualitative data alone" (144). Overall, the combination of qualitative and quantitative evidence helps to highlight complex relationships by centering the experiences of people impacted by an issue (145), which adds critical evidence within this dissertation to our understanding of the experiences of

marginalized women along incarceration trajectories. Since there is a lack of empirical evidence of how incarceration shapes the health, well-being, and experiences of women living with HIV—especially within a Canadian context—a mixed methods approach is useful as it facilitates a nuanced understanding of multifaceted and often complex relationships, perspectives, and experiences (146). Evidence drawn from mixed methods within health research can provide a more complete picture of the needs and priorities of people with lived experience (i.e., clients/patients) (147), which makes it a suitable research method for community-based research (148) and contributes to the goal of ensuring that findings serve as a valuable tool for policy makers and healthcare providers. By combining accounts of lived experiences of incarceration trajectories and statistical analysis, the findings of this dissertation can help inform the development of interventions to improve health outcomes and overall well-being for women living with HIV who experience incarceration. As mixed-methods research has been identified as a useful tool for policy (146,147,149) policy makers and practitioners will benefit from a multifaceted approach to understanding the complexities of the intersections between health and justice for marginalized women who experience incarceration.

1.7.3 Methodological Process and Foundational Research Findings

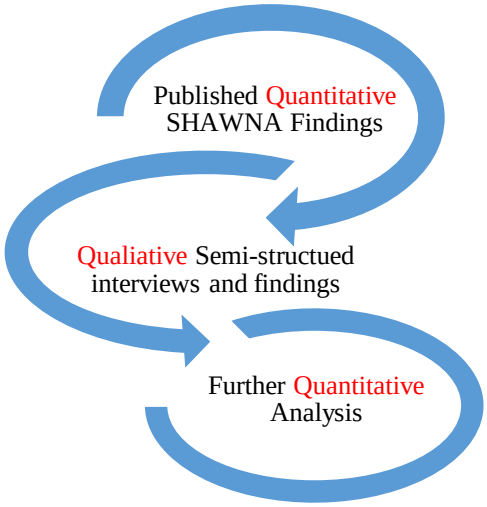
This dissertation builds on an existing foundation of published research led by myself (in collaboration with the SHAWNA team and community co-authors) that was conducted prior to the start of my doctoral studies. Initially, to explore the impact of incarceration for women living with HIV globally, as previously described, I led a systematic review (92) that highlighted the gender-based differences in HIV outcomes for people living with HIV post-release from

incarceration. Findings highlighted that women[21] living with HIV experienced worse overall HIV related outcomes compared to men—especially post-release from incarceration. Additionally, this systematic review pointed to a significant gap in empirical research on the impacts and experiences of incarceration among women living with HIV outside of the US. I also drew on longitudinal SHAWNA cohort data to examine the impact of recent incarceration among SHAWNA cohort participants. Alarmingly high lifetime experience of incarceration among participants (75% of the SHAWNA cohort had been incarcerated at some point in their lives) led to separate quantitative analyses exploring (a) the relationship between recent incarceration and HIV viral load, and (b) the correlates of recent incarceration for women living with HIV in Metro Vancouver. The first analysis established a significant relationship between recent incarceration and unsuppressed HIV viral load among the cohort (91). The second highlighted how incarceration is experienced alongside homelessness, criminalized substance use, and gender-based violence—including violence from police (36). This dissertation therefore builds on a foundation of work—including published systematic reviews (92,93) and quantitative SHAWNA analyses (36,91)—that directly informed the development of the semi-structured qualitative interview guides used in *Chapters 2 & 3* for: (a) recently incarcerated SHAWNA participants, and (b) service providers who support this population (described below). The qualitative data complements and provides further context to the existing published quantitative research. The findings and themes drawn from the qualitative analyses (*Chapters 2 & 3*), and ongoing discussions with women living with HIV, informed variable selection for further quantitative analysis (*Chapter 4*). The third empirical chapter

[21] These results were mostly for cis women, as when trans women were included in the studies the sample sizes were small and results were mixed.

(*Chapter 4*) uses path analysis to investigate pathways from incarceration to ART adherence using the SHAWNA cohort data. Employing definitions from Creswell & Creswell, this dissertation builds on an explanatory sequential mixed methods design (i.e., quantitative data and analysis are used to plan or inform the qualitative phase), as well as an exploratory sequential mixed methods design (i.e., qualitative data and analysis inform are used to test a theory using quantitative data) (144). In summary, this methodological process contributes to a comprehensive body of work centering the impact and experiences of women living with HIV who experience incarceration. **Figure 1.1** below depicts the methodological process underpinning this work.

Figure 1.1 Mixed methods methodological process



1.7.4 Incarceration-Focused Positive Advisory Working Group

In mixed methods research, participatory frameworks can promote involvement from participants in a collaborative way that can help to address inequities and add a layer of depth to the research (144). This dissertation further operationalizes CBPR through development of an incarceration-focused Positive Advisory Working Group. With support from the SHAWNA team, I invited several SHAWNA participants with lived experience of incarceration (n = 5, inclusive of women

who had participated in the qualitative interviews for this dissertation) to join the working group. I sought input from the working group concerning the main themes and findings from the studies presented in this dissertation including analysis of qualitative data (*Chapter 2 & 3*) and interpretation of quantitative findings (*Chapter 4*). In preliminary discussions (March–May 2021), the incarceration-focused Positive Advisory Working Group drew on their own experiences and knowledge to give further context to the findings. To promote innovative knowledge mobilization beyond traditional avenues of academia, I secured funding through the UBC Public Scholars Initiative (June 2021) to support the incorporation of graphic storytelling as a knowledge translation tool in order to highlight and visualize findings and recommendations from this dissertation in a more accessible way. In discussions, I explored with working group members possible options for graphic storytelling, and the working group determined which method would be the most appropriate and accessible to a wide audience (i.e., community, researchers, and policy makers). The process then included working with a graphic illustration team to produce a short 2-minute animated video (script of 200 words) summarizing key findings from this dissertation. Working group participants were involved in all planning sessions and collaborated on and had final say on each step. Activities included script development, narrating voiceover, and participating in multiple rounds of feedback on each iteration of the animation. The process is described further in *Chapter 5* (Section 5.6)

Each meeting with the working group was co-facilitated by the SHAWNA Community Engagement Associates. Members of the incarceration-focused Positive Advisory Working Group were compensated for their time and expertise. In turn, participants benefited from opportunities to engage in discussion, learn about research methods, contribute to analysis, and present findings

back to the community. Through discussions of findings and innovative knowledge translation activities, this doctoral research was greatly enhanced through meaningful engagement and consultation with women with lived experience of HIV and incarceration.

1.8 Overview of Study Instruments

The three empirical chapters in this dissertation draw on (a) qualitative in-depth semi-structured interviews with a subset of SHAWNA participants (n = 19) who had experienced a recent incarceration (*Chapter 2 & 3*), supplemented by (b) in-depth semi-structured interviews with service providers (n = 6) who support women living with HIV along incarceration trajectories (*Chapter 3*), and (c) longitudinal quantitative data collected from SHAWNA baseline and bi-annual interviewer administered questionnaires (*Chapter 4*). A summary of the study instruments is presented below, with additional detailed methodological information presented in each empirical chapter.

1.8.1 Qualitative Interview Guides

Interviews with SHAWNA participants who had experienced a recent incarceration

Individual semi-structured interviews allow for the collection of in-depth, open-ended data, to explore thoughts, feelings, and beliefs about a topic, and offer opportunities to delve into often personal and sensitive issues (150). They also facilitate higher levels of privacy compared to other qualitative data collection approaches such as focus groups (151). The use of semi-structured interviews with SHAWNA participants therefore allowed for a deeper exploration into the experiences of women living with HIV along incarceration trajectories – narratives that were previously missing from the literature and overall knowledge. I developed and revised the semi-structured interview guide in collaboration with the SHAWNA Peer Research Associates and

SHAWNA qualitative principal investigator (AK), alongside input from my co-supervisor (REM) and community partners. The qualitative interview guide was accompanied by a brief questionnaire collecting personal demographics and specific information relating to incarceration (i.e., number of lifetime and recent arrests, and information regarding the most recent incarceration). During the semi-structured interview, participants answered a series of questions exploring: their most recent arrest leading to incarceration, the trajectory from arrest to incarceration, HIV disclosure, access to HIV care while incarcerated (including a focus on HIV-related stigma), and experiences post-release including challenges and facilitators accessing services, supports, and HIV care.

Interviews with key service providers who provide supports to women living with HIV along incarceration trajectories

The interviews with service providers explored the experiences of professionals who provide direct care and services to women living with HIV who experience incarceration in BC, which complemented and provided accompanying perspectives to the interviews with SHAWNA participants. Examples of these service providers include outreach workers from an HIV support organization, HIV specialist physicians and nurses who provide HIV care to women along incarceration trajectories, and peer service providers supporting women upon release. I developed and revised the interview guide based on themes derived from the qualitative analysis of interviews with SHAWNA participants and guidance from the SHAWNA qualitative PI (AK) and co-supervisor (REM), as well as input from community partners (including those involved with the care and support of women living with HIV along incarceration trajectories). The interviews explored: perspectives on the unique challenges of providing services in partnership with the

criminal justice system, supports for marginalized women leaving correctional facilities, impacts of incarceration for women living with HIV, and thoughts on the recent transfer of healthcare leadership within BC Corrections.

1.8.2 Longitudinal Cohort

The longitudinal cohort component of SHAWNA is ongoing. The main interview questionnaire elicits responses related to socio-demographics (e.g., age, gender and sexual identity, race [inclusive of Indigenous identity][22], housing history), and social/interpersonal factors (e.g., trauma, violence, substance use, peer supports, access to housing and income assistance, and experience with incarceration). Participants also complete a clinically focused interview questionnaire, with attention to overall health, pregnancy and motherhood, reproductive health access and outcomes, mental health and supports, and HIV, STI, and substance use treatment and care experiences. The process also includes HIV monitoring and STI/ HCV testing.

As previously mentioned, additional information on the specifics methods of each individual study are outlined in detail in the individual empirical chapters that follow.

1.9 Overview of the Dissertation

This dissertation contains five chapters. *Chapter 1* provides a background and overall introduction to the dissertation. This is followed by three manuscript-based chapters: *Chapter 2* draws on semi-structured qualitative interview data with women living with HIV who have a history of recent

[22] In accordance with the Canadian Institute for Health Information (CIHI) Proposed Standards for Race-Based and Indigenous Identity Data Collection and Health Reporting in Canada (302), the SHAWNA project includes Indigenous identity [i.e., First Nations, Métis, and Inuit] within race-based data collection. The limitations around this are discussed in *Chapter 5* (Section 5.4).

incarceration, to examine how HIV-related stigma shapes access to care during incarceration; *Chapter 3* further draws on the semi-structured qualitative interview data with women living with HIV alongside interviews with key service providers, to explore the experiences and challenges that can occur during the transition from correctional facilities to community; *Chapter 4* uses SHAWNA cohort data to quantitatively examine the pathways from recent incarceration to optimal ART adherence. Finally, *Chapter 5* summarizes the findings from *Chapters 2–4*, presents evidence-based recommendations for improving HIV care trajectories and overall well-being among women living with HIV who experience incarceration, and identifies promising areas for further research.

Chapter 2: "They look at you like you're contaminated": How HIV-related stigma shapes access to care for incarcerated women living with HIV in Metro Vancouver, Canada

2.1 Introduction

As outlined in *Chapter 1*, people living with HIV are disproportionately represented within carceral settings globally (49–51). Though some research indicates that correctional facilities provide an opportunity to engage people living with HIV in HIV treatment and care (152), optimal HIV treatment outcomes for people who experience incarceration remains a challenge, with arrest and detention leading to interruptions in access and adherence to ART (81). Furthermore, women living with HIV are increasingly overrepresented within correctional facilities (52,53), and incarceration is linked to gender disparities along the HIV care continuum, highlighted by sub-optimal HIV health outcomes for women compared to men (92).

In Canada, the number of women incarcerated in federal correctional facilities increased by 50% between 2005 and 2015 (3). This number continues to rise, while the proportion of individuals incarcerated in men's facilities declines (4). As previously discussed, the overrepresentation of Indigenous and Black women in Canadian correctional facilities (47,153) highlights the structural racism entrenched in the criminal justice system that is also firmly rooted in Canada's colonial history; nearly 50% of all women who are incarcerated in Canada are Indigenous (41). Furthermore, although generally women living with HIV are overrepresented in correctional facilities across Canada (3), in federal correctional facilities 11.7% of Indigenous women who are

incarcerated are living with HIV, more than twice the rate of non-Indigenous women who are incarcerated (5.5%)[23] (54).

Findings from the SHAWNA Project—of which 57% are Indigenous—reveal that 76% of all participants have experienced incarceration throughout their lifetime, with recent incarceration being a primary factor for unsuppressed HIV viral load (91). Yet, research into the specific needs and experiences of women living with HIV who experience incarceration is sparse, and there is limited understanding of the specific gendered dynamics that shape poorer HIV health outcomes.

2.1.1 HIV-related stigma as a mechanism for poor health

Goffman described stigma as "an attribute that is significantly discrediting" (154), while others have since conceptualized stigma "as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a context in which power is exercised" (155). HIV-related stigma is a social process that is instrumental in the production and reproduction of structural inequities (126), and operates at the individual, institutional, and structural level (155). HIV-related stigma constitutes a key barrier to the access and use of services, thereby contributing to poor physical and mental health among people living with HIV (129). Similarly, HIV-related stigma can compromise the ability of people living with HIV to successfully adhere to ART (e.g., through concealment of HIV status and medications), resulting in non-adherence and further compromising access to social supports designed for improving health (156). For marginalized women who already experience stigma and discrimination within the criminal justice system (157), HIV-related

[23] This is the most up-to-date data from the Canadian correctional system, and is reflective of federal institutions (i.e., longer sentences) rather than provincial correctional facilities. It is estimated that there are higher rates of HIV within provincial settings.

stigma becomes an additional barrier for women who navigate intersecting levels of oppression including racism, sexism, classism, and transphobia (66,158). For Indigenous women living with HIV, access to care is often complicated by experiences of anti-Indigenous racism and discrimination (159,160) and a lack of culturally safe care and practice[24]. In Canada, where HIV non-disclosure is criminalized, HIV-related stigma is structurally perpetuated, putting women at heightened risk of violence and complicating access to HIV testing and care (64). These negative impacts are also disproportionately experienced by Indigenous women (161).

Research mainly from the US has elucidated ways in which stigma can manifest within correctional facilities and impact adherence and retention in care, including through a lack of privacy (84) and threats of violence (162). Intensified HIV-related stigma within correctional facilities (83) can lead to internalized stigma following release from correctional facilities, contributing to barriers to accessing care (163) and increased levels of depression and anxiety (164). Despite growing attention to the HIV outcomes among people who experience incarceration—including gender disparities for women living with HIV—gaps in the current literature remain. The majority of research exploring the experiences and impact of incarceration for women living with HIV comes from the US, leaving a paucity of research from other regions, including Canada. This dearth of research is particularly salient in the context of increasing incarceration rates among women living with HIV both in Canada and globally. To attempt to fill

[24] As summarized by the First Nations Health Authority, cultural safety strives to provide a safe environment—free of racism and discrimination—for Indigenous people to access healthcare. It requires healthcare professionals to recognize Indigenous history and the impact of colonization and trauma in shaping health and wellness and health care experiences; understand culture as complex and dynamic and recognize what health and wellness means to Indigenous people; employ self-reflection and address power imbalances within the healthcare system; and emphasize experiences of safety for Indigenous people during interactions with health care (180).

in some of these gaps in the literature, the current study investigates how HIV-related stigma within correctional facilities shapes access to HIV care among incarcerated women living with HIV.

2.2 Methods

2.2.1 Research design

This qualitative study is situated within the SHAWNA Project—a longitudinal community-based research cohort of over 350 self-identified cis and trans women living with HIV in Metro Vancouver—as described previously in *Chapter 1* (Section 1.7 and 1.8). To further explore the experiences and perspectives of recently incarcerated SHAWNA participants, members of the SHAWNA team conducted semi-structured interviews among a subset of participants who had indicated a recent incarceration. Eligibility to participate was determined by an affirmative response ("*Yes*") to the following question within the baseline or 6-month follow-up questionnaire: "In the last 6 months, have you been in detention, prison or jail overnight or longer for any reason at all?" All participants who indicated recent incarceration on a previous questionnaire within the last 5 years (at the time of the study recruitment in 2017) were contacted and invited to take part in this qualitative study. Of the 30 SHAWNA participants who were identified as eligible to participate, 22 participants were booked in for an in-depth interview. Among the remaining 8 eligible participants, 2 had moved away, 5 could not be reached (including due to missing contact information), and 1 had passed away. Three participants missed their appointment (despite multiple attempts at re-booked appointments), and as such 19 participants took part in semi-structured interviews.

2.2.2 Data collection

Three experienced interviewers, including one Indigenous woman living with HIV with a history of incarceration, conducted 19 semi-structured interviews between May 2017 and February 2018. Interviews took place at one of two research offices in Vancouver. The semi-structured interview guide was developed, revised, and piloted in collaboration with the SHAWNA Peer Research Associates and community partners. Participant demographics were collected using a brief survey that included questions assessing personal demographics and specifics relating to incarceration (e.g., number of lifetime and recent arrests, and information regarding the most recent incarceration). Participants completed a semi-structured interview exploring experiences navigating incarceration trajectories, including a focus on access to HIV care, services, and supports during and following incarceration. For trans participants, additional questions throughout the interview guide were used to probe for unique experiences that may differ from those of cis participants. All participants provided informed written consent and were remunerated with a CAD $30 honorarium for their time and expertise. Interviews were audio recorded and lasted between 35 and 120 minutes. The study holds approval by the Providence Healthcare/University of British Columbia Research Ethics Board.

2.2.3 Data analysis

Audio recordings were transcribed verbatim, de-identified, and checked for accuracy. Data was coded in an iterative process (165) using deductive and inductive approaches that involved the use of a priori (e.g., experiences of HIV-related stigma during incarceration, concerns around confidentiality of HIV status) and emergent categories (e.g., institutional processes as a vehicle for HIV-related stigma). A coding framework was developed through discussions and input from the

SHAWNA Peer Research Associates and comprising categories derived from the interview guides that were then expanded to include emic categories emerging from the interview data. Drawing on socio-ecological frameworks (126) with intent to capture experiences surrounding HIV-related stigma and discrimination, areas of focus for this analysis included HIV stigma experienced or witnessed within correctional facilities, including interactions with correctional officers and healthcare staff, experiences with disclosure of HIV status, and issues surrounding medical privacy and confidentiality. Nvivo 12 software was used for coding, and pseudonyms were applied to protect the confidentiality of participants.

2.3 Results

Table 2.1 depicts demographic characteristics of the 19 study participants, including 17 cis women and 2 participants who identified as Two-Spirt at the time of the qualitative interview. Both Two-Spirit participants only shared experiences of short-term stays at local city jails and did not speak to HIV-related stigma in relation to their HIV care while incarcerated. Therefore, all responses presented in this analysis are from cis women living with HIV who experienced longer episodes of incarceration (i.e., at the provincial/federal level). At the time of the interview, all participants had been incarcerated at least once within the past 5 years, and 6 participants indicated a recent incarceration within the last 6 months. The majority of recent incarcerations were served within provincial correctional facilities (remand or sentences of up to 2 years less a day). Most participants spoke to experiences of incarceration between 2011 and 2017 within Metro Vancouver[25], with the exception of a few participants who also discussed experiences of incarceration in Canadian

[25] The majority of participants described recent incarcerations within Alouette Correctional Centre for Women (ACCW), the provincial correctional centre dedicated to women in the province of BC.

provinces outside of BC. For participants in the study, and women living with HIV more generally, incarceration is a marker of structural vulnerabilities and experiences of marginalization. Indigenous women represented over half of participants (63%, n = 12), which is reflective of the intersecting inequities faced by Indigenous women living with HIV, including blatant overcriminalization and -incarceration (54). Given the overrepresentation of Indigenous women in this study, it must be emphasized that Indigenous participants' experiences of criminalization, incarceration, HIV, and healthcare access are firmly rooted in the ongoing effects of colonization and oppression of Indigenous peoples and cultures, including severe social and health inequities and barriers to care faced by Indigenous women in Canada (160,166).

Table 2.1 Demographic characteristics of recently incarcerated women living with HIV

Total number	**19 (100%)**
Median age (range)	45.5 (36–55)
Gender (n, % of total)	
Cisgender woman	17 (89.5%)
Two-Spirit	2 (10.5)
Race (n, % total)	
Indigenous	12 (63.2%)
White	7 (36.8%)
Average age at first incarceration (range)	21.7 (13–45)
Number of arrests since 2011 (n, % of total)	
1–5 arrests	13 (68.4)
6–10 arrests	6 (31.6)
Most recent incarceration	
Held at city cells only	5 (26%)
Served time in provincial correctional facility	14 (74%)
Average time served in months (n = 14) (range)	3.25 (.25–24)
Daily criminalized substance use at the time of the interview	11 (57.9)

Results from this analysis highlight complex ways in which HIV-related stigma impacts experiences of incarceration for women living with HIV, including with regards to continued access to HIV care.

2.3.1 HIV-related stigma within correctional facilities

A prominent theme in participants' accounts was an acute awareness of HIV-related stigma within correctional facilities. As described by Beth, "*There's a certain amount of fucking [HIV-related] discrimination that goes on in the prison system . . . the way people treat you. . . you're treated like an outcast. Not only from the staff, but from the other inmates too*" (Beth, white). Participants described both direct and anticipated experiences of stigma based on their HIV status, including experiences of discrimination, labelling, status loss, and separation. Anna, an Indigenous woman who had in total spent 6 years of her life incarcerated, recounted that some women refused to share common spaces such as showers with a woman known to be living with HIV. They would say: "*Why can't she take a shower somewhere else? Why does she have to use this shower?*", while others refused to clean the showers after a woman living with HIV had used them: "*I don't wanna clean that because **she** was in there*". As outlined by Hatzenbuehler et al. (155), participants were being labeled and separated out, and expressed feelings of increased isolation, shame, and embarrassment related to their HIV status. Char described that while spending time outdoors, other women did not want to associate with her: "*They'd be like—she's got HIV don't go near her*" (Char, Indigenous). Experiences of discrimination led participants to be hyper-vigilant in keeping their HIV status private. When Marie was asked by an interviewer if she had any advice for women living with HIV facing incarceration she responded: "*Keep your mouth shut. Don't tell . . . it's better not to . . . you can get picked on. A lot of bullies everywhere you go*" (Marie, white).

One reason for the high degree of HIV-related stigma within correctional facilities might be misinformation about HIV transmission pathways and treatment advances in the context of limited autonomy and control among people who are incarcerated. Marie, who first experienced incarceration at age 21, described: "*They need people to come in and talk . . . [to increase] awareness . . . They think—'oh, like, you have that? You're AIDS and you're gonna die' . . . they look at you like you're contaminated, and they don't know . . . [that] the medication is so powerful*". This response illustrates the continued disconnect between the perceptions of HIV as a "death sentence", and awareness about current HIV treatments and associated increases in life expectancy for people living with HIV (167,168). To reduce HIV-related stigma, participants called for increased educational efforts within correctional facilities both for people who are incarcerated and for facility staff. As noted by Rita: "*It's important to get [information] out there so that people know you don't have to, die anymore, you know? And you don't have to be treated like crap because of [HIV]*" (Rita, white).

2.3.2 Accessing HIV Care in correctional facilities linked to stigma and forced HIV disclosure

With the presence of HIV-related stigma within correctional facilities, many participants shared significant concerns regarding medical privacy during incarceration. Participants described how accessing HIV care while incarcerated can compromise medical privacy and confidentiality of HIV status. Participants referenced a lack of discretion regarding access to treatment, describing medication lines for dispensing ART as a vehicle for stigma: "*I would go up with like three other women to get meds. And it's so open. It's not very discreet*" (Marie, white). Beth, who had spent over 4 years incarcerated since age 14, explained: "*[The women] pretty much know. There's*

always somebody standing right behind you. You have to line up and get [your medication] right? . . . People are nosy" (Beth, white).

The lack of privacy accessing daily medications often led to unwanted inquiries from fellow incarcerated women, fostering an environment where women living with HIV had to navigate disclosing personal medical information. As noted by Susan when asked by her roommate what medications she was on: "*I [just] told her I had health problems, anxiety, cause it's one of [the pills I'm on]*" (Susan, Indigenous). Indigenous participants in particular emphasized feelings of shame and stigmatization when recounting how they navigated HIV disclosure. Char, who was first incarcerated at age 13 and had spent a total of 6 years of her life in correctional facilities, echoed Susan's strategy of deflecting questions about her medications:

> *They [other women] asked, but I never told anybody [that I had HIV], I just said anxiety. They're like 'well how come you got two [pills]?', and I was like anxiety and uh, a flu? . . . I never told anybody I had HIV . . . Just made something up . . . I was still fresh with my HIV [diagnosis]. And I was still embarrassed.* (Char, Indigenous)

Josephine, who also experienced her first incarceration at the age of 13, described a situation that occurred in adult custody involving her roommate where she disclosed her HIV status and was met with discrimination and feelings of hurt:

> *We went [to the healthcare unit] at the same time, [because] we [share] the same room, right? She asked me questions about why I was in so long, and I told her [about my HIV]. [Interviewer: And how did she react?] I dunno kind of like—'Oh, gross' . . . so it was*

> *like, I don't care . . . Told her to get another room . . . if you can't handle it give me the room. It's not like I touch your fucking shit.* (Josephine, Indigenous)

Medication lines were not the only healthcare process at the institutional level that compromised medical privacy. Rita spoke to an experience in 2013 when she was taken on medical escort from the facility to see her HIV care provider in community[26]. She recounted: "*I'm working at horticulture, and all of a sudden my name gets called to [the healthcare unit], and [then] I'm getting [escorted from the prison] in handcuffs and shackles. 'Well where's she going?', 'oh medical escort'. It doesn't take a rocket scientist to figure that out, right?*" (Rita, white). After returning to her unit following her appointment, Rita described that women asked "*oh where'd you go?*", forcing her to navigate disclosure of her HIV status to her peers. Rita further described that during the clinic visit the doctor requested that Rita's shackles be removed. Citing security reasons, the correctional officer refused to leave the room or remove her shackles. Rita expressed anger that her privacy and rights were compromised in that way: "*I was like, this is ridiculous . . . there's no reason for a guard to have to sit in there for my personal appointment*".

