A Place “I Feel is Home”: The Meaning of Home and Implications for Health among People Living with HIV/AIDS in Greater Vancouver

by

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ABSTRACT

Background: Housing continues to be one of the most significant unmet needs for many people living with HIV/AIDS in British Columbia. While there has been a focus on documenting the material aspects of housing and housing extremes (i.e., homelessness), there are important gaps in our understanding of the complex relationship between housing and health for people living with HIV/AIDS. The aim of this research was to identify what “home” meant for people living with HIV/AIDS across a continuum of housing/living situations, the ways in which people living with HIV/AIDS construct meanings of home, and how these factors interact with their (physical, mental, and emotional) health and wellbeing.

Methods: This thesis reports on a secondary analysis of individual interviews from the Positive Living, Positive Homes (PLPH) community-based research study. For the PLPH study, community-based research approaches were used to explore a variety of lived experiences across a continuum of housing situations, while promoting collaborative inquiry among community and academic research team members. For this analysis, a purposively selected sample of 10 transcripts was drawn from 53 semi-structured qualitative interviews with people living with HIV/AIDS in Greater Vancouver (GV). Transcripts were analyzed using a thematic analysis approach, adopting constant comparative and other coding techniques from a grounded theory approach to explore how people constructed the meaning of home, and how people living with HIV/AIDS perceived the various elements of their home environment to interact with their health and wellbeing. Descriptive thematic coding was augmented with higher-level conceptual coding to further develop over-arching conceptual themes. Some participatory analysis elements, including involvement of a community advisory committee (CAC), were included in the analysis process to allow for collaborative inquiry, and to augment and confirm results.

Results: The participants (5 Caucasians, 3 Indigenous persons, 1 Chinese-Canadian and 1 African refugee; 5 females, 1 trans-female, and 4 males) lived in a range of housing situations (market rental, subsidized, supportive, and precarious housing). Results from a thematic analysis showed that even when people had access to four-walled housing structures, they didn’t necessarily feel that their living environment was safe, secure, or conducive to having their health and social needs met. Emerging themes highlighted how people define home and their conditions for this designation revealed the ways in which people manage their living spaces to foster feelings of autonomy, security, constancy, and opportunities to strengthen their identity.

Discussion: Understanding the distinction between housing and home, and the meaningful dimensions of peoples' living environments, can help improve options for appropriate housing by moving away from a 'one-size-fits-all' approach. Furthermore, collaborative inquiry may help address the action-oriented needs of the research findings through community-academic partnerships, knowledge sharing, and knowledge translation activities.

Keywords: HIV and AIDS; meaning of home; meaningful dimensions; home; housing; ontological security; community-based research

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CBR – Community-based research

GT – Grounded Theory

PAN – Pacific AIDS Network

PLN – Positive Living North

PLPH study – Positive Living, Positive Homes study

PSHP study - Positive Spaces Healthy Places study

OHTN – Ontario HIV Treatment Network

HIV – Human Immunodeficiency Virus

AIDS – Acquired Immunodeficiency Syndrome

Hep C – Hepatitis C

BC – British Columbia

GV – Greater Vancouver

DTES – Downtown Eastside (Vancouver)

HAART – Highly active antiretroviral therapies

ART – Antiretroviral therapies

HRQoL – Health-related quality of life

PHAC – Public Health Agency of Canada

CPHA – Canadian Public Health Association

BCCDC – BC Centres for Disease Control and Prevention

BCCE – British Columbia Centre for Excellence in HIV

WHO – World Health Organization

NAHC - The National AIDS Housing Coalition

CMHC – Canada Mortgage and Housing Corporation

UNAIDS – Joint United Nations Programme on HIV/AIDS

TasP – Treatment as Prevention protocol

STOP HIV/AIDS – Seek and Treat for Optimal Prevention of HIV/AIDS

PWD – Persons with Disabilities (BC Ministry of Social Development income program)

MSM – Men who have sex with men

SDH – Social determinants of health

HF – Housing First

TF – Treatment First

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PREFACE: THE MEANING OF HOME FOR ME

Home:
The place where your exhale feels best.