These participant responses not only illustrate how specific institutional policies can be directly linked to experiences of stigma at the interpersonal level (130)—placing women living with HIV at risk for further discrimination—but also how these institutional processes infringe on women's medical privacy.

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[26] Within recent years, HIV physicians and nurses from Oak Tree Clinic at BC Women's Hospital have started doing HIV outreach to the women's provincial correctional facility so that women do not have to go on medical escort to access HIV care. Medical escorts can be humiliating and distressing, but they also infringe on medical privacy, as the correctional officers providing escorts and are privy to certain information (i.e., if someone is being escorted to an HIV clinic).

2.3.3 Concerns about confidentiality of HIV status

Participants' responses emphasized that the institutional processes of accessing HIV care while incarcerated, which left little room for privacy, were also linked to concerns and uncertainty about what medical information correctional officers had access to and the degree of confidentiality of this information:

> *Well I'm sure [your HIV status] goes on your file . . . right? . . . and [the officers] have access to your files . . . if you're on any sort of medications, you get woken up half an hour earlier than everybody else so that you can go down to the meds room. So, you're either getting methadone, or you're getting your antivirals. And you get given a slip of paper and they're two different colours. So, I mean . . . everybody knows what's going on.* (Beth, white)

Beth had served a total of 4 years in correctional facilities. During this time, she was never provided clarification as to the bounds of her medical privacy while incarcerated in a way that addressed her uncertainties. There was a general perception among participants that correctional officers had access to healthcare files: "*I'm sure it's mandatory that [the guards know about your HIV status] . . . I think?*" (Diane, Indigenous). As a result, participants expressed concerns about correctional officers disclosing women's HIV status without their consent. Anna described how she had witnessed correctional officers openly discussing women's medical histories during meal times:

> *Everybody looks at everybody's trays . . . And then I noticed that some people get an extra bagged lunch [. . .] Cause maybe that person's on a high protein diet . . . the girls*

> *would talk to the guards . . . and then the guards say—'oh yeah, so and so has this [health concern], that's why she's getting that'.* (Anna, Indigenous)

The uneven power dynamics and feelings of compromised privacy were not limited to interactions with correctional staff and fellow incarcerated women. Participants also expressed uncertainty about confidentiality when interacting with healthcare staff: "*I had to tell the nurse [about my HIV status] . . . I was really embarrassed. I felt my whole body go hot . . . I didn't know if it was a confidential thing*" (Char, Indigenous). Another Indigenous woman, Marlene, expressed: "*I guess the only thing I was concerned about [when disclosing my HIV status to healthcare] was just the confidentiality*", further explaining that she wished that the privacy of incarcerated women was emphasized more in correctional facilities. Similarly, another woman, Noelle, stated that she didn't trust the correctional healthcare nurses because "*you feel they're not with you, they're against you. They're keeping you there*", highlighting the complicated power dynamics and inherent contradictions of providing care within an institution focused on punishment.

Participants' responses emphasized that women were frequently deprived of adequate information about medical privacy within correctional facilities, revealing another institutional vehicle of HIV-related stigma linked to significant fears and, ultimately for some, barriers to accessing HIV care.

2.3.4 Choosing not to disclose HIV status during healthcare intake

Although disclosure of HIV status to healthcare staff was a necessary condition for access to ART and continued HIV care during incarceration[27], some participants described hesitancy around

[27] Although disclosure of HIV status and access to ART may differ within various provincial and federal institutions in Canada, participants in the study who were incarcerated at the provincial level in BC described being asked about their HIV status through a questionnaire administered by an intake nurse upon arrival at the facility. Prior to October

disclosure due to feelings of shame, fear of stigma, or the stressful context in which they had to disclose their status during a time of significant vulnerability at healthcare intake. Three participants chose not to disclose their HIV status to healthcare staff, foregoing access to HIV treatment and care during incarceration. Participants' accounts highlight that the way HIV disclosure was organized at intake gave rise to conflicting and intense emotions when deciding whether to disclose their status. Beth discussed how she associated her HIV status with the traumatic memories of HIV transmission and diagnosis, and how this trauma continued to influence her ability to disclose her HIV status in a way that felt safe. She chose not to disclose her status to the nurse upon arrival at the correctional facility, describing:

> *When you come in, they have a questionnaire . . . And it's up to you whether or not you decide to answer it honestly. [Interviewer: And what was your thinking there?] . . . Well, I dunno . . . I still have major issues talking about my HIV . . . it was a rape kit that I got my—I was raped . . . that's how I contracted it . . . So it's still something that's really hard . . . I don't talk about it.* (Beth, white)

Anna first found out she was living with HIV while incarcerated in Alberta. Tested in the community before her arrest, social workers visited her during her incarceration to inform her of her HIV diagnosis. The social workers did not provide her with any information or support concerning her HIV status, and instead left her to digest the news on her own. When asked if she sought out correctional healthcare staff to disclose her new diagnosis, she responded: "*I didn't*

2017, BC correctional healthcare was contracted out by correctional services to a private provider, and healthcare staff relied on individuals to disclose their HIV status upon intake, unless they had disclosed their HIV-positive status during a previous incarceration to health care staff or had requested an HIV test during incarceration.

want to . . . Cause there's a lot of girls, and I know a lot of friends in there . . . I was ashamed, and I didn't want anybody to know. Cause if I start getting different meds, if I start getting treated differently, everybody will know" (Anna, Indigenous).

These experiences further elucidate how institutional processes within correctional facilities that do not provide sufficient privacy constitute barriers to accessing care, while illustrating how intersecting past traumas can shape HIV disclosure to correctional healthcare staff. These findings underscore the important role that healthcare staff have in facilitating access to HIV treatment and care, especially during intake, and the need for trauma-informed care and practice[28] for women in correctional facilities (169).

2.4 Discussion

Previous works have conceptualized stigma as a social process operating at the structural, institutional, and individual level to produce and reproduce social and health inequities (126,130). The findings from this study elucidate important institutional mechanisms through which HIV-related stigma in correctional facilities is upheld, and how this shapes interpersonal experiences of discrimination among incarcerated women living with HIV and contributes to barriers to accessing HIV care and treatment. This research also adds to a small but growing body of literature that underscores the impact of HIV-related stigma and lack of medical privacy within correctional facilities in shaping optimal HIV care and adherence to ART (84,85).

[28] A trauma-informed care framework aims to understand the impact of trauma, recognize signs and symptoms, and respond by integrating knowledge around trauma into policies and practice (317).

The high proportion of Indigenous women living with HIV in the criminal justice system reflects the over criminalization of Indigenous women living with HIV (54) rooted in the ongoing effects of colonialism and oppression of Indigenous peoples in Canada (45). Therefore, as outlined above, the experiences of Indigenous participants are situated within the context of colonial oppression. Colonialism and attempts by the state to destroy Indigenous peoples and cultures, including through residential schools and displacement from the land (45), are inseparable from the overcriminalization of Indigenous peoples (170) and the systemic racism and lack of cultural competency perpetuated by the Canadian healthcare system (160). Given the overrepresentation of Indigenous women in this study and among incarcerated women in Canada more generally (171), these findings echo calls for culturally safe practice within correctional facilities for Indigenous women (172).

In this study, participants highlighted institutional processes, including medication dispensing lines and medical escorts, as vehicles for reproducing stigma whereby women living with HIV were forced to navigate concealment of their HIV status around others. The United Nations maintains that people who are incarcerated have the right to the same health services—free of discrimination—as individuals who are not incarcerated (173). This includes the need to counteract HIV-related stigma within correctional facilities to ensure that people living with HIV who are incarcerated have access to healthcare free of fear (174). These findings underscore previous calls for improved care for women living with HIV in Canadian correctional facilities (175,176), and highlight shortcomings in the provision of HIV care within Canadian correctional healthcare

settings, despite ongoing efforts by HIV specialist physicians and community groups aimed at increasing support for women living with HIV during incarceration[29].

Confidentiality and privacy in accessing healthcare services are fundamental human rights (177). As laid out by the Nelson Mandela rules, people who are incarcerated have the right to confidentiality when it comes to their medical information and when accessing healthcare within correctional facilities (107). For people living with HIV, sub-optimal protection of confidentiality and privacy can be a significant barrier to HIV care (178) linked to increased experiences of HIV-related violence and stigma among women living with HIV (179). These findings highlight how fears around confidentiality and privacy of HIV status in carceral settings can constitute a barrier to care among women living with HIV. Participants' uncertainty around the confidentiality of their HIV status while incarcerated underscores the need for healthcare staff to clearly and accessibly communicate the bounds of medical privacy, including providing women living with HIV with information concerning who is privy to their medical records during their incarceration. The findings from this study show how women living with HIV have to weigh the risks of HIV disclosure within correctional facilities against access to HIV treatment and care while incarcerated. Correctional authorities and healthcare officials must ensure that healthcare spaces within correctional facilities are adapted to support HIV disclosure to healthcare staff and ease access to treatment without fear of being outed or experiencing discrimination or isolation. This includes an emphasis on incorporating trauma-informed care and practice in correctional facilities (169) to facilitate disclosure. Importantly, employing a trauma-informed care framework is a key

[29] For example, as offered by BC Women's Health Centre to women living with HIV who are incarcerated at the women's provincial facility to ensure continuity of care.

component of creating culturally safe healthcare spaces (180). Overall, these shifts will require increased education and training within correctional facilities, along with collaborative efforts between healthcare and correctional staff, with input from women living with HIV, to adapt institutional processes.

2.4.1 Limitations

The findings of this study are not generalizable to geographic regions outside of Canada, and mainly speak to the experiences of women living with HIV who had been incarcerated in provincial rather than federal facilities (longer sentences). Given that most participants had been incarcerated multiple times throughout their lives at *various* facilities, participants often recounted incarceration experiences within different facilities and provinces. The two Two-Spirit participants in the study had been held overnight in city jail cells, and did not speak to experiences in gender segregated provincial/federal correctional facilities. Research exploring the unique experiences of trans, Two-Spirit, and gender diverse individuals who have experienced incarceration is critically needed. The sample drew from the SHAWNA cohort, and reports of recent incarceration were limited to white and Indigenous participants. As such, further research is necessary that centres the experiences of Black and other racialized women living with HIV. The interviews in this study addressed participants' experiences along incarceration trajectories with a focus on HIV care, and while interviews inquired about spiritual and cultural well-being during and after incarceration, no questions explicitly asked about experiences of racism—although many Indigenous participants referenced mistreatment from police officers as well as guards within city cells during short-term incarceration. Indigenous-led research using Indigenous epistemologies and/or two-eyed seeing (181) approaches to centre the experiences of Indigenous women living with HIV within the

criminal justice system is urgently needed. Despite these limitations, this research fills an important gap in the literature—especially in a Canadian setting—and contributes to implications for policy.

2.4.2 Implications for Correctional Facilities

As outlined in *Chapter 1*, the delivery of BC's correctional healthcare underwent a transfer from contracted healthcare under the Ministry of Public Safety and Solicitor General to provision under BC's Ministry of Health through the PHSA in October 2017, which occurred after data collection for this study was completed. This shift in healthcare leadership provides a timely opportunity for the findings of this study to inform improvements to healthcare services that impact people who experience incarceration in BC. Moreover, given the limited attention to the specific health needs of women who experience incarceration in Canada (176), these findings have important implications for policy and programming within correctional facilities in Canada and beyond. Educational programs that counteract misinformation regarding HIV transmission and treatment are critical to the creation of safer spaces for people living with HIV (163). As such, programmatic change needs to focus on sustained educational efforts to address HIV-related stigma in correctional facilities (for staff and people who experience incarceration), and should centre people with lived experience of HIV (i.e., peers) whenever possible. Peer-led education and supports have shown to be effective in carceral settings (182,183), as well as in reducing internalized stigma (184). The findings from this study highlight that policy change needs to focus on enhancing medical privacy and rights to confidentiality, including an emphasis on clear and ongoing communication for people who are incarcerated regarding the confidentiality of their health information within carceral settings. This includes the review of institutional processes that

undermine medical privacy, such as medication dispensing procedures and medical escorts. Amid increasingly amplified discourses of prison abolition and the role of the Canadian criminal justice system in perpetuating racial and social inequities (185,186), refocusing the goals and purpose of the criminal justice system away from punishment, retribution, and incapacitation towards rehabilitation and healing (187) will form an important backdrop in moving toward increased emphasis of trauma-informed culturally safe spaces for accessing HIV care.

2.4.3 Conclusion

This study highlights how institutional processes can perpetuate HIV-related stigma among women who are incarcerated and how uncertainty about confidentiality of HIV status and inadequate medical privacy can complicate access to HIV care. These findings point to an urgent need to protect the right to privacy and confidential care for women living with HIV who experience incarceration, and emphasize the importance of continued efforts to counteract HIV-related stigma at the institutional and interpersonal level in order to facilitate optimal access to HIV treatment and care during incarceration. Strategies to strengthen and incorporate trauma-informed and culturally safe care and practice and supports within carceral settings remain critical.

Chapter 3: "They give you a bus ticket and they kick you loose": A qualitative analysis of post-release experiences among recently incarcerated women living with HIV in Metro Vancouver, Canada

3.1 Introduction

As highlighted in *Chapter 1*, women are mainly incarcerated for non-violent, survival-based crimes (18,19), and for many women incarceration is a marker of marginalization (14–16). Both globally and in Canada, women living with HIV are increasingly overrepresented in correctional facilities relative to the general population (3,188), and HIV prevalence among incarcerated women is higher compared to incarcerated men (54,189). As outlined in previous chapters, racialized women, including Indigenous women, remain vastly overrepresented within carceral settings in many high-income countries with a history of settler colonialism (4,5,190,191). In Canada, Indigenous women make up nearly 50% of all women who are incarcerated (41,153), despite accounting for only 4% of adult women in Canada (44). As previously discussed, this overrepresentation cannot be considered outside of the context of the historical and ongoing harms of colonial violence (45) and the structural and historical racism entrenched in the criminal justice system. Within Canadian correctional facilities, Indigenous women also experience HIV prevalence at a rate more than twice that of non-Indigenous women (11.7% vs. 5.5%)[30] (54). Overall, growing numbers of Indigenous women in Canadian correctional facilities point to a continued need to act on the justice-related calls to action and recommendations to redress the

[30] This is the most up-to-date data from the Canadian correctional system, and is reflective of federal institutions (i.e., longer sentences) rather than provincial correctional facilities. It is estimated that there are higher rates of HIV within provincial settings.

over-incarceration of Indigenous women as outlined in various reports including the Truth and Reconciliation Commission (TRC) of Canada (192), recommendations from the report of the Standing Committee on the Status of Women: *A Call to Action: Reconciliation with Indigenous women in the federal justice and correctional systems* (193), and the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (42).

Referenced in previous chapters, a systematic review that I led examined the impacts of incarceration on HIV health outcomes globally (92). Although the majority of studies were from the US, results indicated significant gender differences in access to and retention in HIV care post-release from incarceration (92), whereby women were less likely to be retained in HIV care and experienced sub-optimal HIV health outcomes—including barriers to ART adherence and maintaining viral suppression—compared to men (92). Research from high-income settings points to a multitude of challenges post-release from incarceration faced by women (194,195). In the US, despite men accounting for a significantly greater number of individuals released from correctional facilities each year, women incur unique gendered challenges during the post-release period. Women involved in the criminal justice system experience higher rates of co-occurring mental health and substance use conditions compared to men, and they are often also the sole caregivers to children (196). Although not specific to women living with HIV, a Canadian study demonstrated that upon release from correctional facilities, women face significant barriers and limited supports regarding access to healthcare, housing, addiction treatment, and employment opportunities (197). Studies centering cis and trans women living with HIV who experience incarceration across Canada have highlighted how experiences of incarceration intersect with various structural determinants and vulnerabilities, including homelessness and unstable housing, criminalized

substance use (36,56), and gender-based violence (36). Among people living with HIV involved in the criminal justice system, research from the US shows that experiencing homelessness is strongly linked to recidivism (68). Compared to men, women living with HIV are significantly more likely to experience homelessness following release from incarceration (67), and report higher needs for social and structural supports (95). Despite research consistently documenting these barriers, there remain limited gender-specific supports and programming for women leaving correctional facilities in North America (196,198,199), as well as limited knowledge of the specific needs of women living with HIV during the transition from correctional facilities to community. This is linked to a lack of innovative interventions designed to support marginalized women upon release.

3.1.1 Structural and Symbolic Violence as a Conceptual Framework

As outlined in *Chapter 1*, for this analysis I drew on concepts of structural and symbolic violence, which have previously been useful in framing the harms and poor health experienced by marginalized populations (64,134,200,201), including among people entrenched in the criminal justice system (135,202). Structural violence, which is distinct from personal or direct violence, highlights how unequal power shapes inequities (133), and refers to how arrangements embedded in social structures or institutions (e.g., laws, policing practices, poverty, racism) prevent groups of people from meeting their basic needs, ultimately causing harm (134). Structural violence constitutes a significant determinant of health, and has tangible impacts on health outcomes for marginalized populations, including people living with HIV (131). Furthermore, since structural violence is less blatant and obvious than physical violence, it is often rendered almost invisible (136). Symbolic violence is what "trails in the wake" of structural violence, making those who

experience harms feel shame for their apparent "weakness" in the face of structural barriers (136). Pierre Bourdieu describes symbolic violence as "subtle", whereby we often fail to recognize its very existence, let alone the way it sits at the root of much violence and suffering (132). In more recent iterations, Christian and Dowler have used the term "slow violence" to describe how violence can unfold gradually to the point where the "impacts of violence often come to be understood as personal and private matters, in which victims are left responsible for managing the harm" (203). In other words, since harms can occur incrementally over time, blame is internalized on an individual level, instead of being allocated towards the institutions and structural systems that maintain oppression. Drawing on this more expansive definition of violence provides a useful framework for analyzing the harms that are perpetuated over time through involvement in the criminal justice system.

This research is situated in the context of the limited attention paid to the perspectives of marginalized women who experience incarceration in Canada, and the challenges women face post-release from correctional facilities. As such, this study explores experiences of transition from correctional facilities to the community among women living with HIV and through conversations with service providers who provide care and support to this population along incarceration trajectories.

3.2 Methods

3.2.1 Research Design

This qualitative study is situated within the SHAWNA Project - a longitudinal community-based research cohort of over 350 self-identified cis and trans women living with HIV in Metro Vancouver – as described previously in *Chapter 1* (Section 1.7 and 1.8). This study draws data

from the same 19 semi-structured interviews as described in *Chapter 2*. To explore the lived experiences of recently incarcerated SHAWNA participants, members of the SHAWNA team conducted semi-structured interviews with a subset of participants who had indicated a recent incarceration. Eligibility to participate in the qualitative interview was determined by an affirmative response ("*Yes*"*)* to the following question within the baseline or 6-month follow-up cohort questionnaire: "In the last 6 months, have you been in detention, prison or jail overnight or longer for any reason at all?". All participants who indicated a recent (last 6 months) incarceration during any baseline or follow-up questionnaire within the last 5 years (at the time of study recruitment in 2017) were contacted and invited to take part in this qualitative study.

To complement interviews with SHAWNA participants, a SHAWNA peer researcher and myself conducted interviews with key service providers who work directly with women living with HIV experiencing incarceration in BC. With input from SHAWNA Project partners and facilitated through long-standing community relationships with HIV service organizations and healthcare providers, service providers were purposely sampled to include those who work with women along incarceration trajectories (e.g., from community-based and HIV support organizations and women-centered HIV clinics). Snowball sampling served to add additional service providers. Participants for key interviews were contacted via email or by phone.

3.2.2 Data Collection

Between May 2017 and February 2018, three experienced interviewers, including one Indigenous woman living with HIV with a history of incarceration, conducted semi-structured interviews with 19 SHAWNA participants who had been recently incarcerated. The semi-structured interview guides was developed, revised, and piloted in collaboration with the SHAWNA Peer Research

Associates and community partners. Participant demographics were collected using a brief survey that included questions assessing personal demographics and specifics relating to incarceration (e.g., number of lifetime and recent arrests, and information regarding the most recent incarceration). Participants completed a semi-structured interview exploring experiences navigating incarceration trajectories, including a focus on access to HIV care, services, and supports during and following incarceration. Interviews took place at one of two research office locations within Vancouver. All participants provided informed written consent. Interviews were audio recorded and lasted between 35 and 120 minutes, and participants were remunerated with a CAD $30 honorarium for their time and expertise.

Six service providers took part in the additional interviews. Participants included HIV prison outreach workers, HIV physicians and nurses from women-specific HIV clinical care settings, and support workers from HIV community service organizations and peer-led organizations who support individuals upon release from correctional facilities in BC. The interviews explored experiences providing care and supports to women living with HIV, including but not limited to logistics and unique challenges navigating care within the criminal justice system, barriers and facilitators surrounding transitional supports post-release from incarceration, and the overall impacts of incarceration experienced by this population. The majority of the service provider interviews took place between February–May 2021. Service provider interviews were conducted over the phone or via Zoom to facilitate physical distancing during the COVID-19 pandemic. Service providers at peer-led organizations who identified as people with lived experience of incarceration (n = 2) were compensated $30 for their time and expertise. The study holds approval by the Providence Healthcare/University of British of Columbia Research Ethics Board.

3.2.3 Data Analysis

All audio recordings were transcribed verbatim, de-identified, and checked for accuracy. The transcripts of the 19 semi-structured interviews with SHAWNA participants were coded in an iterative process using deductive and inductive approaches. This involved the use of a priori and emergent categories (165) that were further refined based on multiple rounds of revisiting the data and drawing on constant comparative methods (204). The coding framework was developed through discussions with and input from the SHAWNA Peer Research Associates. The framework comprised categories derived from the interview guides (e.g., pre-release concerns, post-release HIV care, post-release housing, etc.), and then expanded to include emic categories emerging from the interview data (e.g., feelings of anxiety pre-release, urges to use criminalized substances immediately after release, relationships with HIV-specific support workers post-release). To advance beyond thematic description, I drew on concepts of structural and symbolic violence (132,133) to better highlight how structural barriers shape and perpetuate incarceration trajectories. The transcripts of the interviews with the 6 service providers were coded using the same two-step process, with a deductive approach drawing on themes and data from the 19 interviews with SHAWNA participants, and an inductive approach based on additional categories that emerged from the interview data (165). Nvivo 12 software was used for coding, and pseudonyms were applied to protect the confidentiality of participants.

Drawing on CBPR, I convened a small incarcerated-focused Positive Advisory Working Group (n = 5) of women living with HIV with lived experience of incarceration (including women who had participated in the interviews for this study) to discuss and conceptualize the main themes and findings. In discussions, themes and findings from the analysis were discussed amongst the

working group in relation to their own experiences and knowledge. These discussions (n = 2) took place over Zoom (April–May 2021) and were co-facilitated by the SHAWNA Community Engagement Associates.

3.3 Results

Table 3.1 once again depicts the demographic characteristics of the 19 participants. At the time of the interview, the majority (n = 17) identified as cis women and two Indigenous participants identified as Two-Spirit. Both Two-Spirit participants only shared experiences of short-term stays at local city jails (i.e., commonly overnight or weekend stays); therefore, the experiences presented in this analysis are from cis women who experienced longer episodes of incarceration (most commonly at provincial-level correctional facilities). Most participants spoke to experiences of incarceration between 2011 and 2017 within Metro Vancouver, with the exception of a few participants who also discussed experiences of incarceration in Canadian provinces outside of BC. Experiences of sustained cycles of criminalization were common among participants; over a 5-year period, 6 participants had been arrested between 6 and 10 times, while the remaining 13 participants reported being arrested up to 5 times in the same period. Twelve of the 19 participants identified as Indigenous, reflective of the disproportionate criminalization and incarceration of Indigenous peoples in Canada (54). The experiences of Indigenous women presented in this study must be considered within the context of colonial oppression and attempts by the state to destroy Indigenous peoples and culture (45), which is inseparable from the over criminalization of Indigenous peoples across Canada (42,170).

Table 3.1. Demographic characteristics of recently incarcerated women living with HIV

Total number	**19 (100%)**
Median age (range)	45.5 (36–55)
Gender (n, % of total)	
Cisgender woman	17 (89.5%)
Two-Spirit	2 (10.5%)
Race (n, % total)	
Indigenous	12 (63.2%)
White	7 (36.8%)
Average age at first incarceration (range)	21.7 (13–45)
Number of arrests since 2011 (n, % of total)	
1–5 arrests	13 (68.4%)
6–10 arrests	6 (31.6%)
Most recent incarceration	
Held at city cells only	5 (26%)
Served time in a provincial correctional facility	14 (74%)
Average time served in months (n = 14) (range)	3.25 (.25–24)
Daily criminalized substance use at the time of the interview	11 (57.9%)

The service providers were individuals who had current or former roles working with women, and women living with HIV specifically, during and post-release from incarceration in BC. Five women and one man participated.

3.3.1 Pre-Release

3.3.1.1 Planning, supports, and pre-release anxieties

Most participants reported that they received little to no pre-release planning (i.e., support with needs at release including housing, addiction treatment programs, transportation, access to identification, employment opportunities, etc.) from correction staff or outside support organizations. Service providers also noted that this was not uncommon, citing limited corrections-based resources allocated for ensuring adequate transitional support. Additionally, release

planning was complicated by short sentences in provincial correctional facilities (which limit incarceration to a maximum of 2 years less a day, although sentences often last just a few months or weeks), as well as difficulties predicting release dates:

> *All of a sudden, the lawyer would advocate to get somebody out earlier—I often found the women didn't know themselves when they were getting out for sure— it just made it so much more complicated to actually come up with a plan.* (Service provider #4)

In addition to a lack of pre-release planning, many participants described strong feelings of anxiety and fear in the time leading up to release. Lucy detailed how being released into the community with no supports after months of being institutionalized made her feel overwhelmed and brought up suicidal ideation: "*When they let me out after being inside for almost six months, I was fucked up . . . I wanted to walk in front of a semi [truck] . . . I never want to feel like that again*" (Lucy, white). To cope with these intense feelings, Lucy returned to criminalized substance use the day of her release.