– Cleo Wade

* * *

Over the course of doing this research and writing this thesis, I have explored my own definitions of home, and what being “at home” truly meant for me. Paralleling this process of writing came the reshaping of my own home environment, which included changes in my family structure, and moving houses, cities, and even provinces in the course of a year. As I navigated some sense of constancy in these times of instability and variability, I began to dig deeper into what home meant for me, and what my home was comprised of.

I think as humans we strive to create consistency both in our social and material environments, and we do so by holding on to things, like houses, possessions, and people. I believe it to be our way of somehow assuring their permanence, our permanence. The funny thing is, these actions contradict the very humanness and the very nature of things in life – change. As the Greek philosopher Heraclitus put it: the only thing that is constant is change. If this past year has taught me anything it is that these possessions do not define me, nor are they requisite for my feeling at home. Rather, there are other things that I can choose hold on to and keep steadfast – my beliefs, my values, and my attitude, how I choose to respond to a situation, and how much I appreciate the things that I already have.

I for one am choosing to focus on what I already have by appreciating the family and friends that surround me, and remaining steadfast by keeping my two feet rooted and an open heart, happy to be home in the home that is me.

CHAPTER I: INTRODUCTION

The sense and degree of security, stability and tranquility that a home can provide is unique to the person that inhabits the place or space. A living space or dwelling can influence one's emotional, mental, social and physical health since it provides a place where food can be prepared and enjoyed; where routines and events take place; activities of self-care and hygiene can be completed; and where one can turn in and rest after a busy day (Rourke, Bekele, Tucker, Greene, Sobota, Koornstra & Positive Spaces Healthy Places Team, 2012). There is no question that living spaces play pivotal roles in our health and wellbeing, which is why access to adequate and affordable housing is often described as a determinant of health, as well as a basic human right (Canadian AIDS Society, 2008). This chapter will examine the various ways in which housing is regarded as a determinant of health for people living with HIVAIDS. I will also provide contextual information for this thesis research by delivering of an overview of the populations at risk and living with HIV/AIDS, as well as the epidemiology of HIV/AIDS, with a specific focus on the HIV population in British Columbia (BC) and in Greater Vancouver (GV) (the study site for this research). Subsequent sections of this chapter will provide a review of the most up-to-date research examining the relationships between housing, HIV/AIDS, and health, and provide information about the current response to HIV/AIDS in the province of BC.

Housing as a Determinant of Health

Raphael (2004) defines the social determinants of health as the social and economic conditions that determine people's ability to access and acquire the physical, social, and personal resources needed to achieve good health. The concept of health can be defined in many ways across various disciplines, but this thesis will use the World Health Organization's (WHO) (1948) widely known definition, claiming health to be "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity." It is also worth noting that this definition of health is not all encompassing and has been critiqued for not including other important dimensions of health (i.e., spiritual health), and for preserving a perfectionist and individualistic perspective of health (Last, 2002). However, this definition of health does allow researchers to conceptualize the impact that housing has on health, since a relationship can be drawn between both the prevention of illness and poor health outcomes, and the attainment of positive health outcomes because of appropriate housing conditions (Chambers et al., 2014).

Housing, as a structural factor or a social determinant of health, can interact with other social determinants of health, such as employment and food security, in multifaceted ways. The WHO (2010) states, "The promotion and protection of public health through housing and construction measures should lead to increased wellbeing, reduced suffering and lower health care costs" (p. 4). The public health community has given the relationship between housing and health increasing attention (Krieger & Higgins, 2002), but is still challenged to take action and promote action on this social determinant of health. Housing affordability, appropriateness, and availability all remain highly contested issues within a national context and public health professionals face many barriers in their attempts to influence housing policy that is found to be "sensitive to political ideology, as the government's strong pro-privatization and pro-market agenda made housing a ripe area for such activity" (Bryant, 2003, p. 6). This is exemplified by the fact that even though Canada accepted the Universal Declaration of Human Rights (UDHR) declaring housing as a fundamental human right (Centre for Equality Rights in Accommodation, 2008), many Canadians continue to be homeless or 'vulnerably housed', a term that includes "low-income, socially marginalized individuals living in single room occupancy (SRO) hotels and rooming houses" (Hwang et al., 2011, p. 610).