For many participants, the anxiety and fear that marked the time leading up to release[31] was linked to struggles with criminalized substance use. Marlene, an Indigenous participant, recounted: "*I remember praying . . . asking the creator to give me strength to stay away from the drugs and to you know, do something better with my life . . . I didn't wanna go back to [my situation prior to incarceration]*". Similarly, Yvonne described that her "*heart was racing*" prior to release, and expressed that she "*wanted to stay clean*" but received very limited support. When asked to describe what happened immediately post-release, she replied: "*I went out and got high*" (Yvonne,

[31] This phenomenon is sometimes referred to as "gate-fever".

white). For some participants, narratives also highlighted that going back to criminalized substance use served as a form of coping with trauma. For example, Diane, an Indigenous participant, discussed her pre-release anxiety, and how using substances helped her cope with the pain of her child not being in her care:

> *I get the butterflies [pre-release] . . . my mind was focused on getting high again . . . I was anxious. But part of me wanted to get clean as well . . . I had a hard time . . . I just wanted to get my baby back [her child]. But I knew that wasn't gonna happen. So I chose to get high instead.* (Diane, Indigenous)

Diane's narrative speaks to criminalized substance use as a coping method for the trauma and grief associated with child apprehension (205,206). It is also a specific example of the ongoing impacts of colonialism and structural racism highlighted by the cyclical nature of surveillance and institutionalization for generations of Indigenous women and their children (170,207).

Service providers stressed the need for enhanced pre-release supports for women during this sensitive time in order to address the often complex anxieties and fears: "*[We need to] work with people before they get released . . . talk about why [they're] having this mental obsession [with criminalized substances], what is the fear . . . what are [they] nervous about [post-release]? . . . [We need] to address these issues. We'd have way better luck [with post-release success]*" (Service provider #5). In the absence of adequate pre-release planning and supports, many participants experienced substantial challenges in the immediate hours following release from correctional facilities.

3.3.2 Challenges Immediately after Release

3.3.2.1 Transportation, clothing, stigma, and vulnerability to violence

For many participants, transportation back to the community constituted a significant struggle and period of vulnerability. Participants' narratives highlighted that those who did not have someone to pick them up upon release from the correctional facility—which was often located in an unfamiliar city a significant distance from their home community—were left to navigate a multijurisdictional public transit system. As described by one participant: "*They give you a bus ticket and they kick you loose . . . you have to find your way back. I had no idea where the hell I was*" (Beth, white).

Char, an Indigenous woman who reported receiving no pre-release planning support despite being incarcerated for 11 months, described: "*They just said, 'see ya'. [I] even left in a monkey suit [prison clothes]*". Being released from custody wearing clothing issued by corrections is common for various reasons, including if the clothes someone was arrested in no longer fit, are not suitable for the weather, or are dirty after not being laundered for months, or in cases where an individual is released directly from court without access to their personal belongings. A peer service provider with incarceration experience noted: "*It's sad coming out with jail clothes. Like, how do you survive, especially when you're trying to change your life, right?*" (Service provider #6). In addition to this experience being humiliating and demoralizing, corrections-issued clothing increases public visibility, outing women as recently released from corrections and violating their dignity while re-enforcing the stigma surrounding people involved in the criminal justice system.

To avoid public visibility, the need to access a change of clothes immediately post-release put some participants at risk of re-arrest, as explained by Char: "*The first thing I did [when I got out]*

is I went and stole some clothes. Cause I was in one of those prison uniforms". Others had to engage in informal economy (e.g., sex work) to raise funds for basics needs and were exposed to the potential of violence due to their heightened vulnerability and economic need. This was described by Beth, who had no means of immediate financial support after release: "*I stopped in [a Metro Vancouver suburb] and I pulled a trick [sex work]. I didn't know what else to do [for money] . . . In jail clothes, it was ridiculous*". Similarly, Rita highlighted how, aware of the immediate and often desperate financial needs of recently released women, some taxi drivers—who are meant to facilitate transport from the correctional facility to the local bus stop—tried to take advantage of the economic situation of recently incarcerated women. She described: "*They [correctional staff] had the cabs coming to [the correctional facility] and [the cab drivers] would be asking the girls before they even got to the bus stop, if they wanted to pull a date [provide sexual services for a fee]*" (Rita, white). This was also reiterated by service providers who highlighted that despite plans to refrain from using criminalized substances upon release, the absence of supports in the immediate post-release hours contributed to women's vulnerability:

> *[Cab drivers know] these women are desperate. So even if somebody was hanging on by their fingernails . . . and [had] no intentions of getting [high], you have a cab driver right off the bat saying 'hey, you know give me a blow job and I'll give you thirty dollars so you can go get high and I'll take you to a drug house' . . . there goes anything in that woman's [plan] . . . all of a sudden poof.* (Service provider #5)

These narratives highlight the structural violence of releasing women from correctional facilities without supports, and illustrate how a critical lack of supports for participants during the transition from corrections to community places them at increased risk of harms. One service provider added:

"*The correctional system did not ask . . . or seem like they cared where the women [would end up]. It was like: released date, door closed, done*" (Service provider #4).

3.3.3 Lack of Housing Supports in the Post-Release Period

The lack of structural supports post-release was evident among most participants when it came to housing options. Although having a safe place to stay was one of the most pressing needs post-release, participants described significant challenges and barriers to safe and accessible housing.

3.3.3.1 Homelessness, gender-based violence, and health

With limited to no options for safe and supportive housing, many participants ended up homeless after release from corrections. Others opted to move in with their partners or boyfriends; however, this was not always the best or safest option. This phenomenon was described by Anna, who was staying in her partner's low-income, single room occupancy building:

> *I didn't like it. It was small and there [were] cockroaches . . . [we] had to share two washrooms with like, twenty other men . . . It was horrible but I had to stand it. I wanted to go stay at a women's shelter but [my boyfriend] didn't want me to go stay somewhere else.* (Anna, Indigenous)

Anna's narrative alludes to an inability to seek alternative housing arrangements as a result of the control imposed by her partner, which further highlights how the structural violence of a lack of safe housing supports following release from correctional facilities can put women at increased risk of gender-based violence. Several participants spoke to incidences of experiencing violence from abusive partners that led to involvement from police, with the women themselves often being

arrested and charged (e.g., for assault or for breaching conditions, etc.). Service providers spoke to this as a common phenomenon and echoed the importance of access to safe housing post-release:

> *Housing [makes] a huge difference because [then they're] not staying at [their] abusive boyfriend's house where the cops are gonna get called all the time. [They] actually have some safety and some security in [their] own space, and it makes a really big difference.* (Service provider #1)

Beth described the exhausting and challenging experience of being homeless post-incarceration, and how this presented a significant barrier to well-being and perpetuated a cycle of incarceration:

> *[After release] I was living on the streets . . . You lose everything, you start all over again every time you go in [to prison] . . . And of course if I'm on the street, I'm gonna be using [drugs] just to survive . . . then anytime the police see you . . . they just take you in [to jail] overnight, so it's super stressful . . . it's just a circle of accomplishing nothing*. (Beth, white)

Experiences of continued HIV care during the transition from corrections to community varied amongst participants. Some women were provided their HIV medication upon release from correctional facilities, while others made follow-up appointments with their HIV care providers in the days and weeks post-release. Others noted not receiving any medication or supports with regards to continuity of HIV care. For some participants, structural violence by way of lack of housing supports and stability during this period was linked to challenges with adherence, as further described by Beth: "*You're supposed to be in a stable environment when you're on your*

antivirals right? . . . When you're constantly having your stuff stolen, and you got nowhere to stay, then it's impossible" (Beth, white).

Service providers echoed the importance of stable housing for maintaining ART adherence post-release: "*More often than not women weren't calling us to get their meds refilled because they're homeless and [HIV care is] not their priority at that time—their safety and security is—so of course health gets prioritized way lower*" (Service provider #4).

3.3.3.2 Housing instability, criminalized substance use, and unregulated recovery houses

With limited options for housing and/or addiction treatment supports post-release from incarceration, some participants ended up in "recovery houses". In BC, individuals with a history of criminalized substance use are often court-ordered to these types of homes, which are generally co-ed and largely unregulated as described by one service provider:

> *[After getting released from court] I drive her to this recovery house—we knock on the door and some dude answers, no shirt, holding a crack pipe, and he's like 'oh I'm sure we can rustle up a mattress somewhere'.* (Service provider #1)

One participant, Rita, recounted that despite vocalizing her concerns, she was court-ordered to a recovery house in an area where she had a previous history of engaging in criminalized substance use. Pushing back against the symbolic violence of being expected to stay abstinent from criminalized drugs under inadequate and challenging circumstances, Rita noted that she was "*being completely set up for failure*" by having to live in a neighborhood with a significant open drug scene. Another participant, an Indigenous woman named Susan, detailed her experience with a post-release recovery house. She noted: "*There was nothing safe about it at all*", explaining that

the majority of residents were men whom she described as "*really creepy*", and who were openly using drugs in the house. A staff member—whom Susan felt was not qualified to dispense HIV medications—outed her HIV status without her consent. She detailed: "*He yelled it up at me, he goes, 'sorry to hear about your HIV, [Susan]!' . . . And we were at supper. [The residents] were having dinner*". These experiences made Susan feel highly unsafe and she opted to leave the recovery house. However, since she was court-ordered to reside there as part of her release conditions, the housing manager continued to collect rent, leaving her without alternative housing other than to couch surf—which she described as dangerous. Susan's narrative is an example of the harms perpetuated by the structural violence of unsafe conditions imposed by the courts that can expose marginalized women to breaches of confidentiality, highly unsafe housing conditions, and homelessness.

Finally, for some participants, being incarcerated had provided space to consider addiction treatment programs, which, as outlined above, can also offer a temporary housing solution. However, in the absence of pre-release planning, women were left to connect with services on their own. A lack of available safe addiction treatment options in BC coupled with significant waitlists constituted a barrier, as explained by Marlene: "*I tried to stay clean [while waiting to get into treatment], but the addiction took over and I started using again . . . then I started getting down on myself about it and going back to my old lifestyle. [Pressed] the fuck it button*" (Marlene, Indigenous).

In the absence of structural supports post-release, many participants ended up blaming themselves for relapsing, turning back to their old lifestyle, or being re-incarcerated, highlighting the symbolic violence (132) that results from the criminal justice system. A common theme stemming from

participants' stories was the significantly disruptive nature of short-term incarceration, which, coupled with a lack of supports post-release, maintained the cycle in and out of the criminal justice system.

3.3.3.3 Designated post-release supports

Access to designated support programs during the transition back to community was a rare experience for participants. However, some recounted how in addition to structural supports such as access to safe housing and substance use supports, building non-judgmental and supportive relationships with service providers were key to trajectories of resiliency for women. Two participants recounted experiences with the same community-based HIV support worker who had connected with them during their incarceration and supported them with multiple aspects of reintegration, including with housing and addictions supports. Lucy described her experience, illustrating the significance of this supportive relationship during and post-incarceration:

> *She's my rock. She's the whole reason I got through [prison] . . . She's in my life now, right? We go for walks, we go have breakfast or lunch sometimes . . . without her, man I probably wouldn't be here. I probably would have offed myself [death by suicide] a long time ago, or who knows what.* (Lucy, white)

The other participant who connected with this support worker described how "*she took me herself [to appointments] . . . it made a big difference, like a big sister . . . and that's why she's my hero . . . am I worth it? She showed me that . . . she's just wonderful . . . we need her*" (Susan, Indigenous).

Although significant in highlighting the need for trusting relationships and supports for women involved in the criminal justice system, these narratives also highlight the symbolic (136) or *slow* violence (203) of an absence of supports for women following release from correctional facilities. Participants' narratives about the difference a support worker can make even in the context of limited available resources underscored how the absence of supports after release from corrections are often internalized on an individual level, rather than attributed to harms perpetuated over time on a structural level. One peer service provider with lived experience of incarceration echoed this sentiment based on their own experiences:

> *There's more to [being released] than just walking out [of prison] and making sure you have a bed, a treatment center, a safe place. There's so much more that goes on and that's the anxiety, you know [. . .]. We don't think we're good enough . . . we've been broken down as people for so long . . . Mainstream society doesn't take care [of us] because they think we're in this position because you know, it was our choice.* (Service provider #5)

In the wake of complex emotions and stigma during this critical transition period, participants who did not have access to support organizations noted how significant it would have been during the transition to be connected to a designated support worker, peer, or healthcare worker to help them through this time. As one peer service provider explained: "*There's just so much judgement and stigma [post-release] . . . it's really hard, you know? If you can have that person who believes in you it makes all the difference in the world*" (Service provider #6).

3.4 Discussion

The findings of this study highlight intersecting structural barriers experienced by women living with HIV upon release from correctional facilities including limited pre-release planning, a lack of immediate supports at release, challenges accessing safe housing and addiction treatment, and interruptions in HIV treatment and care. The structural violence perpetrated due to a lack of supports post-release perpetuated symbolic violence, leading many women to blame themselves for not being able to escape the cycle of incarceration and criminalization. Conceptualizing the experiences of marginalized women involved with the criminal justice system as a form of structural and symbolic violence foregrounds the connections between structural inadequacies and the intersecting harms and vulnerabilities that are perpetuated by the criminal justice system. These findings highlight how in the hours after release from incarceration, in the absence of even the most rudimentary pre-release planning, women were rendered vulnerable to violent situations and re-arrest. Indeed, many study participants reported multiple arrests over the last 5 years. For Indigenous women, the unjust cycle of incarceration must also be understood in the context of colonial violence that perpetuates structural inequities and ignores the historical systemic injustices rooted in colonialism, including the fact that Indigenous women who are incarcerated are overwhelmingly survivors—or have family members who were survivors—of residential schools (42). This study supports the specific TRC calls to action for meaningful commitments to address the continued colonial violence perpetuated against Indigenous women and eliminate the overrepresentation of Indigenous people in Canadian correctional facilities (192). The findings of this study highlight that the challenges imposed on women post-release are momentous, and in the absence of structural supports blame and responsibility are placed on women themselves when in

reality, as summarized succinctly by anti-oppression, abolition, and liberation educator Rania El Mugammar, *"the guilt belongs to the system"* (208).

Consistent with other women who face incarceration across Canada (28), the majority of study participants experienced significant struggles related to criminalized substance use. The close relationship between criminalized substance use and incarceration among women is well documented (25–27), and this study adds to a body of research illuminating the complex substance use–related anxieties and risks that exist for women leaving correctional facilities (209,210). This is of critical concern given the contaminated illicit drug supply that has fueled an explosive and deadly overdose epidemic in BC (211) and across North America (212). Previous research has identified release from incarceration as a time of heightened risk for overdose and death (213,214)[32]. Reports from the First Nations Health Authority in BC indicates that in 2020, First Nations women died from overdose at a rate almost 10 times that of non-Indigenous women (215), highlighting the devastating toll of drug toxicity on the lives of Indigenous women. This study highlights how an absence of accessible substance-use supports following release from incarceration can leave women feeling defeated and cause them to blame themselves for relapsing—once again highlighting symbolic violence. A lack of comprehensive supports surrounding criminalized substance use is a structural failure that can be fatal, and as such this

[32] Since the time of the qualitative interviews (2017 and 2018), 2 of the 19 participants have passed away from overdose. I honour the lives of these women, and am immensely grateful that they shared their stories of lived experience for this work. Their passing reflects the continued devastating impacts of the overdose crisis on the lives of marginalized women and their communities. These deaths also represent only a fraction of SHAWNA participants who have lost their lives to overdose during the course of the study.

work underscores an urgent need for comprehensive substance use supports, specifically for women involved in the criminal justice system (199).

Study participants recounted major barriers to accessing safe housing following incarceration. These findings align with recent research from a study of women released from provincial corrections in BC in which 85% of participants were found to be either homeless or unstably housed following release (210). For study participants who were placed in "recovery houses" upon release, their narratives echo previous accounts illustrating how these spaces are unregulated and often unsafe for women (216,217). As highlighted by the National Inquiry for Missing and Murdered Indigenous Women and Girls, the current transitional housing system fails to provide comprehensive and safe housing supports and instead places women at risk of further harms while maintaining cycles of incarceration and criminalized substance use (42). Participants' experiences of being court-ordered to these types of unregulated and unsafe recovery houses again highlights the structural violence of harmful policies and under-resourced supports imbedded in the criminal justice system. An absence of structural supports in the form of safe housing was also linked to interruptions in HIV treatment and care for some participants, further highlighting how the structural violence of limited supports and inadequate housing at release shapes health outcomes. Research has consistently shown that homelessness and unstable living situations constitute significant barriers to continued HIV treatment during the transition from incarceration to community (218,219), and has stressed the importance of supportive transitional housing for women (trans-inclusive) in promoting adherence to ART among women post-release from incarceration (220). Culturally safe models of housing supports and interventions are also needed (221–223) in order to support the safety and specific needs of Indigenous women. This includes

supports for Indigenous programming in transitional housing, as outlined by the TRC (192). Studies have also pointed to an intersection between housing instability, criminalized substance use, and decreased adherence to ART (73,74), which is especially pronounced among women living with HIV who experience incarceration (76,219). The results of this study further underline calls for comprehensive pre-release planning and post-release services that encompass supports for both HIV care as well as criminalized substance use (224), and that reiterate the immediate need for safe and gender-specific housing options—including housing specific to addiction treatment—as critical to supporting health and well-being, including HIV outcomes, during reintegration.

The findings of this study further elucidate the intersections between gender-based violence, housing instability, and the cyclical nature of incarceration among marginalized women. Many participants who experienced housing instability post-release expressed how this increased visibility to police and thus risk of re-arrest. Similarly, service providers stressed the importance of housing options in providing women with their own space away from abusive relationships. Experiences of intimate partner violence perpetuated against women involved in the criminal justice system are exceedingly high (34). Research has demonstrated increasing and often inappropriate charges against women in instances where police are called to address intimate partner violence (225), which further perpetuates the cycle of incarceration. This reality also disproportionally impacts Indigenous women, who are exposed to higher rates of violence and then criminalized for protecting themselves or their children (42). As such, this research underscores the TRC justice-related calls for increased culturally relevant services during incarceration, including supports that address experiences of violence and abuse, along with added

programming for Indigenous people in the post-release period (192). These findings further reiterate how accessible housing options are critical to supporting women experiencing violence and addressing the perpetual nature of criminalization. Given the unique needs of women upon release from correctional facilities, including heightened vulnerabilities and exposure to gender-based violence, it is essential that all transitional supports—including housing and substance-use services—be tailored appropriately to include gender-specific options rooted in trauma-informed care and practice (226).

Finally, supports that focus on connecting participants to services—including peer based programs—that build and maintain trusting relationships are crucial. Connections through community and peer-based relationships and initiatives during the transition from incarceration have shown to be instrumental in helping to navigate the post-release transition (209,210,227). Research with women living with HIV in other settings has demonstrated that being connected by a designated service provider during this transitional period can increase feelings of support and self-confidence (219,228,229), and in some cases directly impact increased adherence to ART (219). However, despite growing rates of incarceration among women living with HIV, the prison-based outreach program specifically referenced by participants in this study has since lost funding and been terminated, along with many other HIV-specific community-based organizations and supports across Canada, including supports specifically for women living with HIV (230). This has left a significant gap in supports for marginalized women involved in the criminal justice system. Though some participants recounted significant and positive experiences accessing HIV-specific prison outreach programs post-release, there was an overall lack of accessible designated support services for participants during the transition, which impacted optimal HIV health. These

findings support a critical need for allocation of funding to support women living with HIV during this critical transition period, with an emphasis on culturally safe, peer-led programming along with investment in housing and substance use supports.

3.4.1 Limitations

Findings from this study mainly speak to the experiences of women living in an urban setting who were incarcerated in the main provincial facility for women in BC (ACCW). Further research is needed to elucidate the unique experiences of women who leave correctional facilities to return to rural communities, as well as those from other jurisdictions. The two Two-Spirit participants who were interviewed for this study had been held overnight in city jail cells, and did not speak to experiences transitioning back into the community after being incarcerated for longer periods of time. Since correctional facilities operate on a gender binary, and often do not support gender-affirming practices for trans people, there is limited research discussing the experiences of incarceration—including the impact on HIV care and transitional supports—for trans, Two-Spirit, and gender diverse people living with HIV, and research exploring their unique experiences and needs upon release is urgently needed. The study sample drew from the SHAWNA cohort, and reports of recent incarceration in this sample were limited to white and Indigenous participants. Further research that centres the experiences of Black and other racialized women living with HIV in Canada remains pressing. Finally, a note on a limitation of the semi-structured interview guide: although the majority of women who experience incarceration are mothers whose children are no longer in their care (18), the research team specifically chose not to include questions in the interview guide that asked about children/reunification with children post-release from incarceration given the potential of bringing up trauma during the interview. Despite this, several

participants recounted painful experiences of navigating the histories and relationships with their children.

Finally, as previously mentioned in *Chapter 1*, healthcare delivery in BC provincial correctional facilities was assumed by the PHSA in October 2017. Despite efforts, no correctional healthcare staff from ACCW were interviewed as a part of the service provider interviews[33]. Of note, this shift in healthcare delivery has included the implementation of community transition teams aimed at improving linkages to care and other supports following release from correctional facilities (122). The 19 interviews with SHAWNA participants were conducted prior to the transfer, and transitional supports may have improved since that time. A formal gender-based evaluation of the impact of the transition teams is needed.

3.4.2 Conclusion

This study highlights the intersecting structural barriers that perpetuate structural and symbolic violence among women living with HIV who are transitioning from correctional facilities to community, and demonstrates how involvement in the criminal justice system is sustained for marginalized women. Given the significant overrepresentation of Indigenous women within correctional facilities, this study calls for action to disrupt and remedy the over-incarceration and criminalization of Indigenous women. To improve HIV health outcomes and overall well-being for all women living with HIV following release, there is a critical need for increased transition supports from correctional facilities to community. Enhanced pre-release planning, with a priority on safe housing and addiction treatment options, is critical in order to enhance supports and access

[33] This was largely due to the strain on correctional healthcare within local correctional facilities due to the COVID-19 pandemic.

to care and address cycles of criminalization and incarceration. To meet the unique needs of women involved in the criminal justice system, interventions and programming should be gender-specific and rooted in trauma-informed practice and cultural safety. Whenever possible, options for peer supports should be prioritized.

Chapter 4: Pathways from recent incarceration to ART adherence: Opportunities for interventions to support women living with HIV post-release from correctional facilities in Metro Vancouver, Canada

4.1 Introduction

Chapter 1 established the growing number of women who are incarcerated globally (1), and outlined the gendered structural inequities that characterize women's involvement in the criminal justice system (14–16,22). Further, previous chapters established that the substantial overrepresentation of Indigenous women who are incarcerated in Canada (40,231) is a direct reflection of the ongoing harms of settler colonialism (45) situated within ongoing calls for action to end the over-incarceration of Indigenous peoples (192).

Given the overcriminalization of marginalized women, carceral settings globally (188) as well as within Canada (3,65) house disproportionate numbers of women living with HIV. However, access and adherence to ART remains sub-optimal for people living with HIV who are incarcerated (81). As outlined in *Chapter 2*, although knowledge is limited with regards to how specific institutional processes within correctional facilities might facilitate or hinder continuity of care, research across Canada and the US has pointed to HIV-related stigma in correctional facilities as a barrier to engagement and retention in HIV care during incarceration (83–85). The link between sub-optimal HIV health outcomes among people living with HIV post-release from incarceration is also well established (73,86–90). Along incarceration trajectories, women experience sub-optimal engagement in HIV care compared to men (92), and this is increasingly apparent during the post-

release period, when women face substantial barriers to retention in care, ART adherence, and maintaining viral suppression (92). Multicenter data from the US has shown that women are half as likely as men to achieve viral suppression 6 months post-release from incarceration (67). Further, evidence suggests that incarceration has additional sustained and harmful impacts for women living with HIV, including increased rates of mortality post-release (232).

Current research falls short in the explicit identification of pathways from recent incarceration to sub-optimal HIV health outcomes among women, and a gap in knowledge exists that exposes specific areas of intervention that could improve health outcomes post-release. Evidence from high-income settings suggests that the period of transition from correctional facilities to community presents immense challenges for women (195), including barriers and limited supports to accessing healthcare, housing, addiction treatment, and employment opportunities (197). Research from cohorts of women living with HIV across Canada, including from the SHAWNA team, exemplifies how incarceration is experienced alongside other structural inequities (e.g., homelessness, experiences of violence, and criminalized substance use) (36,56).

As discussed in previous chapters, findings from the US have demonstrated that among people living with HIV, women are significantly more likely to report both homelessness and criminalized substance use following incarceration (67), factors that are also associated with increased rates of recidivism (68). Furthermore, research has shown that housing insecurity or homelessness (69–72) and criminalized substance use (72–78) can create barriers to optimal HIV health, including through impacts on sub-optimal ART adherence and unsuppressed viral load. Unsurprisingly, stable housing in the post-release period can assist in reducing the likelihood of relapse to substance use, while also facilitating adherence to ART (220,233). Given this evidence, it is

important to consider homelessness (as a marker of insecure housing), along with criminalized substance use, as potential mediators in the pathway between recent incarceration and sub-optimal ART adherence.

Another potential mediator in this pathway is gender-based violence. Gendered power dynamics and violence are linked to sub-optimal HIV outcomes for women, including through reduced uptake of and retention in HIV treatment (62,69,234–237). Experiences of gender-based violence perpetuated against women involved in the criminal justice system are extremely high (34), and studies have shown that women living with HIV specifically experience high rates of violence and trauma (36,62,238), including relative to the general population of women (63). Qualitative research has indicated several ways by which intimate partner violence, for example, can impact ART adherence among women, including through increased stress leading to medication forgetfulness, having to leave home without medications, and partners throwing away medications (239). Among a cohort of women living with HIV in Canada (SHAWNA Project), participants who reported recent experiences of gender-based violence had increased odds of needing supports to maintain ART adherence (240). Gender-based violence can also lead to insecure housing and homelessness (241), as well as increased substance use as a coping method (242).

Sub-optimal HIV health outcomes post-release from incarceration cannot be separated from the structural inequities and challenges faced by women upon release; yet, despite mounting evidence demonstrating increased vulnerabilities and sub-optimal HIV health outcomes during this vulnerable time, supports and tailored interventions for women living with HIV post-release from incarceration remain scarce across North America. Studies that center the experiences and health outcomes of women living with HIV remain limited, and few studies have explored in detail the

relationship between recent incarceration and ART adherence among women. A better understanding is needed of the factors that mediate the relationship between recent incarceration and ART adherence. Building on qualitative findings of *Chapter 3*, the aim of this study was to investigate pathways from recent incarceration to ART adherence via social and structural factors, to elucidate specific considerations for interventions designed to improve HIV health outcomes for women along post-incarceration trajectories.

4.2 Methods

4.2.1 Study design and sampling

This analysis draws on 9 years (January 2010–February 2019)[34] of data from an open longitudinal community-based research cohort known as the SHAWNA Project. As previously described in *Chapter 1* (Sections 1.7 and 1.8), SHAWNA includes over 350 self-identified cis and trans women[35] living with HIV aged 14 years and older who reside and/or access HIV services in Metro Vancouver. The SHAWNA Project grew out of extensive community-based consultations with women living with HIV, HIV care providers, and policy experts on research priorities and gaps in services, and is guided by a Positive Women's Advisory Board. Participants have been invited to enroll in the cohort through outreach by a team of Peer Research Associates, self-referrals, and referrals from HIV care providers, peer navigators, HIV/AIDS organizations, and clinical outreach. Participants are referred to the community research office or can identify a safe,

[34] This study sample included observations from 2010-2014 on 87 SHAWNA participants who were also enrolled in An Evaluation of Sex Workers' Health Access (AESHA) (2010-present), a cohort of cis and trans sex workers (14+ years), also led by the CGSHE and described elsewhere (75). Approximately 10% of AESHA participants are WLWH and are followed by the SHAWNA study team.

[35] As mentioned previously although recruitment for the cohort has always focused on cis and trans women, I understand and acknowledge that gender is fluid over time, and may have changed for some participants since joining the cohort at baseline.

confidential space of their choosing to complete the interview. Following informed consent, participants complete an interviewer-administered questionnaire conducted by a trained community interviewer and voluntary HIV monitoring and STI/HCV testing with a sexual health research nurse. SHAWNA interviews are conducted semi-annually and focus on experiences navigating HIV care, community supports, sexual and reproductive health, and treatment outcomes. Participants receive an honorarium of CAD $50 at each visit for their time, expertise, and travel. The project is committed to meaningful inclusion of women living with HIV throughout the research project, with cis and trans women living with HIV represented across project staff, advisories, and co-authorship. This study holds ethical approval through both Providence Health Care/University of British Columbia Research Ethics Board, and BC Women's Hospital.

4.2.2 Path analysis and primary variables of interest

Path analysis is used to evaluate causal models by examining the relationship between one or several outcomes and two or more explanatory variables (243). It is helpful in providing estimates and significance of hypothesized causal connections (244). The foundational research for this dissertation—described in Section 1.7.3—included previous SHAWNA quantitative studies (36,91) that explored the incarceration variable by applying regression using generalized estimating equations. To build upon this work, for this study I drew on path analysis as an extension of multiple regression (244), to help further elucidate the mechanisms through which incarceration might influence HIV outcomes in the post-release period.

Variables in the SHAWNA study are either time-fixed or time-updated to reflect recent occurrences at each semi-annual study visit. Key variables in the path analysis model, along with potential confounders (outlined below) are based on knowledge gathered from previous SHAWNA

research (36,91), including the qualitative studies presented in *Chapters 2 & 3* along with additional conversations with women living with HIV involved in the SHAWNA project through participation on the incarceration-focused Positive Advisory Working Group.

The outcome for this analysis was optimal ART adherence defined as ≥95% adherence to ART. Participants were asked to self-report adherence during the last 3–4 weeks prior to the study visit on a slider scale from 0%–100% (245). The use this variable was based on prior research suggesting self-report as a robust measure of ART adherence, including a 2006 review of 77 studies that employed self-report measures of ART adherence (246), along with specific studies highlighting the validity of scale-based (i.e., visual analog scale) self-report ART adherence measures (245,247), and studies with women living with HIV validating other self-report HIV outcomes measures (i.e., self-report HIV viral load) (248). Participants in this study were categorized as having optimal adherence (i.e., ≥95%) versus sub-optimal adherence (inclusive of participants not on ART at the time of the interview). The primary explanatory variable for this analysis was recent incarceration, defined as being held overnight or longer in a city jail or at a provincial or federal correctional facility during the last 6 months (at study visit). The mediators in this analysis included the following variables capturing events in the last 6 months at each study visit: homelessness (i.e., sleeping on the street for one night or longer), criminalized substance use (i.e., any use of injection or non-injection drugs, excluding cannabis and alcohol), and experiences of gender-based violence (i.e., physical or sexual violence by any perpetrator).

4.2.3 Confounders in the path analysis model

Hypothesized confounders for all pathways in the path analysis model included: age (measured continuously in years); high school graduation status at baseline; lifetime diagnoses of any mental

health condition; self-identification as Indigenous (First Nations, Métis, or Inuit), Black, or otherwise racialized (Latinx, South/East Asian, Middle Eastern, other) versus only reporting white; gender identity (gender minority at any study visit, inclusive of trans [transgender, transsexual, other transfeminine identity], gender diverse [non-binary, genderqueer], or Two-Spirit versus cisgender at all visits); and sexual orientation (sexual minority at any study visit [lesbian, gay, bisexual, queer, asexual, Two-Spirit] versus heterosexual at all study visits)[36]. For the pathways between recent incarceration and the mediators, recent sex work (i.e., exchanged sex for money, food, goods, or other in the last 6 months) was included as an additional confounder, but this was not hypothesized to affect adherence.

4.2.4 Statistical Analyses

Descriptive statistics, including medians and interquartile ranges (IQRs) for continuous variables, and frequencies and proportions for categorical variables, were calculated for the overall sample. Path analysis was used to investigate pathways from recent incarceration to ART adherence through mediators of gender-based violence, homelessness, and criminalized substance use. Path analysis was conducted using a weighted least-squares approach, with mean and variance adjustment to evaluate the hypothesized model using repeated measures among participants (249). The direct effects between recent incarceration, mediating variables, and ART adherence were tested, as well as indirect effects between incarceration and ART adherence mediated by

[36] Participants had the option to provide more than one response to questions on sexual orientation and gender identity. Based on evidence that minority stress processes affect all members of gender minority communities relative to cisgender people (318), and members of sexual minority communities relative to heterosexual communities (319), for the purpose of analysis I combined participants with any response that fell into the gender minority or sexual minority categories into one group, respectively, for each variable.

homelessness, criminalized substance use, and gender-based violence. All mediators were assumed to be correlated with each other and adjusted for confounder variables as described above.

Standardized coefficients, standard errors, critical ratios, and *p*-values are presented for the direct and indirect pathways investigated. Standardized coefficients represent the strength and direction of direct and indirect effects. Path analysis model fit was assessed using chi-square, root mean square error of approximation (RMSEA), and comparative fit index (CFI). A score of <0.05 for RMSEA and a score >0.90 for CFI indicate an acceptable model fit (250,251). Statistical significance was set at $p < 0.05$, and observations with missing responses on exogenous variables were excluded from the path analysis. All *p*-values are two-sided. SAS software version 9.4 (SAS Institute Inc., Cary, NC, USA) and Mplus version 8.2 (Muthén & Muthén, Los Angeles, CA, USA) were used for statistical analyses.

4.3 Results

Among 336 women enrolled in the SHAWNA cohort over the 9-year follow-up (January 2010–February 2019) there were 1950 observations, with a median number of 5 study visits (IQR: 3–7). Baseline characteristics are presented in **Table 4.1**. The median age was 43 (IQR: 36–50). Of the sample, 7.1% self-identified as trans and 92.9% as cis; as the SHAWNA study captures gender fluidity over time, 1.2% reported identifying as gender diverse at some point in the study. Overall, 9.8% of participants reported gender-minority identity and 32.7% of participants reported sexual-minority identity. Overall, 12.6% of Indigenous women reported Two-Spirit identity. Indigenous women accounted for 56.9% of the sample, indicative of the overrepresentation of Indigenous women who have been marginalized and are living with HIV in the Metro Vancouver region. In total, 5.4% identified as Black, 3.6% as otherwise racialized, and 34.2% as white. Lifetime

diagnosis of a mental health condition was reported by 62.5%, less than half (47.9%) of participants had graduated from high school, and overall, 44.1% had engaged in recent sex work at baseline. With regards to the primary variables of interest, 8.9% of participants had experienced a recent incarceration within the last 6 months at the time of their baseline interview. In addition, 22.0% had experienced recent homelessness, 70.2% reported recent injection or non-injection criminalized substance use, and 18.5% had experienced recent gender-based violence. At baseline, only 58.9% of participants reported optimal ART adherence (≥95%) in the last 3–4 weeks.

Table 4.1. Baseline characteristics of women living with HIV in the SHAWNA cohort 2010–2019 (n = 336)

Characteristics	Prevalence n, (%)	Missing
Age, years *(median, IQR)*	43 (36–50)	0
Gender minority identity [∞]	33 (9.8)	2
Sexual minority identity[×]	110 (32.7)	1
Race		0
Indigenous[β]	191 (56.9)	
Black	18 (5.4)	
Otherwise racialized [±]	12 (3.6)	
White	115 (34.2)	
Graduated high school	161 (47.9)	0
Lifetime diagnoses of any mental health condition	210 (62.5)	0
Interpersonal Factors		
Gender-based violence[α]*	62 (18.5)	16
Sex work[*]	148 (44.1)	1
Structural exposures		
Criminalized substance use*	236 (70.2)	2
Incarceration*	30 (8.9)	5
Homelessness*	74 (22.0)	2
HIV specific variables		
Optimal ART adherence (≥95%)[μ]	198 (58.9)	2

[∞] Trans (transgender, transsexual, other transfeminine identity), gender diverse (non-binary, genderqueer), Two-Spirit, other; [×] Lesbian, gay, bisexual, asexual, Two-Spirit, queer, other; [β] First Nations, Métis, or Inuit; [±] Latinx, South/East Asian, Middle Eastern, other; [α] Physical/ sexual; [μ] In the last 3–4 weeks; * In the last 6 months

4.3.1 Path Analysis

After missing data were excluded, 332 participants with 1923 observations were included in the path analysis. Model fit indices suggest the hypothesized model fit well to the data ($\chi 2(1) = 1.100$; $p = 0.294$; CFI = 1.000; RMSEA = 0.007). As an essential element of path analysis is the explicit visual diagram of the conceptual model and hypothesized pathways (243). **Figure 4.1** illustrates the path diagram with standardized coefficients for all significant direct effects. All mediator variables (recent homelessness, criminalized substance use, and gender-based violence) were significantly correlated with each other.

Figure 4.1 Pathways from incarceration to optimal ART adherence

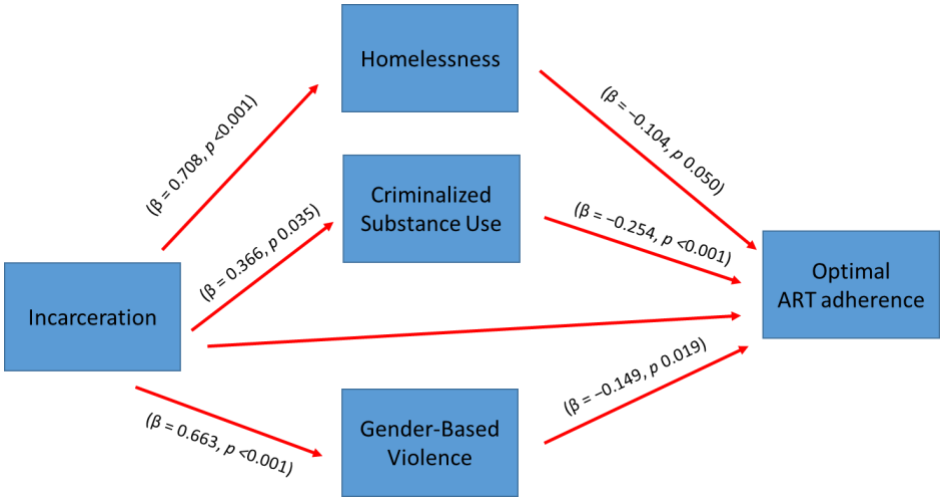


Table 4.2 presents the results for all direct and indirect pathways of interest. The direct paths from recent incarceration to homelessness ($\beta = 0.708$, $p < 0.001$), recent criminalized substance use ($\beta = 0.366$, $p = 0.035$), and recent gender-based violence ($\beta = 0.663$, $p < 0.001$) were significant. Recent homelessness ($\beta = -0.104$, $p = 0.050$), recent criminalized substance use ($\beta = -0.254$, $p < 0.001$), and recent gender-based violence ($\beta = -0.149$, $p = 0.019$) each had a significant negative direct effect on optimal ART adherence. The direct path from incarceration to optimal ART

adherence was not significant (β = −0.170, p = 0.309), with indirect paths suggesting this was fully mediated by recent homelessness (indirect β = −0.074, p = 0.064), recent criminalized substance use (indirect β = −0.093, p = 0.066), and recent gender-based violence (indirect β = −0.099, p = 0.028).

Table 4.2 Standardized parameter estimates from the path analysis model of incarceration and optimal ART adherence among women living with HIV in Metro Vancouver, Canada, 2010–2019 (n = 336)†

Pathway	Standard coefficient	Standard error	Critical ratio	*p*-value
Direct Paths				
Gender-Based Violence[α]*				
Incarceration*	0.663	0.130	5.120	<0.001
Homelessness*				
Incarceration*	0.708	0.140	5.054	<0.001
Criminalized Substance Use*				
Incarceration*	0.366	0.174	2.104	0.035
Optimal ART Adherence (≥95%)[μ]				
Incarceration*	–0.170	0.167	–1.017	0.309
Gender-based violence[α]*	–0.149	0.063	–2.350	0.019
Homelessness*	–0.104	0.053	–1.956	0.050
Criminalized substance use*	–0.254	0.070	–3.646	<0.001
Indirect Paths				
From Incarceration* → Optimal ART Adherence (≥95%)[μ]				
Total indirect path	–0.266	0.066	–4.013	<0.001
Through gender-based violence[α]*	–0.099	0.045	–2.190	0.028
Through homelessness*	–0.074	0.040	–1.853	0.064
Through criminalized substance use*	–0.093	0.050	–1.842	0.066

† All pathways were adjusted for age, race, sexual orientation, gender identity, education, and lifetime diagnosis of any mental health condition. Recent sex work was adjusted for in pathways between incarceration and the mediators of interest.; * Time updated to capture events in the last 6 months ; [μ] Time updated to capture events in the last 3–4 weeks; [α] Physical/sexual

4.4 Discussion

Given the sub-optimal HIV health outcomes among women living with HIV in the period following release from correctional facilities, this study addresses a gap in the current knowledge and highlights key considerations for the development of interventions aimed at improving the overall health and well-being of marginalized women along incarceration trajectories. Research from the US has studied a range of interventions designed to support and enhance HIV care outcomes post-release from incarceration for people living with HIV (252–260); however, results commonly lack a gender-based analysis, making it challenging to draw critical conclusions regarding the effectiveness of interventions based on gender. Recognizing women living with HIV as a unique population within the criminal justice system, calls have been made for policies and interventions that are responsive to the needs of women living with HIV (232). This research adds an important gendered lens when considering post-release interventions by highlighting the interconnectedness of homelessness, criminalized substance use, and gender-based violence as factors that play a critical role in health outcomes. Although these barriers to health are systemic and structural and require resourced solutions, findings from this study provide important insights into how policy and programming might help to mitigate harms by improving supports and referrals for women living with HIV upon release from correctional facilities.

Housing has been identified as the primary unmet need among people living with HIV leaving custody (219), and in this study homelessness was a significant mediator along the pathway from incarceration to optimal ART adherence. Transitional or second-stage housing specific to people leaving correctional facilities aims to provide a safe environment post-release with structured supports (261), and US-based research has outlined clear benefits of supportive transitional

housing for women living with HIV post-release from incarceration, including as a crucial support for ART access and adherence (220). Presently, evidence suggests that dedicated transitional housing for women in Canada remains limited and unsafe (42), and these findings elucidate an urgent need for resources dedicated to increased gender-specific housing options upon release from correctional facilities. Given the high rates of gender-based violence among marginalized women who experience incarceration (34,36), along with research highlighting the relationship between gender-based violence and housing precarity among women living with HIV specifically (71), there is an ongoing need for gender-specific approaches to housing stability (261,262). Housing options could include self-contained units in women-only buildings (14,261), communal areas that foster social support surrounding community reintegration (220,261), and accommodations that are welcoming and suitable for children (263,264). With substantial gaps in gender-affirming housing for trans, Two-Spirit, and gender diverse people within women-centered programs (265), women-centred housing must include and enforce trans and gender-inclusive policies to promote accessibility and safety for trans, Two-Spirit, and gender diverse people.

This research also highlights the significant impact of criminalized substance use on ART adherence post-release from incarceration, which is also of critical concern given the heightened risk of overdose and death among people leaving correctional facilities (213,214) and within the context of the overdose crisis in North America (211,212). Research and policies have stressed the importance of housing first principles (i.e., viewing housing as a human right, which should not be conditional on abstaining from criminalized substances) in supporting people upon release from incarceration (261). Growing research has pointed to the importance of gender-specific transitional housing that is low-barrier in terms of drug use (220), while other work has highlighted the need

for drug-free living environments in the post-release period (261). Central to this work of course is the emphasis on client-centered care that provides meaningful options and choice when it comes to housing and associated supports (261,266). The inclusion of harm reduction principles (267) within housing strategies (266), ensuring that gender-specific housing options are within proximity to pre-existing harm reduction and substance use services (71), and supporting women's access to services tailored to their individual goals and needs (268) will be essential in supporting women's health and well-being.

Finally, this research draws attention to a critical need for continued efforts to redress alarmingly high rates of violence perpetuated against marginalized women, including women living with HIV. This includes specific calls to action to address and eliminate ongoing and systematic violence perpetuated against Indigenous, Black, and other racialized women (37,46,269). Findings emphasize that at the very minimum it is essential that *all* supports and services for women leaving correctional facilities—including for housing, addiction needs, and HIV care—be trauma-informed, and equipped with appropriate referrals to services for women experiencing violence[37]. Central to trauma-informed care and practice is safety and autonomy for the service user (270). Trauma-informed care and practice is also a fundamental component of creating culturally safe spaces for Indigenous people (180). The creation of culturally safe housing spaces and associated services that meet the needs of Indigenous women (180,223) is of critical importance in light of

[37] Of note, as conversations around trauma-informed care and practice continue to evolve, principles have expanded from a trauma-informed care framework - that aims to realize and understand the impact of trauma and integrate knowledge around trauma into policies and practice (317), to a trauma- and violence-informed care framework to account for intersecting impacts of systemic and interpersonal violence and structural inequities (226). I have used "trauma-informed care" throughout this dissertation for consistency and accuracy when citing existing resources but acknowledge the importance of recognizing and responding to violence as critical to trauma-informed care and practice.

the significant overrepresentation of Indigenous women within the criminal justice system in Canada (4) and other countries with a history of settler colonialism (5,190,191). Mandated education for service providers surrounding the impacts of colonialism, the residential school system, intergenerational trauma, and the systematic over-incarceration of Indigenous peoples (45) is critical in the delivery of culturally safe care for Indigenous women involved in the criminal justice system. Overall, adopting culturally safe trauma-informed care and practice into service delivery is a manageable and fundamental step in ensuring that the lived experiences of women are recognized, and that supports and services acknowledge the complexities of trauma and the ongoing experience of gender-based violence when tailoring services to marginalized women.

4.4.1 Limitations

This study has several limitations to consider. Results should not be interpreted as causal, and there is potential for reverse directionality between recent incarceration and the mediators discussed. Although clinical measures of HIV viral load are often regarded as the gold standard in measuring HIV health (271), and used as a hard marker for ART adherence, HIV viral load data for participants in the SHAWNA Project was only available until 2017 (through BC's Drug Treatment Program), which would have had a negative effect on the study's statistical power. Despite this however, the specific purpose of this study was not to look at HIV viral load, but rather to investigate which mechanisms might influence participant's ability to maintain optimal adherence in the post-release period. As mentioned previously, evidence suggests that self-reported ART adherence measures, including scale-based measures, are robust for measuring adherence (246–248). Further, although self-report measures do have the potential to introduce social desirability

(272) the SHAWNA research team employs strategies to build and maintain long-lasting and trusting relationships with study participants in order to minimize responder bias.

The study's smaller sample size may not have been sufficient to detect some associations, though the effective sample size was increased through the use of longitudinal data. Given the small number of participants who had experienced recent incarceration, there was insufficient statistical power to present the path analysis model stratified by potential key variables, such as race [inclusive of Indigenous identity] or gender identity[38], which potentially could have highlighted differences in post-release experiences and retention in care for different groups. Larger samples are needed—including those led by and/or bringing to the forefront the perspectives of Indigenous women as well as trans women, Two-Spirit, and gender diverse people—to be able to draw out intersectional analysis and elucidate considerations for tailored interventions. Future research could also explore more complex pathways, including how additional mediators such as experiences of HIV-related stigma, ongoing mental health diagnoses, and food insecurity might impact pathways from incarceration to optimal ART adherence.

4.4.2 Conclusion

Recent homelessness, criminalized substance use, and experiences of gender-based violence emerged as important mediators along the pathway from recent incarceration to optimal ART adherence among women living with HIV post-release from correctional facilities. Findings provide important insights into the gendered impacts of incarceration and highlight critical

[38] Among non-cis participants in this analysis, there were only 3 events of recent incarceration among 3 trans women participants; 8 events of recent incarceration among 5 Two-Spirit participants; and 0 events among gender diverse participants.

considerations for interventions in the post-release period. To improve ART adherence and subsequent HIV health outcomes among women post-release from incarceration, there is an urgent need for expanded services and interventions. Dedicated resources to increase the availability of accessible, safe, and gender-specific housing—including transitional housing following release from correctional facilities—remains urgent. There is also a critical need for post-release supports to emphasize tailored approaches to adequate care and supports surrounding criminalized substance use and heightened levels of violence, while ensuring that services and programs are trauma-informed, culturally safe, and sensitive to the ongoing impacts of gender-based violence among marginalized women.

Chapter 5: Conclusion

5.1 Summary of Findings

Despite the growing number of women living with HIV who experience incarceration globally (53), and gendered impacts of incarceration that are highlighted by sub-optimal HIV health for women in high income settings (67,92,273), there is a paucity of research focused on the lived experience of incarceration among women living with HIV, and the mechanisms that lead to sub-optimal HIV health outcomes, including ART adherence, along incarceration trajectories. Recognizing this, calls have been made for research that centers the experiences of women living with HIV in order to increase gender-specific supports for this population (232). Further, although a growing body of research examines the health of people living with HIV post-release from incarceration (252–255,257–260,274), there is an evidence gap surrounding the gendered impacts of post-release interventions designed to support HIV health (93). This gap in knowledge has impeded understanding of the unique needs of women living with HIV along incarceration trajectories. Guided by critical social science scholarship, and through use of both qualitative (*Chapters 2 & 3*) and quantitative (*Chapter 4*) methods, this dissertation drew on data from SHAWNA, a community-based research project with self-identified cis and trans women living with HIV in Metro Vancouver, alongside interview data with service providers, to begin to address this critical evidence gap. Results from this dissertation provide key insights into the experiences of incarceration trajectories among women living with HIV in BC, and how these experiences shape HIV health outcomes, including ART adherence.

Drawing on the concept of structural stigma as a key barrier to optimal health (126,129,130), *Chapter 2* investigated how HIV-related stigma shapes access to HIV care among women living

with HIV during incarceration. Results highlight how experiences of HIV-related stigma within correctional facilities can lead to isolation and discrimination for women living with HIV. Findings also elucidate important mechanisms—including institutional processes, compromised privacy, and uncertainty about confidentiality—that reinforce and uphold HIV-related stigma. These mechanisms directly influence interpersonal experiences of discrimination for women living with HIV and contribute to barriers and challenges for continued HIV care and treatment during incarceration.

Chapter 3 drew on the concepts of structural and symbolic violence (131,132) to explore experiences of transition from correctional facilities back to community among women living with HIV. This chapter also included perspectives from service providers who work with women living with HIV along incarceration trajectories. Findings from *Chapter 3* highlight a myriad of intersecting structural barriers faced by women upon release from custody and during the transitional period that follows. These barriers include limited pre-release planning, a lack of immediate supports and accessible programs at release, challenges accessing safe housing and addiction treatment, and interruptions in HIV treatment and care. In the face of various structural barriers, many women blamed themselves for not being able to break the cycle of incarceration, perpetuating symbolic violence where those who are structurally oppressed come to blame themselves for the systemic barriers they face (132,203).

Building on these qualitative findings, along with gaps in knowledge regarding the mechanisms that lead to sub-optimal HIV outcomes for women in the post-release period, *Chapter 4* investigated pathways from recent events of incarceration to optimal ART adherence among women living with HIV. Findings from this chapter elucidated important factors along the pathway

to optimal HIV health in the post-release period. Experiences of homelessness, gender-based violence, and criminalized substance use were found to each fully mediate the relationship between incarceration and optimal ART adherence, highlighting crucial points of intervention to support women living with HIV post-release from incarceration.