The Impact of Housing for People Living with HIV/AIDS

HIV, or human immunodeficiency virus, is a virus that attacks the infection-fighting CD4 cells of the immune system. Without treatment, HIV continues to invade a person's immune system and accelerates the progression of HIV to AIDS, the most advanced stage of HIV infection (CATIE, n.d.). HIV infection is possible through the transmission of the virus through various bodily fluids, including blood, semen (and pre-seminal fluid), vaginal fluids, rectal fluids, and breast milk, and HIV is most likely to be transmitted through sexual activity and the sharing of needles or other equipment to inject drugs (CATIE, n.d.). Homelessness and precarious housing have been long recognized as contributing to people's vulnerability to HIV infection (Chambers et al., 2014), and "being homeless/marginally-housed has been identified as independently associated with a shorter time to HIV seroconversion" among people who use illicit substances (Milloy, Marshall, Montaner & Wood, 2012, p. 365). So although the risks of HIV transmission are associated with behavioural factors, such as substance use, it is also true that social factors, such as access to housing, contribute to driving and sustaining the HIV epidemic (Aidala et al., 2016; Parashar, 2014).

The research also shows that people living with HIV/AIDS often face financial and economical vulnerabilities (i.e., issues with maintaining employment), and have increased vulnerability to stigma and discrimination. These factors serve to further challenge their ability to secure appropriate and affordable living conditions (Chambers et al., 2014). Health-specific vulnerabilities (i.e., co-morbid illnesses) also put people living with HIV/AIDS at a heightened risk of poorer health outcomes in the absence of stable housing (Chambers et al., 2014). Since housing and health intersect in complex ways, the following section is dedicated to revealing the various ways that housing status impacts both the risk of HIV transmission, and the health and wellbeing of those living with HIV/AIDS.

HIV-risk

As noted above, being homeless or unstably housed puts individuals at increased risk of HIV infection (Rourke et al., 2012). The lived realities of many people that are either homeless or unstably housed make it more probable to engage in risky sexual and/or substance using behaviours (Aidala et al., 2005). Furthermore, the chronic stress often associated with the daily challenges and routines for survival tend to supersede efforts made to reduce the risk of HIV transmission (Aidala et al., 2005). The research community, therefore, has increasingly recognized that individual factors (i.e., risky behaviours) are not solely responsible for increasing a person's risk and management of HIV. There are structural and contextual factors that exist beyond the immediate control of individuals that contribute to a person's risk of infection and/or transmission of HIV (Aidala et al., 2005). Housing status has the ability to heighten or reduce one's risk of HIV infection, and has the ability to create unfavourable conditions for people living with or at risk of HIV/AIDS. For instance, Aidala and colleagues (2005) found that when people were able to improve their housing status, they had lower measured odds for engaging in risky substance use (i.e., sharing needles), compared to participants whose living situation remained the same. Study findings also revealed that participants were more likely to adopt safer sexual practices when their housing situation improved. Furthermore, the risks of precarious sexual and/or substance use behaviours were found to rest upon a housing continuum: individuals who were homeless were more likely to engage in risky behaviours than those who are marginally housed, and individuals living in these two housing categories were more likely to engage in risky behaviours than individuals who were stably housed. In addition to the reduction of HIV risk, stable housing was shown to reduce the risk of co-morbidities and infections, such as hepatitis C, pneumonia, tuberculosis, anxiety, depression, poorer self-rated health, and mortality (Rourke et al., 2012, p. 2362).