Collectively, the results presented in this dissertation highlight the complex ways in which social and structural factors profoundly shape the experiences of women living with HIV along incarceration trajectories, and point to mechanisms that directly influence the HIV care continuum for women who experience incarceration. The findings underscore heightened vulnerability in the post-release period and elucidate specific considerations for interventions and policy reforms tailored for improving HIV health outcomes, supporting overall well-being, and redressing rates of incarceration for women living with HIV.

5.2 Study Contributions

This dissertation makes several unique and important contributions to research and methods, alongside considerations for policy and practice.

5.2.1 Contributions to the literature on incarceration and HIV

First, this dissertation extends the current literature on the impact of incarceration among people living with HIV by centering and bringing to the forefront the experiences of women living with HIV along incarceration trajectories in high-income settings. This dissertation serves as the first published research within a Canadian setting to draw on qualitative interviews with both women living with HIV who have experienced incarceration in Canada and service providers who support them. While a small number of studies—including from the SHAWNA team—have focused on

sub-optimal HIV outcomes for women living with HIV who experience incarceration in Canada (56,91) and the US (67,232), there has been limited research into the specific mechanisms that impact continued HIV care and treatment for women along incarceration trajectories. This evidence gap is especially salient in the Canadian context. As such, findings from *Chapter 2* extend the knowledge by elucidating the specific ways in which institutional processes within correctional facilities can uphold and reinforce HIV-related stigma and shape continued HIV care in correctional facilities for women. These findings add a gendered lens to our understanding of HIV-related stigma in carceral settings as a key barrier to HIV care among people who are incarcerated (83,85,162,275). With evidence documenting post-release gendered discrepancies in HIV health outcomes for women (92), coupled with a dearth of published research investigating intervention outcomes through a gendered lens, findings outlined in *Chapters 3 & 4* contribute novel evidence to this field of research. Specifically, this research highlights barriers and challenges faced by women living with HIV post-release and elucidates specific considerations for gender-specific interventions for improving ART adherence and overall well-being for women living with HIV post-release from incarceration.

5.2.2 Unique methodological contributions

Concerning methods, this dissertation emphasizes the value of employing a mixed methods approach, while drawing and building upon foundational and existing published research to inform study design. Combining interview data of the lived-experiences of incarceration with survey data and statistics using a mixed methods approach creates a powerful account to help inform policy change (146,147). It also gives way to innovative approaches to knowledge translation. The qualitative semi-structured interviews with women living with HIV (*Chapters 2 & 3*) brought

forward a nuanced understanding of the experiences and challenges faced by women along incarceration trajectories. The interviews with service providers (*Chapter 3*) helped to provide context and additional perspectives. These firsthand documented accounts brought a richness to this dissertation and contributed to our understanding of the lived experiences of incarceration for marginalized women in a way that would not have been possible by relying on quantitative data alone. Expanding on qualitative methods by drawing on quantitative data through path analysis in *Chapter 4* provided additional validation to the unique findings outlined in *Chapter 3*, and highlighted specific opportunities for interventions to address sub-optimal ART adherence for women post-release. These findings add critical epidemiological evidence to this understudied topic and provide important information for considering points of interventions specific to supporting ART adherence and promoting continuity of HIV care among women post-release from incarceration. Collectively, the mixed methods approach drew on strengths of both qualitative and quantitative data to create a combined analysis that allowed for a more comprehensive and detailed understanding of the lived experiences of incarceration trajectories and how they shape the HIV continuum of care for women living with HIV. These comprehensive methods are central to the creation of knowledge that is useful and actionable for policy makers (149), including those responsible for change making within carceral settings.

Lastly, the conceptual framework applied to this dissertation extends the use of critical social science scholarship to understand and conceptualize the harms perpetuated by the criminal justice system. Specifically, by drawing on concepts of structural stigma, this dissertation highlights how institutional-level processes reinforce HIV-related stigma and perpetuate HIV-related discrimination, which shape the HIV continuity of care. Highlighting how stigma is perpetuated

at the institutional level within correctional facilities provides a unique contribution to a small but growing body of published literature concerning stigma and HIV care in carceral settings (83–85,162–164). Drawing on concepts of structural and symbolic violence helped to elucidate how the absence of post-release supports reinforces harms and poor health, including through compromised HIV care. As a result, this dissertation extends the literature that centers the relationships between incarceration and the intersecting harms and vulnerabilities that are perpetuated as a result (135,202).

5.3 Study Recommendations: Areas for Interventions

Findings from the empirical chapters of this dissertation offer a number of concrete recommendations and considerations for interventions tailored to support the health and well-being of women living with HIV along incarceration trajectories and redress the over-incarceration of marginalized women across Canada. Though specific recommendations are outlined in detail in each empirical chapter, in this section I highlight overarching recommendations based on cumulative findings across *Chapters 2–4*.

Redress the over-incarceration of marginalized women

Central to the overall findings of this dissertation is the urgent need to redress the over-incarceration of marginalized women across Canada. Women experience unique pathways to incarceration often marked by poverty and gendered inequities. Furthermore, an overwhelming number of women who are incarcerated have experienced extreme violence and sexual abuse, and women who are incarcerated are also more likely to suffer from mental health and substance use issues compared to men who are incarcerated (22). Recognizing this, calls for gender-responsive programming *within* Canadian correctional facilities have been made (276,277), along with

international research calling for correctional facilities to be trauma-informed as to not perpetuate experiences of trauma among women (278). Additionally, in response to the growing number of women who are incarcerated across Canada, the 2021 Report on the Human Rights of Federally-Sentenced Persons stressed the need for the development of *preventative* strategies that address the unique needs and circumstances of women involved in the criminal justice system (22).

To address overcriminalization and incarceration, this dissertation therefore underscores the need for policy and programming to focus on supporting the social and structural needs of marginalized women in order to disrupt the cyclical nature of incarceration. This includes an emphasis on strategies and supports tailored to the unique needs of Indigenous women (22) to address the structural vulnerabilities they face due to the ongoing effects of colonialism. As noted by Canada's Correctional Investigator Ivan Zinger, the continued and devastating trend in incarceration rates among Indigenous women *"remains one of Canada's most pressing human rights issues, and is evidence of public policy failures over successive decades [to reverse this trend]"* (41). Strategies designed to disrupt cycles of incarceration must address the continued colonial violence perpetuated against Indigenous women in Canada responsible for the gross overrepresentation of Indigenous women in correctional facilities. As outlined throughout this dissertation, these findings reiterate ongoing and urgent calls to the Canadian government to act on the justice-related calls to action laid out in the TRC (192), recommendations from the report of the Standing Committee on the Status of Women: *A Call to Action: Reconciliation with Indigenous women in the federal justice and correctional systems* (193), and calls for justice outlined in the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (42).

Finally, changes to Canadian laws and policing practices that criminalize and disproportionally target certain marginalized groups and actions, while perpetuating involvement in the criminal justice system, are critical to reducing the number of women who are incarcerated. This includes the need to decriminalize substance use and end the war on drugs (279–281), end the criminalization of homelessness and poverty (282), decriminalize sex work (283,284), end the criminalization of HIV non-disclosure (64,285), and address systemic racism within policing practices and the judicial system (39,46,192).

To reverse the increasing trend of incarceration within Canada, long-term goals must work to refocus the purpose of the criminal justice system away from punishment, retribution, and incapacitation, and towards rehabilitation and healing (187,286–290). This includes redirecting funding away from law enforcement (i.e., defunding the police) (279,291,292) and instead investing in structural, social, and healthcare supports and services, along with capacity building for marginalized and criminalized communities.

Improve the HIV continuum of care for women living with HIV during incarceration

In the midst of redressing the criminalization and disproportionate incarceration of marginalized women, the lived reality of ongoing violence and harms perpetuated as a result of involvement in the criminal justice system remains. This dissertation contributes novel evidence towards recommendations for improving HIV care and supports within correctional facilities. Findings underscore previous calls for improved care for women living with HIV who are incarcerated in Canada (175,176), and point to steps that can be taken through collaboration between corrections and correctional health services to improve HIV health and overall well-being among women living with HIV during incarceration.

(a) Implement ongoing HIV education within correctional facilities

Chapter 2 underscores the importance of reducing HIV-related stigma in facilities as a crucial step in promoting access to continued HIV care during incarceration. Correctional facilities must commit to ongoing efforts to counteract HIV-related stigma by implementing sustained and comprehensive HIV educational programming for people who are incarcerated as well as facility staff. HIV-related stigma is fueled by misinformation and poor understanding of HIV transmission and treatment, and education is a key intervention to target myths and address knowledge gaps (293,294). An increase in education around HIV transmission and treatment for people who are incarcerated, as well as correctional and healthcare staff, will help to promote access to healthcare for people living with HIV that is free from fear and discrimination or isolation. The development and delivery of HIV education programming should center people with lived experience of HIV whenever possible, including through purposeful peer involvement (i.e., with people living with HIV) in educational programming (295).

(b) Create safer spaces for HIV disclosure to correctional healthcare staff, and improve confidentiality and privacy

The findings of *Chapter 2* further highlight a critical need to facilitate continued HIV care for women who are incarcerated. Correctional health services must ensure that healthcare spaces (i.e., at intake and health appointments) are adapted to support HIV disclosure to healthcare staff in order to promote treatment access and uptake. To encourage trust and facilitate disclosure of HIV status among women who are incarcerated, it is necessary for healthcare staff to employ a trauma-informed approach (226,270) with an emphasis on cultural safety (180). Recognizing that the reality of being incarcerated means limited autonomy and constant surveillance and supervision by

correctional staff (295), encouraging access to HIV care requires an emphasis on clear, ongoing, and accessible communication between healthcare staff and clients concerning the confidentiality of medical information within correctional facilities. Corrections and healthcare leadership and staff must work together to ensure the maximum possible privacy for people who are incarcerated, which includes addressing institutional processes that undermine medical privacy and reinforce stigma. People living with HIV must be able to access HIV healthcare without being forced to navigate concealment of their HIV status around others or having to weigh the risks of HIV disclosure to healthcare staff against access to HIV treatment and care while incarcerated.

Increase structural and gender-specific supports for marginalized women leaving correctional facilities

The findings of this dissertation point to fundamental and significant gaps in services and care for marginalized women leaving correctional facilities in BC, and findings from *Chapters 3 & 4* further underscore the urgent need for gender-specific interventions that address systematic structural inequities and experiences of trauma among women involved in the criminal justice system. Meaningful commitment from a municipal, provincial, and federal level to take necessary action to address the lack of services is essential to supporting women leaving corrections.

(a) Address gap in supports immediately post-release from correctional facilities

Findings from *Chapter 3* underscore the critical need for enhanced pre-release planning and supports upon release to improve safety and dignity and promote optimal outcomes related to HIV among women leaving correctional facilities. Findings highlight the immediate post-release period as a highly vulnerable time that increases risk of harms. In early 2021, 3 days after her release from Pine Grove Correctional Centre (the provincial facility dedicated to women in the province

of Saskatchewan), 34-year-old Indigenous woman and mother Kimberly Squirrel was found frozen outside after she had succumbed to illicit drug poisoning (i.e., overdose) (296). Her family was never notified of her release and insisted they would have provided transportation from the facility had they been informed. Kimberly Squirrel's death, which otherwise would have been preventable, signals the fatal consequences of limited pre-release planning and a lack of basic supports upon release from custody for marginalized women. This dissertation underscores previous calls for action on a national level surrounding added supports and pre-release planning for women leaving correctional facilities across Canada (276), including recent and urgent calls for Indigenous-specific supports for cis and trans women and Two-Spirit people upon release (297).

Central to supporting women at release, *Chapter 3* further underlines the critical importance of supportive relationships in the post-release period as crucial within the transition period (209,210). Dedicated funding from government, health authorities, and other agencies to support development and scale-up of programs for women leaving correctional facilities (with a focus on peer-led support programs such as Unlocking the Gates Services Society (298)) remains pressing. This includes an urgent need to re-allocate and increase funding to HIV organizations that provide outreach to correctional facilities and transitional support services via support workers as crucial to ensuring that the most marginalized women do not fall through the cracks in terms of their continuity of HIV care. These recommendations echo the 2020 calls from the Senate of Canada to the Federal Government to reaffirm its commitment to meeting the UNAIDS 90-90-90 targets by recommitting HIV funding support that was previously cut in 2019 (299), which included cuts to funding supports specifically for women living with HIV (230).

(b) Increase availability of structural supports and interventions

The findings outlined in *Chapters 3* & *4* complement and build on each other to elucidate the challenges for women who face unsafe housing or homelessness in the post-release period. Housing instability and unsafe housing increase the risk of experiencing violence, along with being a key factor undermining optimal ART adherence. Obtaining housing following release from correctional facilities in Canada constitutes a significant challenge (22), and official recommendations have been made to ensure that people leaving correctional facilities have housing upon release (22). In the context of ongoing violence perpetuated against marginalized women, meaningful commitments from government agencies to increase the availability of accessible, safe, and supportive housing for women is urgently needed. This includes housing models rooted in trauma-informed care and practice (199,226) that include culturally appropriate programs and services (192,193) and HIV supports as needed (220). Although this research did not explore the experiences of incarceration and parenthood, reunification with children is of critical concern for many women who experience incarceration (194,300), and as such there is a need for housing options that can accommodate and are suitable for children (263,264). Housing also needs to be gender-affirming and safe for trans, Two-Spirit, and gender diverse people (265). Finally, findings from *Chapter 3* & *4* further highlight the relationship between criminalized substance use, sub-optimal HIV health outcomes, and perpetuated cycles of incarceration. Increased supports including access to substance use treatment, harm reduction services (71,266), and low-barrier housing options (220) that are client-centered and tailored to the needs of women who experience incarceration are essential.

5.4 Strengths and Limitations

Although I have previously outlined the specific strengths and limitations of each empirical chapter (*Chapters 2–4*), this section highlights several strengths and limitations of the body of research presented in this dissertation as a whole. As outlined above, drawing on mixed methods research through the use of both qualitative and quantitative methods is a key strength of this dissertation; relying on a single method (qualitative or quantitative) would not have provided the same depth of analysis to address the complexities and unique experiences of women living with HIV along incarceration trajectories. Employing mixed methods is central to the applicability of these findings for policy and practice, because it provides unique insights for change making. A challenge of mixed methods research is that it requires added skillsets of both qualitative and quantitative training, along with additional resources and time (147). I have been fortunate to be able to draw on the expertise and guidance of my committee and colleagues in helping me build these skillsets.

As highlighted throughout this dissertation, a strength of this work is the community-based participatory approach. Women living with HIV were involved throughout this research as SHAWNA staff and via participation in the incarceration-focused Positive Advisory Working Group. The purposeful inclusion of women living with HIV throughout this doctoral research—including in the study design, co-development of the semi-structured interview guide, data collection, discussions of findings, and through knowledge dissemination (via co-authorship of empirical chapters, and involvement in the animated video process)—tremendously enriched the findings of this dissertation. The meaningful inclusion of women living with HIV in this research

is essential to ensuring that findings are relevant to the community and significant for directing policy change.

The SHAWNA Project is supported by a wonderful and committed team of researchers and staff who have worked to build and maintain trusting relationships with cohort participants over the years (e.g., through extensive outreach, and by helping to facilitate access to services). Interviewers with long-standing community relationships, including one Indigenous woman living with HIV with experience of incarceration, conducted the qualitative interviews with SHAWNA participants. The efforts to ensure that participants feel safe and supported through participation in this research helps build rapport within the data collection process and in this way enhances the credibility of the findings (301). All together, these aspects are likely to have further enhanced the richness and credibility of the data.

The ability to draw on longitudinal data via the SHAWNA Project is an important strength of this research, allowing for more complex quantitative analysis. Although the path analysis in *Chapter 4* could have explored additional variables and pathways for a fuller understanding of the factors that influence ART post-release, the use of path analysis in this dissertation allowed for a greater understanding of key factors that contribute to sub-optimal HIV outcomes for women living with HIV post-release from incarceration. However, while the path analysis assumed a direction from incarceration to HIV outcomes, all variables are measured in the same time-frame (i.e., within the last 6 months at follow-up), and therefore it is not possible to know for sure that incarceration occurred prior to the mediators or the outcome of sub-optimal adherence[39]. To mitigate this, I

[39] However, within the SHAWNA study (ongoing), adherence is reported and measured in the last 3–4 weeks at follow-up, whereas experiences of incarceration are reported for any time in the last 6 months at follow-up. As such,

explored the possibility of conducting the path analysis with the event of recent incarceration at Time 1 while looking at the ART adherence variable at Time 2; however, insufficient statistical power rendered this option unfeasible due to the small number of participants who had an event of recent incarceration.

I also explored the possibility of stratifying the path analysis to consider if the relationships were the same according to race (including Indigenous identity). Again, this option was limited by the small number of participants with a recent event of incarceration. Of note, Black and otherwise racialized participants make up less than 10% of the SHAWNA cohort, and experience of incarceration among this group in SHAWNA is low[40]. Due to the small number of Black and otherwise racialized participants who had experienced a recent incarceration at the time of recruitment for the qualitative interviews, no Black or otherwise racialized women participated in the qualitative interviews. This highlights a limitation of the sample and limits the generalizability of the findings.

A final note on Indigenous identity and race-based data. In accordance with the Canadian Institute for Health Information (CIHI) Proposed Standards for Race-Based and Indigenous Identity Data Collection and Health Reporting in Canada (302), the SHAWNA project includes Indigenous identity [i.e., First Nations, Métis, and Inuit] within race-based data collection and reporting, while recognizing that categorizing Indigenous identity within "race" does not fully capture the complexity and diversity of Indigenous communities, membership and Nations. As outlined by

there is an argument for temporality here, as in the chance of a recent experience of incarceration occurring prior to sub-optimal adherence is more likely and then other way around.

[40] Only three participants in SHAWNA who are Black or otherwise racialized (excluding Indigenous participants) have experienced incarceration.

CIHI, data collection and reporting around Indigenous identity continues to evolve and change with input from Indigenous communities, and the SHAWNA project will shift and adapt its data collection and reporting practices accordingly.

Concerning gender, as previously described, eligibility for the SHAWNA Project is self-identified cis and trans women. The vast majority of SHAWNA participants who took part in the qualitative interviews identified as cis women, and no participants identified as trans. The two participants who self-identified as Two-Spirit at the time of the qualitative interview (via the brief demographic questionnaire) had only ever been incarcerated overnight in jail cells. This limited my ability to analyze the qualitative data in an in-depth way based on gender identity. Similarly, concerning the path analysis, as outlined in *Chapter 4* (Section 4.4.1), only a small number of trans, Two-Spirit, and gender diverse individuals had experienced a recent incarceration, making additional analysis challenging on the basis of gender. Overall, the findings of this dissertation do not adequately capture or do justice to the experiences of trans, Two-Spirit, and gender diverse participants in SHAWNA who experience incarceration.

Further, the application of intersectional analyses in scientific research is complex and evolving (303,304), and for quantitative analysis it depends on sample size, composition of the study population, study design, and statistical power. With the qualitative analysis, I attempted to draw on the principles of intersectionality as much as possible through the various stages of the coding process and interpretation of the data. This included, for example, paying close attention to any differences between the narratives of Indigenous and non-Indigenous participants, along with detailed review of the interviews with Two-Spirit participants. However, I was not able to fully explore the complex interrelationships between multiple social positionings such as race and

gender identity among SHAWNA participants who experienced incarceration. Although I did attempt to draw on intersectional frameworks when thinking through how to frame the findings and interventions in a way that would speak to and address the multiple facets of oppression that impact the lives of women involved in the criminal justice system. As such, centering the underpinnings of intersectionality throughout the interpretation of the data[41] constitutes a strength of this dissertation especially when it comes to the overall recommendations and framing of the findings.

Finally, recruitment for SHAWNA is limited to participants who are either living in or accessing their HIV care in Metro Vancouver. Although some participants who took part in the qualitative interview had been incarcerated in other provinces, most spoke to experiences of being incarcerated in BC at ACCW, which is a provincial facility located approximately 1 hour from Vancouver. As a result, the generalizability of the findings from this dissertation may not extend to other urban settings, or rural settings in Canada. Being incarcerated and released in a rural setting presents unique challenges that are not captured in the findings of this dissertation.

5.5 Directions for Future Research

Findings from this dissertation, along with the limitations highlighted above, provide important insights into directions for future research. To effectively address the gendered impacts of incarceration leading to sub-optimal HIV outcomes among women living with HIV who experience incarceration, there is a need for additional research on a global scale that focuses on women living with HIV along incarceration trajectories. Further, research that investigates the

[41] Acknowledging the limitations of that as a white researcher.

impacts of incarceration among people living with HIV of all genders should employ gender-based analysis at the reporting stage and speak to any discrepancies (94). To design comprehensive interventions with the aim of supporting *all* people living with HIV along incarceration trajectories, an emphasis on robust, high-quality research studies with large sample sizes that can support intersectional analysis (303,304) is critical. The ability to analyze results based on complex interrelationships between multiple social positionings including race, gender, and other facets of oppression will enable nuanced understanding of the unique and diverse needs among people living with HIV who experience incarceration, and will be instrumental to informing equitable policy and programs (140,304,305).

As outlined throughout this dissertation, there is growing attention to the significant and disproportionate representation of Indigenous people who experience incarceration as a result of ongoing colonial violence in Canada (37). Future research should highlight the specific experiences of Indigenous people—including Indigenous people living with HIV—along incarceration trajectories to better inform culturally safe interventions and supports that are Indigenous-specific and include Indigenous approaches to justice (306). Further, despite growing rates of incarceration among Black people—and especially Black women (46,47)—in Canada due to racist policing practices and historical and ongoing anti-Blackness in Canada (46), research that centres the unique experiences of Black people who have been—or who are presently—incarcerated in Canada remains limited, and pressing. There is also a need for research that elucidates the unique experiences of other racialized groups who face incarceration across Canada. Future research that involves people living with HIV along incarceration trajectories should

include the specific experiences and needs of Black and other racialized people living with HIV to develop appropriate and effective supports and interventions.

Although reports indicate that ongoing discrimination, violence, and human rights abuses are experienced by trans individuals who are incarcerated in Canada (22), there is an overall paucity of research and understanding of incarceration trajectories among trans, Two-Spirit, and gender diverse people, including individuals living with HIV. As mentioned in *Chapter 1,* the way that data on gender is collected and used in reporting statistics within the criminal justice system effectively maintains and perpetuates cis-normativity and the gender binary, making it challenging to speak to and reference the specific experiences and impacts of incarceration among trans, Two-Spirt, and gender diverse people. Correctional facilities should be mandated to collect and report data on gender that goes beyond the binary in order to improve visibility of gender minority populations, although data gathering around gender in carceral settings must be done in a safe and confidential way with guidance from trans, Two-Spirit, and gender diverse people with meaningful considerations for data collection around gender (307,308). Data on gender collected in a safe and ethical way could set a precedent in terms of evidence to support increased programming and effective interventions that are sensitive to the needs of trans, Two-Spirit, and gender diverse people involved in the criminal justice system. Research that centres the specific experience of trans, Two-Spirit, and gender diverse people living with HIV along incarceration trajectories is also necessary to ensure that supports and interventions designed for people living with HIV are gender-affirming, inclusive, and tailored to meet the needs of trans, Two-Spirit, and gender diverse people. Moreover, researchers centering people living with HIV along incarceration trajectories

should strive to ensure that their study design, analysis, and reporting, challenge the gender binary and draw on intersectional analyses whenever possible.

Finally, concerning policy implications, there is a need for research that focuses on the experiences of people—and especially women—living with HIV who experience incarceration outside of urban settings. This will highlight the unique experiences in more rural communities that may be characterized by limited post-release services and supports.

5.6 Knowledge Translation and Dissemination of Research Findings

The overarching goal of this dissertation was to generate knowledge that will have implications for ongoing and future efforts to support marginalized women along incarceration trajectories. As a trainee at the CGSHE, member of the UBC Transformative Health & Justice Research Cluster (309), and collaborator on the BC Centre for Disease Control Pathways to Sexually Transmitted and Blood Borne Infections Care in BC Corrections (310), I am embedded within a diverse network of academics, community partners—including people with lived experience of incarceration—and organizations committed to and involved with community-based research and the care of people who experience incarceration. Drawing on these existing supports and established networks, I employed a multipronged participatory knowledge translation approach to disseminate the key findings of this dissertation in strategic ways aimed at informing policy, practice, and advocacy.

I continue to disseminate findings from each empirical chapter through traditional academic routes, including publications in peer-reviewed journals as well as presentations at academic conferences. To tailor findings for policy makers, I worked with the CGSHE communications team to translate

the findings from *Chapter 2* into a Research to Policy Brief (See *Appendix A*) in conjunction with the publication of this study in the *Canadian Journal of Public Health*. I circulated the brief to leadership responsible for healthcare delivery in BC Corrections, and distributed it through relevant networks and collaborating working groups. Similar briefs will be produced and circulated when findings from *Chapter 3 & 4* are published in their respective journals.

Finally, as described in *Chapter 1*, I built on existing CBPR research methods embedded in the SHWANA Project to mobilize knowledge through innovative and visual representations of research findings by way of graphic storytelling and animation. Through collaboration and co-facilitation with the SHAWNA Community Engagement Associates and participation from members of the incarceration-focused Positive Women's Advisory Group (SHAWNA participants with lived experience of incarceration), we worked with a graphic illustration team (*Drawing it Out*) to develop and produce a short animated video (200 word script), highlighting key findings from this dissertation. Through multiple meetings, working group members had the final say on all aspects of the animated video, including developing and approving the script, participating in multiple rounds of feedback on each iteration of the animation, recording music and voiceover for the narration (at a professional recording studio), and approving the final cut of the animation. The animated video serves as a visual accompaniment to this dissertation, grounded in CBPR, and will be circulated and disseminated through various avenues (including via social media platforms) to community and relevant stakeholders. The storyboard of the animation—which is a static scene-by-scene depiction of the animation inclusive of script and animation description—is presented in *Appendix B.*

5.7 Conclusions

The findings of this dissertation contribute important empirical evidence that extends the limited existing body of research documenting the complex ways in which social and structural factors profoundly shape the unique experiences of women living with HIV along incarceration trajectories. The results illustrate how HIV-related stigma within correctional facilities, reinforced by institutional processes that compromise privacy and confidentiality, shape experiences and continued HIV care. Findings further elucidate how key intersecting structural barriers and heightened vulnerability following release from incarceration place women at further risk of harms, perpetuate re-incarceration, and contribute to interruptions in HIV treatment and care. This research calls for changes to institutional processes within correctional facilities, increased gender-specific and culturally safe structural interventions for women post-release from incarceration, and efforts to redress the overcriminalization of marginalized women and end the ongoing violence perpetuated by the criminal justice system.

References

1. Penal Reform International. Global Prison Trends 2021. London; 2021. Available from: www.penalreform.org/global-prison-trends-2021
2. World Health Organization. People in prisons and other closed settings. 2020. Available from: https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/people-in-prisons
3. The Correctional Investigator Canada. Office of the Correctional Investigator Annual Report 2014–2015. Ottawa; 2015. Available from: https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20142015-eng.pdf
4. The Correctional Investigator Canada. Office of the Correctional Investigator Annual Report 2017-2018. Ottawa; 2018. Available from: http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20172018-eng.aspx#s8
5. The Sentencing Project. Fact Sheet: Incarcerated Women and Girls. Washington, DC; 2020. Available from: https://www.sentencingproject.org/wp-content/uploads/2016/02/Incarcerated-Women-and-Girls.pdf
6. Bloom B, Owen B, Covington S. Women offenders and the gendered effects of public policy. Rev Policy Res. 2004;21(1):31–48.
7. United Nations Development Program. Mapping of Good Practices for the Management of Transgender Prisoners. Bangkok; 2020. Available from: https://www.th.undp.org/content/thailand/en/home/library/democratic_governance/mapping-of-good-practices-for-the-management-of-transgender-pris.html
8. Van Hout MC, Crowley D. The “double punishment” of transgender prisoners: a human rights-based commentary on placement and conditions of detention. Int J Prison Health. 2021;17(4).
9. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. The Report of the 2015 U.S. Transgender Survey. Washington, DC; 2016.
10. Reisner SL, Bailey Z, Sevelius J. Racial/Ethnic Disparities in History of Incarceration, Experiences of Victimization, and Associated Health Indicators Among Transgender Women in the U.S. Women Health. 2014 Nov 17;54(8):750–67.
11. Bureau of Justice Statistics. Prison Rape Elimination Act Data Collection Activities, 2015. 2015 Jun. Available from: https://bjs.ojp.gov/content/pub/pdf/pdca15.pdf
12. Boyer Y, Odeyemi AS, Fletcher E, Fletcher J. Vulnerable targets: Trans prisoner safety, the law, and sexual violence in the prison system. Can J Women Law. 2019;31(2):386–412.
13. Penal Reform International. Women in prison: incarcerated in a man’s world. Vol. 1, Penal Reform Briefing No 3. London: Penal Reform International; 2008. Available from: https://www.penalreform.org/wp-content/uploads/2013/06/brf-03-2008-women-in-prison-en.pdf
14. Currie J. Women Offenders: characteristics, needs and impacts of transitional housing. Victoria; 2004. Available from: https://publications.gc.ca/collections/collection_2011/schl-cmhc/nh18-1-2/NH18-1-2-110-2004-eng.pdf
15. Herbst JH, Branscomb-Burgess O, Gelaude DJ, Seth P, Parker S, Fogel CI. Risk profiles of women experiencing initial and repeat incarcerations: Implications for prevention

programs. AIDS Educ Prev. 2016;28(4):299–311.
16. McKendy L, Ricciardelli R. Women Offenders Under Community Supervision: Comparing the Profiles of Returners and Non-Returners to Federal Prison. Front Psychiatry. 2019;0:875.
17. Wright EM, Van Voorhis P, Salisbury EJ, Bauman A. Gender-Responsive Lessons Learned and Policy Implications for Women in Prison: A Review. Crim Justice Behav. 2012;39(12):1612–32.
18. Corsten J. The Corston Report: A review of women with particular vulnerabilities in the criminal justice system. London: Sage Publications; 2007. Available from: https://webarchive.nationalarchives.gov.uk/+/http://www.homeoffice.gov.uk/documents/corston-report/
19. Kajstura A. Women's Mass Incarceration: The Whole Pie 2017. 2017. Available from: https://www.aclu.org/sites/default/files/field_document/womenprisonreport_final.pdf
20. Correctional Service Canada. Prevalence of mental disorder among federal women offenders: Intake and in-custody. Ottawa; 2018. Available from: https://www.csc-scc.gc.ca/005/008/092/r-420-en.pdf
21. Fazel S, Yoon IA, Hayes AJ. Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. Addiction. 2017;112(10):1725–39.
22. Standing Senate Committee on Human Rights. Human Rights of Federally-Sentenced Persons. Ottawa; 2021. Available from: https://sencanada.ca/en/info-page/parl-43-2/ridr-federally-sentenced-persons/
23. Butler A. Mental health needs, substance use patterns, and risk of reincarceration among adults admitted to provincial prisons in British Columbia, Canada. Simon Fraser University; 2021.
24. Correctional Service Canada. Comparing Lifetime Substance Use Patterns of Men and Women Offenders. Ottawa; 2015 Mar. Available from: https://www.csc-scc.gc.ca/005/008/092/005008-rb14-44-eng.pdf
25. Gobeil R, Blanchette K, Stewart L. A Meta-Analytic Review of Correctional Interventions for Women Offenders: Gender-Neutral Versus Gender-Informed Approaches. Crim Justice Behav. 2016;43(3):301–22.
26. Johnson JE, Carney T, Kline T, Browne FA, Wechsberg WM. Incarceration history relative to health, substance use, and violence in a sample of vulnerable South African women: implications for health services in criminal justice settings. Subst Abuse Rehabil. 2012;3(Suppl 1):59–69.
27. Strathdee SA, West BS, Reed E, Moazan B, Azim T, Dolan K. Substance use and HIV among female sex workers and female prisoners: Risk environments and implications for prevention, treatment, and policies. J Acquir Immune Defic Syndr. 2015;69(0 1):S110–7.
28. Cram S, Farrell MacDonald S. Substance Use Patterns of Indigenous and Non-Indigenous Women Offenders. 2019 Jun. Available from: https://www.csc-scc.gc.ca/005/008/092/rib-19-08-en.pdf
29. Canadian Centre for Justice and Community Safety Statistics. Adult and youth correctional statistics in Canada, 2018/2019. Statistics Canada. 2020. Available from: https://www150.statcan.gc.ca/n1/pub/85-002-x/2020001/article/00016-eng.htm
30. Correctional Service Canada. Statistics and research on women offenders. Government of

Canada. 2019. Available from: https://www.csc-scc.gc.ca/women/002002-0008-en.shtml
31. John Howard Society of Ontario. Standing Committee on Prison Conditions in Ontario - Second Report to the Board - Remand in Ontario. 2007; Available from: http://www.johnhoward.on.ca/Library/library.htm
32. Correctional Service Canada. Exposure to Trauma among Women Offenders: A Review of the Literature. Ottawa; 2014 Aug. Available from: https://www.csc-scc.gc.ca/005/008/092/005008-0333-eng.pdf
33. Ervin S, Jagannath J, Zweig J, Willison JB, Jones KB, Maskolunas K, et al. Addressing Trauma and Victimization in Women's Prisons: Trauma-Informed Victim Services and Programs for Incarcerated Women. 2020 Oct. Available from: https://www.urban.org/research/publication/addressing-trauma-and-victimization-womens-prisons/view/full_report
34. McMillan TM, Aslam H, Crowe E, Seddon E, Barry SJE. Associations between significant head injury and persisting disability and violent crime in women in prison in Scotland, UK: a cross-sectional study. The lancet Psychiatry. 2021;8(6):512–20.
35. Green BL, Dass-Brailsford P, De Mendoza AH, Mete M, Lynch SM, DeHart DD, et al. Trauma experiences and mental health among incarcerated women. Psychol Trauma Theory, Res Pract Policy. 2016 Jul 1;8(4):455–63.
36. Erickson M, Pick N, Ranville F, Martin RE, Braschel M, Kestler M, et al. Violence and other social structural factors linked to incarceration for women living with HIV in Metro Vancouver: need for trauma-informed HIV care in prisons and post-Release. AIDS Care. 2020;32(9):1–9.
37. National Inquiry into Missing and Murdered Indigenous Women and Girls. Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1b. Vol. 1b. 2019. Available from: https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1b.pdf
38. Bodkin C, Pivnick L, Bondy SJ, Ziegler C, Martin RE, Jernigan C, et al. History of Childhood Abuse in Populations Incarcerated in Canada: A Systematic Review and Meta-Analysis. Am J Public Health. 2019;109(3):e1–11.
39. British Columbia's Office of the Human Rights Commissioner. Equity is safer: Human rights considerations for policing reform in British Columbia. Vancouver; 2021 Nov. Available from: https://bchumanrights.ca/publications/scorpa/
40. Statistics Canada. Aboriginal Peoples in Canada: First Nations People, Metis and Inuit. Census Program. 2011. Available from: https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm
41. The Correctional Investigator. Proportion of Indigenous Women in Federal Custody Nears 50%: Correctional Investigator Issues Statement. Government of Canada. 2021. Available from: https://www.oci-bec.gc.ca/cnt/comm/press/press20211217-eng.aspx
42. National Inquiry into Missing and Murdered Indigenous Women and Girls. Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls, Volume 1a. 2019. Available from: https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf
43. Reece R. Carceral Redlining: White Supremacy is a Weapon of Mass Incarceration for Indigenous and Black Peoples in Canada. Yellowhead Institute. 2020. Available from: www.yellowheadinstitute.org

44. Arriagada P. First Nations, Métis and Inuit Women. 2016. Available from: https://www150.statcan.gc.ca/n1/pub/89-503-x/2015001/article/14313-eng.htm
45. Truth and Reconciliation Commission of Canada. Honouring the Truth , Reconciling for the Future: Summary of the Final Report of the Turth and Reconciliation Commision of Canada. 2015. Available from: www.trc.ca
46. Maynard R. Policing Black Lives: State Violence in Canada from Slavery to the Present. Halifax: Fernwood Publishing; 2017.
47. The Correctional Investigator Canada. A Case Study of Diversity in Corrections: The Black Inmate Experience in Federal Penitentiaries. 2013. Available from: http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20131126-eng.aspx#toc4b
48. Owusu-Bempah A, Jung M, Sbaï F, Wilton AS, Kouyoumdjian F. Race and Incarceration: The Representation and Characteristics of Black People in Provincial Correctional Facilities in Ontario, Canada. Race Justice. 2021;1–13.
49. Jürgens R, Nowak M, Day M. HIV and incarceration: prisons and detention. J Int AIDS Soc. 2011;14:26.
50. Rubenstein LS, Amon JJ, McLemore M, Eba P, Dolan K, Lines R, et al. HIV, prisoners, and human rights. Lancet. 2016;388(10050):1202–14.
51. UNAIDS. The Gap Report 2014. UNAIDS. Geneva; 2014.
52. UNODC; UNAIDS. Women and HIV in prison settings. Austria; 2008. Available from: https://www.unodc.org/documents/middleeastandnorthafrica/drug-prevention-health-publications/WOMEN_AND_HIV_IN_PRISON_SETTINGS.pdf
53. Beyrer C, Kamarulzaman A, McKee M. Prisoners, prisons, and HIV: time for reform. Lancet. 2016;388(10049):1033–5.
54. Correctional Service Canada. Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey. Ottawa; 2010. Available from: http://publications.gc.ca/collections/collection_2010/scc-csc/PS83-3-211-eng.pdf
55. Kouyoumdjian F, Frcpc C, Schuler A, Matheson FI, Hwang SW. Health status of prisoners in Canada: Narrative review. Clin Rev. 2016 Mar;62.
56. Gormley R, Lin SY, Carter A, Nicholson V, Webster K, Martin RE, et al. Social Determinants of Health and Retention in HIV Care Among Recently Incarcerated Women Living with HIV in Canada. AIDS Behav. 2020;24(4):1212–25.
57. Beckwith C, Castonguay BU, Trezza C, Bazerman L, Patrick R, Cates A, et al. Gender differences in HIV care among criminal justice-involved persons: Baseline data from the CARE+ correction Study. PLoS One. 2017;12(1):1–15.
58. Sprague C, Scanlon ML, Radhakrishnan B, Pantalone DW. The HIV Prison Paradox: Agency and HIV-Positive Womens Experiences in Jail and Prison in Alabama. Qual Health Res. 2016;27(10):1427–44.
59. Aziz M, Smith KY. Challenges and successes in linking HIV-infected women to care in the united states. Clin Infect Dis. 2011;52(SUPPL. 2):231–7.
60. Carter A, Eun Min J, Chau W, Lima VD, Kestler M, Pick N, et al. Gender Inequities in Quality of Care among HIV-Positive Individuals Initiating Antiretroviral Treatment in British Columbia, Canada (2000–2010). PLoS One. 2014;9(3):e92334.
61. Turner BJ, Laine C, Cosler L, Hauck WW. Relationship of gender, depression, and health care delivery with antiretroviral adherence in HIV-infected drug users. J Gen Intern Med. 2003;18(4):248–57.

62. Lichtenstein B. Domestic violence in barriers to health care for HIV-positive women. AIDS Patient Care STDs. 2006;20(2):122-132 11p.
63. Machtinger EL, Wilson TC, Haberer JE, Weiss DS. Psychological Trauma and PTSD in HIV-Positive Women: A Meta-Analysis. AIDS Behav. 2012;16(8):2091–100.
64. Krüsi A, Ranville F, Gurney L, Lyons T, Shoveller J, Shannon K. Positive sexuality: HIV disclosure, gender, violence and the law-A qualitative study. PLoS One. 2018;13(8):e0202776.
65. Public Health Agency of Canada. HIV and AIDS in Canada: Surveillance Report to December 31, 2013. Ottawa; 2014. Available from: https://www.canada.ca/content/dam/canada/health-canada/migration/healthy-canadians/publications/diseases-conditions-maladies-affections/hiv-aids-surveillance-2014-vih-sida/alt/hiv-aids-surveillance-2014-vih-sida-eng.pdf
66. Logie CH, James Ll, Tharao W, Loutfy MR. HIV, gender, race, sexual orientation, and sex work: A qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada. Daniels K, editor. PLoS Med. 2011;8(11):e1001124.
67. Meyer JP, Zelenev A, Wickersham JA, Williams CT, Teixeira PA, Altice FL. Gender Disparities in HIV Treatment Outcomes Following Release from Jail: Results from a Multicenter Study. Am J Public Health. 2014;104(3):434–41.
68. Fu JJ, Herme M, Wickersham JA, Zelenev A, Althoff A, Zaller ND, et al. Understanding the revolving door: individual and structural-level predictors of recidivism among individuals with HIV leaving jail. AIDS Behav. 2013;17 Suppl 2(0 2):S145-55.
69. Duff P, Goldenberg S, Deering K, Montaner J, Nguyen P, Dobrer S, et al. Barriers to Viral Suppression Among Female Sex Workers. JAIDS J Acquir Immune Defic Syndr. 2016;73(1):83–90.
70. Cornelius T, Jones M, Merly C, Welles B, Kalichman MO, Kalichman S. Impact of Food, Housing, and Transportation Insecurity on ART Adherence: A Hierarchical Resources Approach HHS Public Access. AIDS Care. 2017;29(4):449–57.
71. Zhao Y. Housing Precarity, Correlates, and Unmet Health Care and HIV Care Needs among Women Living with HIV in Metro Vancouver, Canada. University of British Columbia; 2021.
72. Kerkerian G, Kestler M, Carter A, Wang L, Kronfli N, Sereda P, et al. Attrition Across the HIV Cascade of Care Among a Diverse Cohort of Women Living With HIV in Canada. JAIDS J Acquir Immune Defic Syndr. 2018;79(2):226–36.
73. Haley DF, Golin CE, Farel CE, Wohl DA, Scheyett AM, Garrett JJ, et al. Multilevel challenges to engagement in HIV care after prison release: a theory-informed qualitative study comparing prisoners' perspectives before and after community reentry. BMC Public Health. 2014;14(1):1253.
74. Friedman MS, Marshal MP, Stall R, Kidder DP, Henny KD, Courtenay-Quirk C, et al. Associations between substance use, sexual risk taking and HIV treatment adherence among homeless people living with HIV. AIDS Care. 2009;21(6):692–700.
75. Goldenberg SM, Montaner J, Duff P, Nguyen P, Dobrer S, Guillemi S, et al. Structural Barriers to Antiretroviral Therapy Among Sex Workers Living with HIV: Findings of a Longitudinal Study in Vancouver, Canada. AIDS Behav. 2016;20(5):977–86.
76. Chitsaz E, Meyer JP, Krishnan A, Springer SA, Marcus R, Zaller N, et al. Contribution of substance use disorders on HIV treatment outcomes and antiretroviral medication

adherence among HIV-infected persons entering jail. AIDS Behav. 2013;17 Suppl 2(2):S118-27.
77. Zhang Y, Wilson TE, Adedimeji A, Merenstein D, Milam J, Cohen J, et al. The impact of substance use on adherence to antiretroviral therapy among HIV-infected women in the United States. AIDS Behav. 2018;22(3):896.
78. Gonzalez A, Mimiaga MJ, Israel J, Andres Bedoya C, Safren SA. Substance use predictors of poor medication adherence: The role of substance use coping among HIV-infected patients in Opioid dependence treatment. AIDS Behav. 2013 Jan;17(1):168–73.
79. Hogg RS, Milloy M-J, Kerr T, Zhang R, Guillemi S, Hogg RS, et al. Rates of Disease Progression by Baseline CD4 Cell Count and Viral Load After Initiating Triple-Drug Therapy. JAMA. 2001;286(20):2568.
80. Hull MW, Wu Z, Montaner JSG. Optimizing the engagement of care cascade: a critical step to maximize the impact of HIV treatment as prevention. Curr Opin HIV AIDS. 2012;7:579–86.
81. Uthman OA, Oladimeji O, Nduka C. Adherence to antiretroviral therapy among HIV-infected prisoners: a systematic review and meta-analysis. AIDS Care. 2017;29(4):1–9.
82. Fuge TG, Tsourtos G, Miller ER. A systematic review and meta-analyses on initiation, adherence and outcomes of antiretroviral therapy in incarcerated people. Baggio S, editor. PLoS One. 2020 May;15(5):e0233355.
83. Muessig KE, Rosen DL, Farel CE, White BL, Filene EJ, Wohl DA. "Inside These Fences is Our Own Little World": Prison-Based HIV Testing and HIV-Related Stigma Among Incarcerated Men and Women. AIDS Educ Prev. 2016;28(2):103–16.
84. Roberson DW, White BL, Fogel CI. Factors Influencing Adherence to Antiretroviral Therapy for HIV-Infected Female Inmates. J Assoc Nurses AIDS Care. 2009;20(1):50–61.
85. Small W, Wood E, Betteridge G, Montaner J, Kerr T. The impact of incarceration upon adherence to HIV treatment among HIV-positive injection drug users: A qualitative study. AIDS Care - Psychol Socio-Medical Asp AIDS/HIV. 2009 Jun;21(6):708–14.
86. Westergaard RP, Kirk GD, Richesson DR, Galai N, Mehta SH. Incarceration Predicts Virologic Failure for HIV-Infected Injection Drug Users Receiving Antiretroviral Therapy. Clin Infect Dis. 2011;53(7):725–31.
87. Joseph B, Kerr T, Puskas CM, Montaner J, Wood E, Milloy MJ. Factors linked to transitions in adherence to antiretroviral therapy among HIV-infected illicit drug users in a Canadian setting. AIDS Care - Psychol Socio-Medical Asp AIDS/HIV. 2015;27(9):1128–36.
88. Milloy MJ, Kerr T, Buxton J, Rhodes T, Guillemi S, Hogg R, et al. Dose-response effect of incarceration events on nonadherence to HIV antiretroviral therapy among injection drug users. J Infect Dis. 2011;203(9):1215–21.
89. Spaulding AC, Messina LC, Kim BI, Chung K-W, Lincoln T, Teixeira P, et al. Planning for Success Predicts Virus Suppressed: Results of a Non-Controlled, Observational Study of Factors Associated with Viral Suppression Among HIV-Positive Persons Following Jail Release. AIDS Behav. 2013;17(S2):203–11.
90. Dennis AC, Barrington C, Hino S, Gould M, Wohl D, Golin CE. "You're in a world of chaos": experiences accessing HIV care and adhering to medications after incarceration. J Assoc Nurses AIDS Care. 2015;26(5):542–55.
91. Erickson M, Pick N, Ranville F, Brashcel M, Kestler M, Kinvig K, et al. Recent

Incarceration as a Primary Barrier to Virologic Suppression Among Women Living with HIV: Results from a Longitudinal Community-Based Cohort in a Canadian Setting. AIDS Behav. 2020;24(4):1243–1251.
92. Erickson M, Shannon K, Sernick A, Pick N, Ranville F, Martin RE, et al. Women, incarceration and HIV: a systematic review of HIV treatment access, continuity of care and health outcomes across incarceration trajectories. AIDS. 2019;33(1):101–11.
93. Moher M, Erickson M, Black P, Price M, Fraser C, Norman W V., et al. Improving Post-Release Care Engagement for People Living with HIV Involved in the Criminal Justice System: A Systematic Review. AIDS Behav. 2021;Online Fir.
94. Heidari S, Babor TF, De Castro P, Tort S, Curno M. Sex and Gender Equity in Research: rationale for the SAGER guidelines and recommended use. Res Integr Peer Rev. 2016;1(1):2.
95. Williams CT, Kim S, Meyer J, Spaulding A, Teixeira P, Avery A, et al. Gender differences in baseline health, needs at release, and predictors of care engagement among HIV-positive clients leaving jail. AIDS Behav. 2013;17 Suppl 2(0 2):S195-202.
96. Lichtenstein B, Malow R. A Critical Review of HIV-Related Interventions for Women Prisoners in the United States. J Assoc Nurses AIDS Care. 2010 Sep;21(5):380–94.
97. Nowatzki N, Grant KR. Sex is not enough: The need for gender-based analysis in health research. Health Care Women Int. 2011;32(4):263–77.
98. UNODC, ILO, UNDP, WHO, UNAIDS. HIV prevention, treatment and care in prisons and other closed settings: a coprehensive package of interventions. Vienna; 2013.
99. Correctional Service Canada. Frequently asked questions. Government of Canada. 2019. Available from: https://www.csc-scc.gc.ca/media-room/009-0002-eng.shtml
100. Correctional Service Canada. Facilities and security. Government of Canada. 2021. Available from: https://www.csc-scc.gc.ca/facilities-and-security/index-eng.shtml
101. Correctional Service Canada. Institutional profiles: Prairie region: Okimaw Ohci Healing Lodge for Aboriginal Women. Government of Canada. 2017. Available from: https://www.csc-scc.gc.ca/institutions/001002-4007-en.shtml
102. BC Corrections. BC Corrections Profile 2021. Victoria; 2021. Available from: https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/corrections/reports-publications/bc-corrections-profile.pdf
103. El Fakhry Tuttle M. Transgender Inmates in Canada. Law Now - Relating law to life in Canada. 2021. Available from: https://www.lawnow.org/transgender-inmates-in-prison/
104. Prisoners' Legal Services. Trans prisoner rights: Information for federal prisoners in British Columbia. 2018. Available from: https://prisonjustice.org/wp-content/uploads/2019/01/Federal-Trans-Rights-2018.pdf
105. Correctional Service Canada. Gender Dysphoria. Government of Canada. 2017. Available from: https://www.csc-scc.gc.ca/acts-and-regulations/800-5-gl-eng.shtml
106. Adult Custody Division Corrections Branch Ministry of Justice. Adult Custody Policy. Victoria; 2013. Available from: http://docs.openinfo.gov.bc.ca/d26445513a_response_package_jag-2013-00337.pdf
107. United Nations Office on Drugs and Crime. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). Vienna; 2015. Available from: https://www.unodc.org/pdf/criminal_justice/UN_Standard_Minimum_Rules_for_the_Treatment_of_Prisoners.pdf