In terms of contextual factors influencing HIV risk and disease progression, Druyts and colleagues (2009) found that certain neighbourhoods were more likely to have higher rates of mortality for individuals living with HIV/AIDS than others. In their study, the researchers compared two neighbourhoods in Vancouver that had a higher than average concentration of people living with HIV/AIDS: the West End urban neighbourhood known for its high concentration of gay men and the Downtown Eastside (DTES), with a larger concentration of injecting drug use population. When comparing these two neighbourhoods, "a threefold increase was observed in the risk of death among HIV-infected individuals on HAART in the neighbourhood with a high concentration of injecting drug users…" (Druyst et al., 2009, p. 274).

Although Greene and colleagues' (2010) affirm the relationship between HIV/AIDS and housing insecurity, their review of the literature revealed that women, Indigenous populations, and new Canadians living with HIV/AIDS were at an increased risk of homelessness. Furthermore, the National AIDS Housing Coalition (2005) highlighted growing evidence that veers away from the "risky person" model linking housing and HIV risk that places emphasis on individual risk behaviours, and instead emphasizes the contextual factors that heighten the risk of a person's situation.

Mortality

A US study examining the influence of socioeconomic status (SES) on mortality found that at a time when HAART was already improving clinical outcomes, people living with HIV/AIDS in impoverished conditions (having a personal annual income less than $10,000) were 1.5 times more likely to have increased mortality than their more privileged counterparts

(McMahon, Wanke, Terrin, Skinner & Knox, 2011). Moreover, hunger, education, poverty, and homelessness were all shown to have an impact on an individual's CD4 count, albumin, and viral load, all of which are strong predictors of mortality among people living with HIV/AIDS (McMahon et al., 2011). The mortality rate of populations living with HIV/AIDS may be influenced by several factors, but housing status and homelessness continues to be widely acknowledged in the literature as a key factor.

People with lower SES living with HIV/AIDS often struggle with the financial resources to afford both appropriate treatment and adequate housing. HIV-positive individuals often face extensive treatment regimens that are costly, which may create financial pressure in being able to afford other subsistence needs, such as food and shelter (Cunningham et al., 1999). For some individuals, their financial strain is further exacerbated by the high levels of unemployment and poverty often associated with living with HIV/AIDS (Rourke et al., 2012). With increased energy devoted to survival and finding adequate shelter, people living with HIV/AIDS in transient environments are less likely to engage in healthy behaviours, such as regular doctor visits (Goering et al., 2014), and are thus at a heightened risk of poorer health outcomes.

Physical and mental health

HIV/AIDS is a life-long disease and the needs of people living with HIV/AIDS can be complex and change over time. The Canadian Public Health Association (2005) suggests that the main challenges associated with HIV diagnosis, care, treatment and support are issues related to the co-morbidities and co-infections associated with HIV/AIDS; the diversity of populations affected and the diversity of contexts in which they are situated; mental health and substance dependence issues; the unique treatment needs of women living with HIV/AIDS (i.e., reproductive issues); the neurocognitive disorders associated with HIV/AIDS; the impact of stigma and discrimination; access to the social determinants of health (i.e., meaningful employment); and the increasing demands for long-term care services. Furthermore, poor housing conditions, such as overcrowding, inadequate water, sanitation, and basic services are intensified by the impact of HIV and AIDS, and these housing conditions are shown to increase the risk of opportunistic infections (Interagency Coalition on AIDS and Development & Rooftops Canada, 2010).

Housing stability has been described as a health-promoting feature for many people living with HIV/AIDS (Chambers et al., 2014), and can also indirectly or directly influence many of the abovementioned challenges of HIV diagnosis, care, treatment and support. Chambers and colleagues (2014) found that “housing stability was seen to reduce stress, facilitate medication adherence, support harm reduction and foster mental and physical well-being” for people living with HIV/AIDS (p. 324). Furthermore, housing stability was perceived as a precursor for economic security, which also has positive benefits for health and wellbeing (Chambers et al., 2014). In addition to the impact housing has on physical health, housing stability has also shown to be associated with the level of mental health quality of life among people living with HIV/AIDS (Greene et al., 2010).