108. The Correctional Investigator Canada. Office of the Correctional Investigator Annual Report 2018-2019. Ottawa; 2019. Available from: https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20182019-eng.pdf
109. Scallan E, Lancaster K, Kouyoumdjian F. The "problem" of health: An analysis of health care provision in Canada's federal prisons: Heal An Interdiscip J Soc Study or Heal Illn Med. 2019;25(1):3–20.
110. Miller A. Prison health care inequality. CMAJ. 2013 Apr;185(6):E249–50.
111. Minister of Justice. Corrections and Conditional Release Act. Amended 2019 Government of Canada; 1992. Available from: https://laws-lois.justice.gc.ca/eng/acts/C-44.6/
112. McLeod KE, Martin RE, Butler A, Young JT, Southalan L, Borschmann R, et al. Global prison health care governance and health equity: A critical lack of evidence. Am J Public Health. 2020;110(3):303–8.
113. United Nations Office on Drugs and Crime WHO. Good governance for prison health in the 21st century: A policy brief on the organization of prison health. Copenhagen; 2013. Available from: http://www.euro.who.int/pubrequest
114. The College of Family Physicians of Canada. Position Statement on Health Care Delivery: Prison Health Program Committee, Community of Practice in Family Medicine . Mississauga; 2016. Available from: https://www.cfpc.ca/CFPC/media/Resources/Prison-Health/Health-Care-Delivery_EN_Prison-Health.pdf
115. Webster PC. Integrating prison health care into public health care: the global view. Can Med Assoc J. 2013;185(7):E283.
116. Rinfret M. Protecteur Citoyen: 2019-2020 Annual Report . 2020 Sep. Available from: https://publications.virtualpaper.com/protecteur-citoyen/annual_report_2020/#10/
117. McLeod KE, Martin RE. Health in correctional facilities is health in our communities. CMAJ. 2018;190(10):E274–5.
118. Lam R. B.C. Health Ministry to take responsibility for inmate health care. The Globe and Mail. 2018; Available from: https://www.theglobeandmail.com/news/national/bc-health-ministry-to-take-responsibility-for-inmate-health-care/article34207554/
119. Government of British Columbia. Continuity of care is the focus of inmate health-care change | BC Gov News. 2017. Available from: https://news.gov.bc.ca/releases/2017HLTH0044-000493
120. Provincial Health Services Authority. Our Unique Role. 2022. Available from: http://www.phsa.ca/about/who-we-are/our-unique-role
121. BC Mental Health and Substance Use Services. Correctional Health Services . Provincial Health Services Authority. Available from: http://www.bcmhsus.ca/our-services/health-services-for-people-in-custody/correctional-health-services
122. BC Mental Health and Substance Use Services. Community transition teams aim to prevent overdose deaths among people recently released from a correctional facility . Provincial Health Services Authority. 2019. Available from: http://www.bcmhsus.ca/news/Pages/Community-transition-teams-aim-to-prevent-overdose-deaths-among-people-recently-released-from-a-correctional-facility.aspx
123. Mcleod KE. The impact of prison health policy: a multimethod study of the context and outcomes of the transfer of healthcare services in British Columbia's provincial correctional facilities to the ministry of health. University of British Columbia; 2021.
124. Rhodes T, Simic M. Transition and the HIV risk environment. Vol. 331, British Medical

Journal. British Medical Journal Publishing Group; 2005. p. 220–3.
125. Rhodes T. The 'risk environment': a framework for understanding and reducing drug-related harm. Int J Drug Policy. 2002 Jun 1;13(2):85–94.
126. Parker R, Aggleton P. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. Soc Sci Med. 2003;57(1):13–24.
127. Collins PH. Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment. Second. New York: Routledge; 2000.
128. Hatzenbuehler ML, Link BG. Introduction to the special issue on structural stigma and health. Soc Sci Med. 2014 Feb;103:1–6.
129. Logie C, Gadalla TM. Meta-analysis of health and demographic correlates of stigma towards people living with HIV. Vol. 21, AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV. Taylor & Francis Group; 2009. p. 742–53.
130. Link B, Hatzenbuehler ML. Stigma as an unrecognized determinant of population health: Research and policy implications. J Health Polit Policy Law. 2016 Aug 1;41(4):653–73.
131. Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. Vol. 3, PLoS Medicine. Public Library of Science; 2006. p. 1686–91.
132. Eagleton T, Bourdieu P. Doxa and Common Life. New Left Rev. 1992;1(191):111–21.
133. Rhodes T, Wagner K, Strathdee S, Shannon K, Davidson P, Bourgois P. Structural violence and structural vulnerability within the risk environment: Theoretical and methodological perspectives for a social epidemiology of HIV risk among injection drug users and sex workers. Rethink Soc Epidemiol Towar a Sci Chang. 2012 Aug;205–30.
134. Farmer P. On suffering and structural violence: A view from below. Am Amademy Arts Sci MIT Press. 1996;125(1):261–83.
135. Armstrong S. At Risk of Rights: Rehabilitation, Sentence Management and the Structural Violence of Prison. Crit Criminol. 2020;28:85–105.
136. Scheper-Hughes N, Bourgois P. Introduction: Making Sense of Violence. Violence War Peace An Anthol. 2004;(January 2004):1–32.
137. Crenshaw K. Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum. 1989.
138. Hankivsky O. Intersectionality 101. Vol. 32, Journal of Public Policy and Marketing. The Institute for Intersectionality Research & Policy, SFU; 2014.
139. Lopez N, Gadsden VL. Health Inequities, Social Determinants, and Intersectionality. NAM Perspect. 2016;6(12).
140. Sen G, Iyer A, Mukherjee C. A Methodology to Analyse the Intersections of Social Inequalities in Health. J Hum Dev Capab. 2009 Nov 1;10(3):397–415.
141. Tremblay M-C, Martin DH, McComber AM, McGregor A, Macaulay AC. Understanding community-based participatory research through a social movement framework: a case study of the Kahnawake Schools Diabetes Prevention Project. BMC Public Heal 2018 181. 2018;18(1):1–17.
142. Marullo K, Cutforth SJ, Stoecker N, Donohue R. Principles of Best Practice for Community-Based Research. Vol. 9, Michigan Journal of Community Service Learning. 2003.
143. Springer M V., Skolarus LE. Community-based participatory research: Partnering with communities. Stroke. 2019;50(3):E48–50.

144. Creswell JW, Creswell DJ. Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. 5th ed. London: SAGE Publications Ltd.; 2018.
145. Dixon-Woods M, Agarwal S, Jones D, Young B, Sutton A. Synthesising qualitative and quantitative evidence: A review of possible methods. Vol. 10, Journal of Health Services Research and Policy. 2005. p. 45–53.
146. Shorten A, Smith J. Mixed methods research: Expanding the evidence base. Evid Based Nurs. 2017;20(3):74–5.
147. Regnault A, Willgoss T, Barbic S. Towards the use of mixed methods inquiry as best practice in health outcomes research. J Patient-Reported Outcomes. 2018 Dec 11;2(1):19.
148. Mertens DM. Transformative Mixed Methods Research. Qual Inq. 2010;16(6):469–74.
149. Burch P, Heinrich CJ. Introduction: The Demand for and Value of Fully Integrated Qualitative and Quantitative Research. In: Mixed Methods for Policy Research and Program Evaluation. Thousand Oaks: SAGE Publications, Inc.; 2017. p. 1–12.
150. DeJonckheere M, Vaughn LM. Semistructured interviewing in primary care research: a balance of relationship and rigour. Fam Med Community Heal. 2019 Mar 1;7(2):e000057.
151. Sim J, Waterfield J. Focus group methodology: some ethical challenges. Qual Quant. 2019 Jul 16;53(6):3003–22.
152. Avery AK, Ciomcia RW, Lincoln T, Desbrais M, Jordan AO, Rana AI, et al. Jails as an Opportunity to Increase Engagement in HIV Care: Findings from an Observational Cross-Sectional Study. AIDS Behav. 2013 Oct 28;17(S2):137–44.
153. Clark S. Overrepresentation of Indigenous People in the Canadian Criminal Justice System: Causes and Responses. Ottawa; 2019. Available from: https://www.justice.gc.ca/eng/rp-pr/jr/oip-cjs/index.html
154. Goffman E. Stigma: Notes on the management of a spoiled identity. New York: Simon & Schuster; 1963.
155. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. Am J Public Health. 2013;103(5):813–21.
156. Katz IT, Ryu AE, Onuegbu AG, Psaros C, Weiser SD, Bangsberg DR, et al. Impact of HIV-related stigma on treatment adherence: systematic review and meta-synthesis. J Int AIDS Soc. 2013 Nov;16(3 Suppl 2):18640.
157. Benoit C, Jansson SM, Smith M, Flagg J. Prostitution Stigma and Its Effect on the Working Conditions, Personal Lives, and Health of Sex Workers. Vol. 55, Journal of Sex Research. Routledge; 2018. p. 457–71.
158. Lipira L, Williams EC, Huh D, Kemp CG, Nevin PE, Greene P, et al. HIV-Related Stigma and Viral Suppression Among African-American Women: Exploring the Mediating Roles of Depression and ART Nonadherence. AIDS Behav. 2019;23(8):2025–36.
159. Hatala AR, Bird-Naytowhow K, Pearl T, Peterson J, Del Canto S, Rooke E, et al. Being and Becoming a Helper: Illness Disclosure and Identity Transformations among Indigenous People Living With HIV or AIDS in Saskatoon, Saskatchewan. Qual Health Res. 2018;28(7):1099–111.
160. Turpel-Lafond ME. In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care. 2020. Available from: https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf
161. Snyder E. The Impacts of the Criminalization of HIV Non-Disclosure on Indigenous People: A Case Study of Regina. 2018. Available from:

http://allnationshope.ca/userdata/files/187/HIV Non Disclosure Project/HIV Non-Disclosure Report - ESnyder.pdf%0Ahttp://allnationshope.ca/userdata/files/187/HIV Non Disclosure Project/HIV Non-Disclosure Report - ESnyder.pdf NS -
162. Culbert GJ. Violence and the perceived risks of taking antiretroviral therapy in US jails and prisons. Int J Prison Health. 2014;10(2):94–110.
163. Swan H. A Qualitative Examination of Stigma Among Formerly Incarcerated Adults Living With HIV. Sage Open. 2016;6(1):1–18.
164. Kemnitz R, Kuehl TC, Hochstatter KR, Barker E, Corey A, Jacobs EA, et al. Manifestations of HIV stigma and their impact on retention in care for people transitioning from prisons to communities. Heal Justice. 2017;5(1):7.
165. Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. Health Serv Res. 2007 Aug;42(4):1758–72.
166. Bourassa C, McKay-McNabb K, Hampton M. Racism, Sexism and Colonialism: The Impact on the Health of Aboriginal Women in Canada. Can Woman Stud. 2004;24(1).
167. UNAIDS. Global AIDS Update 2016. Geneva; 2016. Available from: http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf
168. Montaner JSG, Lima VD, Harrigan PR, Lourenço L, Yip B, Nosyk B, et al. Expansion of HAART Coverage Is Associated with Sustained Decreases in HIV/AIDS Morbidity, Mortality and HIV Transmission: The "HIV Treatment as Prevention" Experience in a Canadian Setting. Sluis-Cremer N, editor. PLoS One. 2014;9(2):e87872.
169. Harner H, Burgess AW. Using a Trauma-Informed Framework to Care for Incarcerated Women. J Obstet Gynecol Neonatal Nurs. 2011;40(4):469–76.
170. Chartrand V. Unsettled times: Indigenous incarceration and the links between colonialism and the penitentiary in Canada. Can J Criminol Crim Justice. 2019;61(3):67–89.
171. Statistics Canada. Women in Canada: A Gender-based Statistical Report. Women and the Criminal Justice System. 2017. Available from: https://www150.statcan.gc.ca/n1/pub/89-503-x/2015001/article/14785-eng.htm
172. Kendall S, Lighton S, Sherwood J, Baldry E, Sullivan EA, Sullivan EA. Incarcerated Aboriginal women's experiences of accessing healthcare and the limitations of the "equal treatment" principle. Int J Equity Health. 2020;19(1):48.
173. World Health Organization. Prisons and Health. Copenhagen; 2014. Available from: http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/prisons-and-health/facts-and-figures
174. United Nations Office on Drugs and Crime. HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response. Vienna; 2006. Available from: https://www.unodc.org/pdf/HIV-AIDS_prisons_Oct06.pdf
175. Dicenso AM, Dias G, Gahagan J, Mackay J, Jordi D', Lilly ', et al. Unlocking our future: A National study on women, prisons, HIV, and Hepatitis C. Toronto; 2003. Available from: https://www.drugsandalcohol.ie/5394/1/PASAN_Unlocking_Our_Futures.pdf
176. Paynter M, Heggie C, McKibbon S, Martin-Misener R, Iftene A, Murphy GT. Sexual and Reproductive Health Outcomes among Incarcerated Women in Canada: A Scoping Review. Can J Nurs Res. 2021 Jan 28;Online Fir.
177. Canadian HIV/AIDS Legal Network. Privacy protection and the disclosure of health information: legal issues for people living with HIV/AIDS in Canada. Montreal: Canadian HIV/AIDS Legal. 2002. Available from: http://www.hivlegalnetwork.ca/site/wp-

content/uploads/2013/04/PrivacyReport+-+ENG.pdf
178. Geter A, Herron AR, Sutton MY. HIV-Related Stigma by Healthcare Providers in the United States: A Systematic Review. AIDS Patient Care STDS. 2018;32(10):418–24.
179. Barreto D. The impact of structural inequities and interpersonal violence on food security and HIV care among women living with and affected by HIV in a Canadian Setting. [Vancouver]: University of British Columbia; 2017. Available from: https://open.library.ubc.ca/cIRcle/collections/ubctheses/24/items/1.0357238
180. First Nations Health Authority. FNHA's Policy Statement on Cultural Safety and Humility. 2016. p. 24. Available from: http://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf
181. Wright AL, Gabel C, Ballantyne M, Jack SM, Wahoush O. Using Two-Eyed Seeing in Research With Indigenous People: An Integrative Review. Int J Qual Methods. 2019;18:1–19.
182. Bagnall AM, South J, Hulme C, Woodall J, Vinall-Collier K, Raine G, et al. A systematic review of the effectiveness and cost-effectiveness of peer education and peer support in prisons. BMC Public Health. 2015;15(1).
183. Ross MW, Harzke AJ, Scott DP, McCann K, Kelley M. Outcomes of Project Wall Talk: an HIV/AIDS Peer Education Program Implemented within the Texas State Prison System. AIDS Educ Prev. 2006;18(6):504–17.
184. Conner KO, McKinnon SA, Ward CJ, Reynolds CF, Brown C. Peer Education as a Strategy for Reducing Internalized Stigma among Depressed Older Adults. Psychiatr Rehabil J. 2015 Jun 1;38(2):186–93.
185. Chartrand V. Abolition in the land known as Canada in the wake of COVID-19. Curr Issues Crim Justice. 2021;Online Fir.
186. Paynter M, Mussell L, Junter-Young N. If Canada is serious about confronting systemic racism, we must abolish prisons. SaltWire & The Conversation. 2020 Jul 8; Available from: https://www.saltwire.com/atlantic-canada/opinion/national-perspectives/if-canada-is-serious-about-confronting-systemic-racism-we-must-abolish-prisons-470943/
187. Kershnar S, Haines S, Harkins G, Greig A, Wiesner C, Levy M, et al. Toward Transformative Justice: A Liberatory Approach to Child Sexual Abuse and other forms of Intimate and Community Violence. 2007. Available from: http://www.generationfive.org/wp-content/uploads/2013/07/G5_Toward_Transformative_Justice-Document.pdf
188. Dolan K, Wirtz AL, Moazen B, Ndeffo-mbah M, Galvani A, Kinner SA, et al. Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees. Lancet. 2016;388(10049):1089–102.
189. UNODC. Fast track to end AIDS by 2030: For people in prisons. Vienna; 2019. Available from: www.unodc.org/unodc/en/hiv-aids/new/index.html
190. Australian Law Reform Commission. Disproportionate incarceration rate. Australian Government. 2018 Sep. Available from: https://www.alrc.gov.au/publication/pathways-to-justice-inquiry-into-the-incarceration-rate-of-aboriginal-and-torres-strait-islander-peoples-alrc-report-133/executive-summary-15/disproportionate-incarceration-rate/
191. Department of Corrections. Over-representation of Māori in the criminal justice system An exploratory report Policy, Strategy and Research Group Department of Corrections. 2007.

192. Truth and Reconciliation Commission of Canada. Truth and Reconciliation Commission of Canada: Calls to Action. Truth and Reconciliation Commission of Canada. 2015. Available from: http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf
193. Standing Committee on the Status of Women. A Call to Action: Reconciliation with Indigenous women in the federal justice and correctional systems. Ottawa; 2018. Available from: https://www.ourcommons.ca/Content/Committee/421/FEWO/Reports/RP9991306/feworp13/feworp13-e.pdf
194. Substance Abuse and Mental Health Services Administration. After Incarceration: A Guide to Helping Women Reenter the Community. Rockville; 2020 Apr. Available from: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-01-001_508.pdf
195. Pyper D, Lalic M. Research Briefing: Support for women leaving prison. 2021. Available from: https://commonslibrary.parliament.uk/research-briefings/cdp-2021-0032/
196. Ventura Miller H. Female Reentry and Gender-Responsive Programming: Recommendations for Policy and Practice. 2021. Available from: https://nij.ojp.gov/topics/articles/female-reentry-and-gender-responsive-programming
197. Martin R, Buxton J, Smith M, Hislop G. The scope of the problem: The health of incarcerated women in BC. BC Med J. 2012;54(10).
198. Janssen PA, Korchinski M, Desmarais SL, Albert AYK, Condello L-L, Buchanan M, et al. Factors that support successful transition to the community among women leaving prison in British Columbia: a prospective cohort study using participatory action research. C Open. 2017;5(3):E717–23.
199. Salem BE, Kwon J, Ekstrand ML, Hall E, Turner SF, Faucette M, et al. Transitioning into the Community: Perceptions of Barriers and Facilitators Experienced By Formerly Incarcerated, Homeless Women During Reentry—A Qualitative Study. Community Ment Health J. 2021;57(4):609–21.
200. Argento E, Reza-Paul S, Lorway R, Jain J, Bhagya M, Fathima M, et al. Confronting structural violence in sex work: lessons from a community-led HIV prevention project in Mysore, India. AIDS Care. 2011;23(1):69–74.
201. Quesada J, Hart LK, Bourgois P. Structural Vulnerability and Health: Latino Migrant Laborers in the United States. Med Anthropol. 2011;30(4):339.
202. Ortiz JM, Jackey H. The System Is Not Broken, It Is Intentional: The Prisoner Reentry Industry as Deliberate Structural Violence. Prison J. 2019;99(4):484–503.
203. Christian JM, Dowler L. Slow and fast violence: A feminist critique of binaries. Acme. 2019;18(Spicialissue5):1066–75.
204. Corbin J, Strauss A. Strategies for Qualitative Data Analysis. In: Basics of Qualitative Research (3rd ed): Techniques and Procedures for Developing Grounded Theory. 2012.
205. Thumath M, Humphreys D, Barlow J, Duff P, Braschel M, Bingham B, et al. Overdose among mothers: The association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada. Int J Drug Policy. 2020;91.
206. Kenny KS. Mental Health Harm to Mothers When a Child Is Taken by Child Protective Services: Health Equity Considerations. Can J Psychiatry. 2018;63(5):304–7.
207. Mussell L. Intergenerational Imprisonment: Resistance and Resilience in Indigenous Communities. J Law Soc Policy. 2020;33:15–37.

208. El Muggabar R. Transformative Justice: Practices in Interpersonal & Community Repair. Toronto: Free Up! Abolition & Transformative Justice Series; 2021. Available from: https://www.eventbrite.ca/o/free-up-abolition-amp-transformative-justice-series-32954084063
209. Elwood Martin R, Korchinski M, Fels L, Leggo C. Releasing Hope: Stories of Transition from Pison to Community. Toronto: Inanna Publications and Education Inc.; 2019.
210. McLeod KE, Korchinski M, Young P, Milkovich T, Hemingway C, DeGroot M, et al. Supporting women leaving prison through peer health mentoring: a participatory health research study. C Open. 2020;8(1):E1–8.
211. British Columbia Coroners Service. Illicit Drug Toxicity Deaths in BC: January 1, 2011 - April 30, 2021. 2021 Jun. Available from: https://www2.gov.bc.ca/gov/content/life-
212. Centers for Disease Control and Prevention. CDC's Response to the Opioid Overdose Epidemic. Vol. 70, National Center for Injury Prevention and Control. Centers for Disease Control MMWR Office; 2021. Available from: https://www.cdc.gov/opioids/basics/epidemic.html
213. Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, et al. Release from Prison — A High Risk of Death for Former Inmates. N Engl J Med. 2007;356(2):157–65.
214. Gan WQ, Kinner SA, Nicholls TL, Xavier CG, Urbanoski K, Greiner L, et al. Risk of overdose-related death for people with a history of incarceration. Addiction. 2021;116(6):1460–71.
215. First Nations Health Authority. First Nations in BC and the Toxic Drug Crisis: January - December 2020. 2021. Available from: https://www.fnha.ca/AboutSite/NewsAndEventsSite/NewsSite/Documents/FNHA-First-Nations-in-BC-and-the-Toxic-Drug-Crisis-January-December-2020-Infographic.pdf
216. Homles T. Grieving mom says son who died in B.C. recovery house 'would've been better off homeless' – Nanaimo News Bulletin. Nanaimo News Bulletin. 2019 May 29; Available from: https://www.nanaimobulletin.com/news/grieving-mom-says-son-who-died-in-b-c-recovery-house-wouldve-been-better-off-homeless/
217. Woodward J. B.C. enticing private drug recovery homes to register | CTV News. CTV News. 2012 Dec 7; Available from: https://bc.ctvnews.ca/b-c-enticing-private-drug-recovery-homes-to-register-1.1071251
218. Meyer JP, Chen NE, Springer SA. HIV treatment in the criminal justice system: Critical knowledge and intervention gaps. Vol. 2011, AIDS Research and Treatment. 2011.
219. Nunn A, Cornwall A, Fu J, Bazerman L, Loewenthal H, Beckwith C. Linking HIV-positive jail inmates to treatment, care, and social services after release: results from a qualitative assessment of the COMPASS Program. J Urban Health. 2010;87(6):954–68.
220. Ghose T, Ali S, Shubert V, Stanton M, Walker L, Chaudhuri S. "It's my room and my life": Housing's influence on medication adherence for HIV-positive women released from incarceration. J Health Care Poor Underserved. 2019;30(1):182–201.
221. Thistle J, Smylie J. Pekiwewin (coming home): Advancing good relations with Indigenous people experiencing homelessness. Cmaj. 2020;192(10):E257–9.
222. Christensen J. "Our home, our way of life": spiritual homelessness and the sociocultural dimensions of Indigenous homelessness in the Northwest Territories (NWT), Canada. Soc Cult Geogr. 2013;14(7):804–28.

223. Bingham B. Indigenous and Gender Informed Approaches to Understanding Health, Social, and Mental Wellness Among Indigenous People Experiencing Homelessness and Mental Illness in Two Canadian Cities. Simon Fraser University; 2020.
224. Swan H. Different patterns of drug use and barriers to continuous HIV care post-incarceration. J Drug Issues. 2015;45(1):38–52.
225. Grace A. "They Just Don't Care": Women Charged with Domestic Violence in Ottawa. Manit Law J. 2019;42(3).
226. Equip Health Care. Trauma and Violence-Informed Care (TVIC) A Tool for Health & Social Service Organizations & Providers. 2021. Available from: https://equiphealthcare.ca/files/2021/05/GTV-EQUIP-Tool-TVIC-Spring2021.pdf
227. Heidemann G, Cederbaum JA, Martinez S. "We Walk Through It Together": The Importance of Peer Support for Formerly Incarcerated Women's Success. J Offender Rehabil. 2014;53(7):522–42.
228. Fuller SM, Koester KA, Maiorana A, Steward WT, Broaddus MR, Lass K, et al. "I don't have to do this all by myself": Systems Navigation to Ensure Continuity of HIV Care for Persons Leaving Prison. AIDS Behav. 2019;23(s1):14–24.
229. Koester KA, Morewitz M, Pearson C, Weeks J, Packard R, Estes M, et al. Patient navigation facilitates medical and social services engagement among HIV-infected individuals leaving jail and returning to the community. AIDS Patient Care STDS. 2014;28(2):82–90.
230. Easton R. Dozens of community organizations lose funding as Public Health Agency shifts focus to prevention | CBC News. CBC News. 2016 Oct 24; Available from: https://www.cbc.ca/news/health/hiv-funding-changes-aboriginal-1.3806641
231. The Correctional Investigator Canada. Office of the Correctional Investigator Annual Report 2019-2020. Ottawa; 2020 Jun. Available from: https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20192020-eng.pdf
232. Meyer JP. The Sustained Harmful Health Effects of Incarceration for Women Living with HIV. J Women's Heal. 2019;28(8):1017–8.
233. Buchanan D, Kee R, Sadowski LS, Garcia D. The health impact of supportive housing for HIV-positive homeless patients: a randomized controlled trial. Am J Public Health. 2009;99 Suppl 3(Suppl 3):S675.
234. Espino SR, Fletcher J, Gonzalez M, Precht A, Xavier J, Matoff-Stepp S. Violence screening and viral load suppression among HIV-positive women of color. AIDS Patient Care STDS. 2015;29(Suppl 1):S36–41.
235. Donastorg Y, Barrington C, Perez M, Kerrigan D, Baral S, Beyrer C, et al. Abriendo Puertas: Baseline Findings from an Integrated Intervention to Promote Prevention, Treatment and Care among FSW Living with HIV in the Dominican Republic. PLoS One. 2014;9(2):e88157.
236. Hatcher AM, Smout EM, Turan JM, Christofides N, Stöckl H. Intimate partner violence and engagement in HIV care and treatment among women. AIDS. 2015;29(16):2183–94.
237. Machtinger EL, Haberer JE, Wilson TC, Weiss DS. Recent Trauma is Associated with Antiretroviral Failure and HIV Transmission Risk Behavior Among HIV-Positive Women and Female-Identified Transgenders. AIDS Behav. 2012;16(8):2160–70.
238. Orza L, Bewley S, Chung C, Crone ET, Nagadya H, Vazquez M, et al. "Violence. Enough already": Findings from a global participatory survey among women living with HIV. J

Int AIDS Soc. 2015;18(6 Suppl 5).
239. Roberts S, Haberer J, Celum C, Mugo N, Ware NC, Cohen CR, et al. Intimate Partner Violence and Adherence to HIV Pre-exposure Prophylaxis (PrEP) in African Women in HIV Serodiscordant Relationships: A Prospective Cohort Study. J Acquir Immune Defic Syndr. 2016;73(3).
240. Erickson M, Shannon K, Ranville F, Magagula P, Braschel M, Ratzlaff A, et al. Interpersonal violence and other social-structural barriers associated with needing HIV treatment support for women living with HIV: J Interpers Violence. 2021;
241. Gilroy H, McFarlane J, Maddoux J, Sullivan C. Homelessness, housing instability, intimate partner violence, mental health, and functioning: A multi-year cohort study of IPV survivors and their children. J Soc Distress Homeless. 2016;25(2):86–94.
242. Gezinski LB, Gonzalez-Pons KM, Rogers MM. Substance Use as a Coping Mechanism for Survivors of Intimate Partner Violence: Implications for Safety and Service Accessibility. Violence Against Women. 2021;27(2):108–23.
243. Klem L. Path Analysis. In: Grimm LG, Yarnold PR, editors. Reading and Understanding Multivariate Statistics. Washington, DC: American Psychological Association; 1995. p. 63–97.
244. Webley P, Lea S. PSY6003 Advanced statistics: Multivariate analysis II: Manifest variables analyses; Topic 3: Path analysis. University of Exeter. Available from: http://people.exeter.ac.uk/SEGLea/multvar2/pathanal.html
245. Walsh JC, Mandalia S, Gazzard BG. Responses to a 1 month self-report on adherence to antiretroviral therapy are consistent with electronic data and virological treatment outcome. AIDS. 2002;16(2):269–77.
246. Simoni JM, Kurth AE, Pearson CR, Pantalone DW, Merrill JO, Frick PA. Self-report measures of antiretroviral therapy adherence: A review with recommendations for HIV research and clinical management. AIDS Behav. 2006;10(3):227–45.
247. Buscher A, Hartman C, Kallen M, Giordano T. Validity of self-report measures in assessing antiretroviral adherence of newly diagnosed, HAART-Naïve, HIV patients. HIV Clin Trials. 2011 Jan 1;12(5):244–54.
248. Carter A, De Pokomandy A, Loutfy M, Ding E, Sereda P, Webster K, et al. Validating a self-report measure of HIV viral suppression: An analysis of linked questionnaire and clinical data from the Canadian HIV Women's Sexual and Reproductive Health Cohort Study. BMC Res Notes. 2017 Mar 24;10(1):1–7.
249. Asparouhov T. Sampling Weights in Latent Variable Modeling. Struct Equ Model. 2005;12(3):411–34.
250. Mueller RO, Hancock GR. Best Practices in Structural Equation Modeling. In: Best Practices in Quantitative Methods. SAGE Publications, Inc.; 2008. p. 488–508.
251. Suhr D. Step your way through Path Analysis. University of Northern Colorado. 2008. Available from: https://www.lexjansen.com/wuss/2008/pos/pos04.pdf
252. Jordan AO, Cohen LR, Harriman G, Teixeira PA, Cruzado-Quinones J, Venters H. Transitional care coordination in new york city jails: Facilitating linkages to care for people with hiv returning home from rikers Island. AIDS Behav. 2013;17(SUPPL. 2):212–9.
253. MacGowan RJ, Lifshay J, Mizuno Y, Johnson WD, McCormick L, Zack B. Positive Transitions (POST): Evaluation of an HIV Prevention Intervention for HIV-Positive

Persons Releasing from Correctional Facilities. AIDS Behav. 2015;19(6):1061–9.
254. Wohl DA, Golin CE, Knight K, Gould M, Carda-Auten J, Groves JS, et al. Randomized controlled trial of an intervention to maintain suppression of HIV viremia after prison release: The impact trial. In: Journal of Acquired Immune Deficiency Syndromes. Lippincott Williams and Wilkins; 2017. p. 81–90.
255. Wohl DA, Scheyett A, Golin CE, White B, Matuszewski J, Bowling M, et al. Intensive case management before and after prison release is no more effective than comprehensive pre-release discharge planning in linking HIV-infected prisoners to care: a randomized trial. AIDS Behav. 2011;15(2):356–64.
256. Khawcharoenporn T, Zawitz C, Young JD, Kessler HA. Continuity of Care in a Cohort of HIV-Infected Former Jail Detainees. J Correct Heal Care. 2013;19(1):36–42.
257. Brantley AD, Page KM, Zack B, Friedrich KR, Wendell D, Robinson WT, et al. Making the Connection: Using Videoconferencing to Increase Linkage to Care for Incarcerated Persons Living with HIV Post-release. AIDS Behav. 2019;23(s1):32–40.
258. Reznick OG, McCartney K, Gregorich SE, Zack B, Feaster DJ. An Ecosystem-Based Intervention to Reduce HIV Transmission Risk and Increase Medication Adherence Among Inmates Being Released to the Community. J Correct Heal Care. 2013;19(3):178–93.
259. Cunningham WE, Weiss RE, Nakazono T, Malek MA, Shoptaw SJ, Ettner SL, et al. Effectiveness of a peer navigation intervention to sustain viral suppression among HIV-positive men and transgender women released from jail the LINK la randomized clinical trial. JAMA Intern Med. 2018 Apr 1;178(4):542–53.
260. Myers JJ, Dufour MSK, Koester KA, Morewitz M, Packard R, Klein KM, et al. The effect of patient navigation on the likelihood of engagement in clinical care for HIV-infected individuals leaving jail. Am J Public Health. 2018 Mar 1;108(3):385–92.
261. Desai A. Homes for the "Hard to House": A Model for Effective Second Stage Housing. Ottawa; 2012 Oct.
262. Fotheringham S, Walsh CA, Burrowes A. "A place to rest": the role of transitional housing in ending homelessness for women in Calgary, Canada. Gender, Place Cult. 2014;21(7):834–53.
263. Gouvis Roman C, Jeremy T. Taking Stock: Housing, Homelessness, and Prisoner Reentry. 2004. Available from: http://webarchive.urban.org/UploadedPDF/411096_taking_stock.pdf
264. Prison Reform Trust. Home truths: housing for women in the criminal justice system. London; 2018. Available from: http://www.prisonreformtrust.org.uk/portals/0/documents/home truths june 2018.pdf
265. Lyons T, Krüsi A, Pierre L, Smith A, Small W, Shannon K. Experiences of Trans Women and Two-Spirit Persons Accessing Women-Specific Health and Housing Services in a Downtown Neighborhood of Vancouver, Canada. LGBT Heal. 2016;3(5):373–8.
266. Centre for Addictions Research of BC. Housing and Harm Reduction: A Policy Framework for Greater Victoria. Victoria; 2011. Available from: https://homelesshub.ca/resource/housing-and-harm-reduction-policy-framework-greater-victoria
267. National Harm Reduction Coalition. Principles of Harm Reduction. 2021. Available from: https://harmreduction.org/about-us/principles-of-harm-reduction/

268. Springer SA, Spaulding AC, Meyer JP, Altice FL. Public health implications for adequate transitional care for HIV-infected prisoners: Five essential components. Clin Infect Dis. 2011;53(5):469–79.
269. Martin CM, Walia H. Red Women Rising. Vancouver; 2019. Available from: https://dewc.ca/wp-content/uploads/2019/03/MMIW-Report-Final-March-10-WEB.pdf
270. BC Centre for Excellence for Women's Health; BC Ministry of Health; Vancouver Island Health Authority. Trauma-Informed Practice Guide. 2013.
271. Cogswell HA, Ohadi E, Avila C. Viral-load point-of-care technologies to achieve an AIDS-free generation. Vol. 11, Future Microbiology. Future Medicine Ltd London, UK; 2016. p. 5–9.
272. Latkin CA, Edwards C, Davey-Rothwell MA, Tobin KE. The relationship between social desirability bias and self-reports of health, substance use, and social network factors among urban substance users in Baltimore, Maryland. Addict Behav. 2017 Oct 1;73:133–6.
273. Meyer JP, Cepeda J, Taxman FS, Altice FL. Sex-Related Disparities in Criminal Justice and HIV Treatment Outcomes: A Retrospective Cohort Study of HIV-Infected Inmates. Am J Public Health. 2015;105(9):1901–10.
274. Khawcharoenporn T, Cole J, Claus J, Bell T, Lewis A, Zawitz C, et al. A randomized controlled study of intervention to improve continuity care engagement among HIV-infected persons after release from jails. AIDS Care - Psychol Socio-Medical Asp AIDS/HIV. 2019;31(7):777–84.
275. Derlega VJ, Winstead BA, Gamble KA, Kelkar K, Khuanghlawn P. Inmates with HIV, stigma, and disclosure decision-making. J Health Psychol. 2010;15(2):258–68.
276. Canadian Human Rights Commission. Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women. 2003.
277. Johnson JE, Schonbrun YC, Nargiso JE, Kuo CC, Shefner RT, Williams CA, et al. "I know if I drink I won't feel anything": substance use relapse among depressed women leaving prison. Int J Prison Health. 2013;9(4):169–86.
278. Jewkes Y, Jordan M, Wright S, Bendelow G. Designing 'healthy' prisons for women: Incorporating trauma-informed care and practice (TICP) into prison planning and design. Int J Environ Res Public Health. 2019;16(20).
279. Canadian Drug Policy Coalition. Decriminalization Done Right: A Rights-Based Path for Drug Policy. 2021. Available from: https://www.drugpolicy.ca/decrim-done-right/
280. Carter C, MacPherson D. Getting to Tomorrow: A report on Canadian Drug Policy. Vancouver; 2013. Available from: www.drugpolicy.ca/progress/%0Agetting-to-tomorrow
281. Wood E, Werb D, Kazatchkine M, Kerr T, Hankins C, Gorna R, et al. Vienna Declaration: a call for evidence-based drug policies. Lancet. 2010 Jul 31;376(9738):310–2.
282. Couloute L. Nowhere to Go: Homelessness among formerly incarcerated people. American Psychiatric Association; 2018. Available from: https://www.prisonpolicy.org/reports/housing.html
283. Sex Workers United Against Violence, Allan S, Bennett D, Chettiar J, Jackson G, Krüsi A, et al. My Work Should Not Cost Me My Life: The Case against Criminalizing the Purchase of Sex in Canada. 2014; Available from: http://d3n8a8pro7vhmx.cloudfront.net/pivotlegal/pages/615/attachments/original/1401811234/My_Work_Should_Not_Cost_Me_My_Life.pdf?1401811234

284. Centre for Gender and Sexual Health Equity. Harms of end-demand criminalization: Impact of Canada's PCEPA laws on sex workers' safety, health & human rights. Vancouver; 2019. Available from: https://www.cgshe.ca/app/uploads/2019/12/Harms_2019.12.16.v1.pdf
285. Canadian HIV/AIDS Legal Network. The criminalization of non-disclosure in Canada: Current status and the need for change. 2019. Available from: http://www.aidslaw.ca/site/download/17878/
286. Davis AY. Are prisons obsolete? Are prisons obsolete? New York: Seven Stories Press; 2003. 60–83 p.
287. Kaba M. We Do This 'Til We Free Us: Abolitionist Organizing and Transforming Justice. Nopper TK, editor. Chicago, Illinois, Illinois: Haymarket Books; 2021.
288. Kushner R. Is Prison Necessary? Ruth Wilson Gilmore Might Change Your Mind. The New York Times. 2019 Apr 17; Available from: https://www.nytimes.com/2019/04/17/magazine/prison-abolition-ruth-wilson-gilmore.html
289. Howes H, Guenther L. Notes on Abolition and Decolonization. noprisons.ca. Available from: https://static1.squarespace.com/static/5e87d4e1eaa9be375415ac85/t/5f238c70b1ec7d2b38701e26/1596165232511/Notes+on+Abolition+and+Decolonization+%28naphtali%2C+Hadley%2C+Lisa%29.pdf
290. El Muggabar R. Free Up! Transformative Justice and Abolition Learning Seires. Virtual Learning Series; 2021. Available from: https://www.raniawrites.com/free-up-abolition-series.html
291. Black Lives Matter. What Defunding the Police Really Means - Black Lives Matter. 2020. Available from: https://blacklivesmatter.com/what-defunding-the-police-really-means/?__cf_chl_jschl_tk__=wBcFqUJmTzLeBzD69y_T5gP3WMYlSj_0Ivd3ghZuEXw-1638233147-0-gaNycGzNCJE
292. Vitale A. The End of Policing. London: Verso; 2017.
293. Public Health Agency of Canada. Addressing Stigma: Towards a More Inclusive Health System. 2019 Dec. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf
294. Collaborating Centre for Prison Health & Education. Peer Health Rep Program: Preventing HIV, HCV, and STBBI with federally incarcerated people in BCLE IN BC. 2019.
295. PASAN. Pros & Cons: A Guide to Creating Successful Community-Based HIV and HCV Programs for Prisoners. Toronto; 2011. Available from: http://librarypdf.catie.ca/ATI-20000s/26374.pdf
296. James T. After learning how Kimberly Squirrel died, her sister asks about supports that could have prevented her death. The Star Pheonix. 2021 Apr 26; Available from: https://thestarphoenix.com/news/local-news/after-learning-how-kimberly-squirrel-died-her-sister-asks-about-supports-that-could-have-prevented-her-death
297. Butsang T, Lawford K. Indigenous women, transgender and Two-Spirit people need support when leaving prison. The Conversation. 2020 Dec 1;111(6):971–4. Available from: https://theconversation.com/indigenous-women-transgender-and-two-spirit-people-

need-support-when-leaving-prison-158024
298. Unlocking the Gates Services Society. 2021. Available from: https://unlockingthegates.org/
299. Lourenco D. Senate calls on feds to increase HIV funding as new infections rise | CTV News. CTV News. 2020 Dec 7; Available from: https://www.ctvnews.ca/health/senate-calls-on-feds-to-increase-hiv-funding-as-new-infections-rise-1.5220580
300. Leap J, Benson S, Davidson C, Lompa K. A New Way of Life Re-Entry Project: A Case Study. 2016. Available from: https://anewwayoflife.org/wp-content/uploads/2018/10/case_study_a_new_way_of_life_re-entry_project.pdf#
301. Creswell JW, Poth CN. Qualitative Inquiry & Research Design: Choosing Among Five Approaches 4th edition. 4th ed. Sage Publicatons Inc. Thousand Oaks; 2017. 1–646 p.
302. Canadian Institute for Health Information. Proposed Standards for Race-Based and Indigenous Identity Data Collection and Health Reporting in Canada. CIHI. Ottawa; 2020. Available from: https://www.cihi.ca/sites/default/files/document/proposed-standard-for-race-based-data-en.pdf
303. Bowleg L. When Black + Lesbian + Woman ≠ Black Lesbian Woman: The Methodological Challenges of Qualitative and Quantitative Intersectionality Research. Sex Roles. 2008;59(5):312–25.
304. Bauer GR. Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. Soc Sci Med. 2014;110:10–7.
305. Grace D. Intersectionality-informed Mixed Method Research: A Primer. 2014.
306. BC First Nations Justice Council. BC First Nations Justice Strategy : Transforming the legal system into a justice system-just and fair for Indigenous peoples in BC. 2020. Available from: https://bcfnjc.com/wp-content/uploads/2020/10/Justice-Strategy-Summary.pdf
307. Bauer GR, Braimoh J, Scheim AI, Dharma C. Transgender-inclusive measures of sex/gender for population surveys: Mixed-methods evaluation and recommendations. PLoS One. 2017;12(5):e0178043.
308. Centre for Gender and Sexual Health Equity. Gender & Sex in Methods & Measurement Research Equity Toolkit. Vancouver; 2022. Available from: https://cgshe.ca/practice/research-toolkits/gender-and-sex-toolkit/
309. Transformative Health & Justice Research Cluster. University of British Columbia. Available from: https://transformhealthjustice.ubc.ca/
310. BC Centre for Disease Control. You Matter: Pathways to STBBI care Project. 2021. Available from: https://stbbipathways.ca/
311. Pruden H. Two-Spirit Conversations and Work: Subtle and at the Same Time Radically Different. In: Transgender: a Reference Handbook. ABC-CLIO Greenwood; 2019. p. 134–6.
312. The National Collaborating Centre for Determinants of Health. Glossary: Marginalized populations. St. Francis Xavier University. 2022. Available from: https://nccdh.ca/glossary/entry/marginalized-populations
313. Butler A, Nicholls T, Fabian S, Lavergne R. Prevalence of Mental Health Needs, Substance Use, and Co-occurring Disorders Among People Admitted to Prison. Psychiatr Serv. 2021 Nov 23;Online Fir.

314. Trevethan S, Rastin C. A Profile of Visible Minority Offenders in the Federal Canadian Correctional System. Ottawa; 2004 Jun.
315. Osazuwa E. Canadian Women in Prison: A Racial and Gendered Discursive Analysis. Soc Justice Community Engagem. 2015;13. Available from: https://scholars.wlu.ca/brantford_sjce/13
316. World Health Organization. WHO Gender Responsive Assessment Scale: criteria for assessing programmes and policies. In: Gender Mainstreaming for health managers: a practical approach. Geneva; 2011. Available from: https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAssessmentScale.pdf
317. SAMHSA's Trauma and Justice Strategic Initiative. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Substance Abuse and Mental Health Services Administration; 2014. Available from: https://calio.dspacedirect.org/handle/11212/1971
318. Tan KKH, Treharne GJ, Ellis SJ, Schmidt JM, Veale JF. Gender minority stress: A critical review. J Homosex. 2020 Aug;67(10):1471–89.
319. Meyer IH, Frost DM. Minority Stress and the Health of Sexual Minorities. In: Handbook of Psychology and Sexual Orientation. Oxford University Press; 2013.

Appendices

Appendix A Research to Policy Brief

CENTRE FOR GENDER & SEXUAL HEALTH EQUITY

SHAWNA

THE UNIVERSITY OF BRITISH COLUMBIA

How stigma reinforced through institutional processes contributes to barriers to health care for incarcerated women living with HIV

September 2021

BACKGROUND

The number of women who are incarcerated across Canada is growing and women living with HIV are overrepresented within prison settings and are over criminalized and policed. Previous research indicates that during and after release from incarceration, women face worse HIV health outcomes compared to men, yet little is known about their lived experiences and access to HIV care while incarcerated.

Many jurisdictions across Canada have made the switch in health care delivery from private, under the privy of correctional services, to public, under the responsibility of provincial health care authorities. This research has timely implications for policy and programming to promote increased continuity of care and continued investment in the health of marginalized women who experience incarceration.

FINDINGS

Heightened experiences of HIV-related stigma within correctional facilities can lead to experiences of isolation and discrimination for women living with HIV while incarcerated.

- This is re-enforced by institutional processes within prisons, such as medications dispensing procedures and medical escorts, which limit medical privacy and compromise confidentiality.
- Women living with HIV expressed a lack of clarity with regards to the bounds of confidentiality of medical information with in prison settings.
- These factors can lead to barriers to care access and impact continued HIV treatment during incarceration.

> "They'd be like she's got HIV. Don't go near her."

IMPLICATIONS AND RECOMMENDATIONS FOR POLICY AND PRACTICE

IMPLEMENT educational programs in prison settings that counteract misinformation regarding HIV transmission and treatment

Programmatic change needs to focus on sustained educational efforts to address HIV-related stigma, for both prison staff and people who are incarcerated. Educational efforts should centre people with lived experience of HIV whenever possible.

> "They look at you like you're contaminated."

REVIEW institutional processes that undermine medical privacy and reinforce stigma

Institutional processes including medications dispensing procedures and medical escorts must be reviewed and adapted to promote privacy. Input from people who experience incarceration is crucial.

> "I would go up with like three other women to get meds. And it's so open. It's not very discreet."

FOSTER clear and ongoing communication about the confidentiality of medical information within correctional facilities to promote access to care

This includes an emphasis on transparent communication surrounding the confidentiality of health information in prison settings.

REDRESS the criminalization of women living with HIV and implement trauma-informed and culturally safe practice and supports

Trauma-informed and culturally safe practice will support HIV disclosure and access to care. Long-term goals should refocus the purpose of the criminal justice system away from punishment, retribution and incapacitation towards rehabilitation and healing.

About the Research

This research was led by the Centre for Gender & Sexual Health Equity at the University of British Columbia, in close partnership with longstanding community partnerships, and draws on qualitative findings from a community-based research project of women living with HIV in Metro Vancouver. Since its inception, the research has involved women living with HIV across the project and holds ethic approvals at UBC and Providence Health Care. This research is funded by the Canadian Institutes of Health Research.

About the Centre for Gender & Sexual Health Equity

CGSHE is a University of British Columbia and Simon Fraser University academic centre housed at Providence Health Care. Its mission is to provide leadership in gender equity and sexual health for all in BC, Canada and globally through conducting rigorous community-engaged research that meets the highest scientific and ethical standards; promoting evidence-based policy development; and fostering the implementation of innovative, patient-centered and equity-oriented clinical and community practices through guidelines and education.

Citation: Erickson M, Shannon K, Ranville F, Pooyak S, Howard T, McBride B, Pick N, Elwood Martin R, Krüsi A. "They look at you like you're contaminated": How HIV-related stigma shapes access to care for incarcerated women living with HIV in a Canadian setting. *Canadian Journal of Public Health*. 2021; Online First. doi:10.17269/s41997-021-00562-z

Appendix B Storyboard for Animated Video

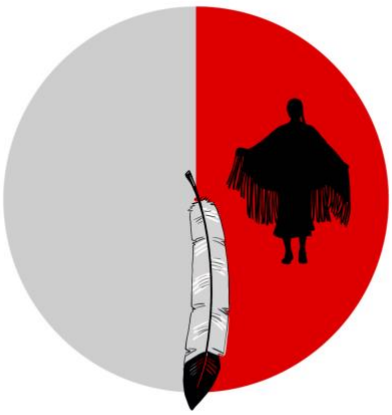
Scene 1:

Narration: "More women are incarcerated in Canada than ever before."
Animation: *Map of Canada and prison is drawn out. One by one, silhouetted women appear on the map.*

Scene 2:

Narration: "Prisons are a symptom of poverty, racism, trauma, the war on drugs, and the impacts of ongoing colonial violence."
Animation: *Prison building appears in background. Words appear coming from the prison windows.*

Scene 3:



Narration: "Indigenous women account for almost half of all women who are incarcerated."
Animation: *A feather rotates 180 degrees, filling ½ the circle with red.*

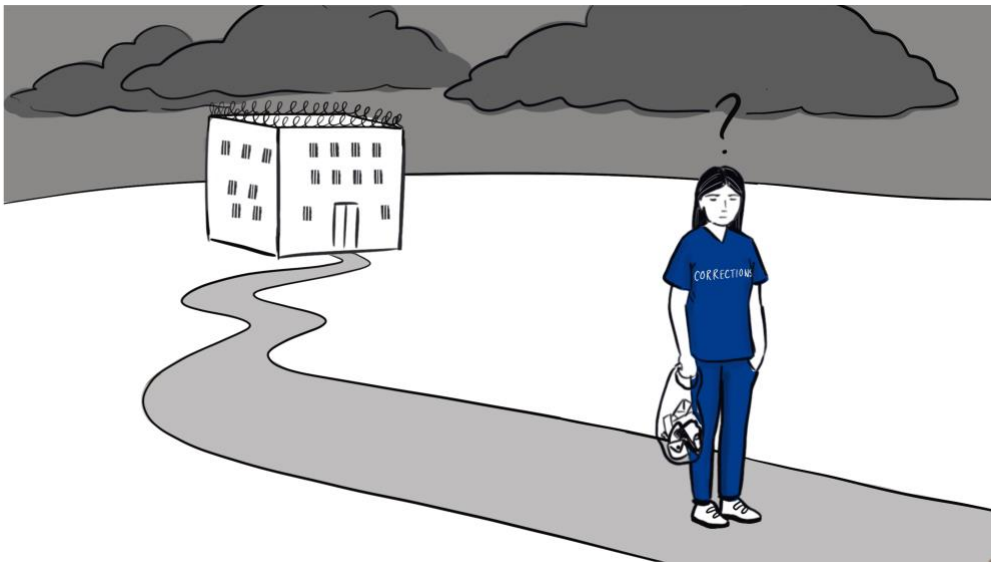
Scene 4:

Narration: "Women living with HIV are also over-represented."
Animation: *Women in line are drawn out. Red ribbons appear on two of the women standing in a line.*

Scene 5:

Narration: "In prison, many women living with HIV face stigma and discrimination, which creates barriers to accessing HIV care."
Animation: *Scene is drawn out. Two women at end of line whisper and move away from the woman living with HIV.*

Scene 6:



Narration: "Upon release from prison, the challenges are enormous."
Animation: *Scene is drawn out; rain starts falling.*

Scene 7:

Narration: "Many leave in prison clothes, without money, I.D., food security, or transportation."
Animation: *Rain continues to fall. Woman stands at the bus top in prison clothes, with a clear plastic bag of her belongings.*

Scene 8:

Narration: "A lack of housing means women can end up homeless or in housing that is unsafe."
Animation: *Rain continues to fall. Scene is drawn out.*

Scene 9:

Narration: "This puts women at risk of experiencing violence."
Animation: *Scene is drawn out.*

Scene 10:

Narration: "Addressing healthcare needs can become a low priority if you're just trying to survive"
Animation: *Woman appears and various thought bubbles appear showing myriad of considerations.*

Scene 11:

Narration: "Without supports, women can end up back in the same situations that got them arrested in the first place."
Animation: *Scene is drawn out. Action lines around lights flash in the background (police car).*

Scene 12:

Narration: "Sometimes we blame ourselves for not being able to break the cycle of incarceration."
Animation: *A woman cycles through a revolving door at the entrance of a prison.*

Scene 13:

Narration: "But the system was never set up to support us in the first place."
Animation: *The revolving door and prison fade away from the scene and just the women in a circle remain.*

Scene 14:

Narration: "We turn to each other for hope and understanding. Our past does not define us."
Animation: *Women appear, their hands form a heart and the words "Peers" and "Supports" appear.*

Scene 15:

Narration: "We need a seat at the table. We need services and supports for us, by us."
Animation: *The table scene draws out, the silhouetted women appear on the outside of the conversation. The empty chair pops in.*

Scene 16/17: Credits

This video was based on research findings from the SHAWNA Project
(Sexual Health & HIV/AIDS: Longitudinal Women's Needs Assessment)

This video was created in collaboration with women involved in the project and was narrated by women with lived experience of incarceration

Thank you to all research participants and SHAWNA team members who contributed to this work

SHAWNA

CENTRE FOR GENDER & SEXUAL HEALTH EQUITY

UBC

DRAWING IT OUT

Animation by Drawing it Out
Anika Bauman and Yolanda Liman