Adherence and access to treatment and services

Without access to stable housing, persons are less likely to benefit from HIV risk reduction programs and treatments that slow the progression of HIV (Rourke et al., 2012). A number of studies affirm the difficulties of adhering to antiretroviral therapies, and utilizing medical services in general, among people who are homeless or unstably housed (Leaver, Bargh, Dunn & Hwang, 2007; Rourke et al., 2012). Without access to stable housing, people living with HIV/AIDS are less likely to benefit from the structure of consistent routines and schedules, which further challenges the management of their illness (and adherence to treatment regimens), even when individuals allegedly have access to medical care (Aidala et al., 2016). As stated previously, more attention needs to be given to the social environments and contexts in which people live that can influence people’s ability to afford and effectively adhere to treatments regimens, specifically highly active antiretroviral therapies (HAART). These social implications should be explored for each stage along the treatment cascade, which links newly diagnosed individuals with care and treatment so that they can reach a virally suppressed status (Aidala, Vardy & Yomogida, 2013).

Studies examining the spatial elements of housing are concerned with the environment that exists outside of the home, including neighbouring houses, community amenities, and public spaces (Bryant, 2003). For people living with HIV/AIDS, important community amenities include the availability of and access to HIV/AIDS-related services and supports. Fulcher and

Kaukinen (2005) further claim that the location and distribution of HIV-related health and social services are determining factors of their utilization. This can be exemplified by the fact that there is seemingly a migration of people living with HIV/AIDS into large urban centers, since HIV-related services tend to concentrate in larger cities (Fulcher & Kaukinen, 2005; Lima, Druyts, Montaner & Hogg, 2010).

Rourke and colleagues (2012) also found that the social meaning that persons living with HIV attribute to their dwelling and surrounding neighbourhood can determine where they reside but can also be a strong predictor of mental health-related quality of life (HRQoL). Researchers suggest that this association exists because of the proximity of one’s dwelling to community facilities, public infrastructure (i.e., bus for transportation), and health and social services (Rourke et al., 2012). In a study examining constructions of “home” for female substance users living with HIV in Vancouver's DTES, their understanding of home was related to “their proximity to health care, the daily supervision of medical and treatment regimens, and/or contact with agency workers, counsellors, pharmacists, nurses and physicians” (Robertson, 2007, p. 541).

Social wellbeing and belonging

In the Ontario Positive Spaces Healthy Places study (discussed in further detail in subsequent sections), people who perceived their living situation as unsafe were more likely to experience fear and social isolation than those who did not (Chambers et al., 2014). Furthermore, feelings of anxiety, depression, guilt and hopelessness were often associated with unsafe living situations where children were involved (Chambers et al., 2014). Rourke and colleagues (2012) also found that living in low-quality accommodations and neighbourhoods was likely to influence people’s perceptions of their own self-worth. This research finding indicates the importance of supporting people living with HIV in practicing their own agency when securing appropriate housing circumstances.

In another study examining the relationship between housing status and HIV risk among people actively using illicit substances in a variety of housed and homeless situations in the US, people living in independent housing situations were perceived as having more control over their living environment (Dickson-Gomez et al., 2009). Dickson-Gomez and colleagues (2009) found that participants were more likely to exercise control over their own substance using behaviours if they were able to control the entry of visitors into their living space (which also controlled the influence of substance using behaviours). Other authors affirm the importance of having control over one's living situations and the value of "taming [one's] space", which involves ongoing negotiations and decision-making that "highlight identity-constituting activities that are themselves shaped by spatial and representational regimes" (Robertson, 2007, p. 529).

Various studies exploring the influence of social environments for people living with HIV/AIDS highlight issues related to stigma (PHAC, 2015). Both discrimination and stigma further disadvantage people's ability to secure safe and affordable housing (CERA, 2008). The Ontario Human Rights Commission (2008) reported that one third of people living with HIV/AIDS had experienced some form of discrimination when attempting to access housing and 20% of individuals had experienced stigma. Furthermore,

> [Persons] living with HIV/AIDs report double, triple, or even multiple layering of stigma if the mode of infection is also stigmatized (e.g., drug use); if they belong to certain cultural groups (e.g., Aboriginal) or gender (e.g., female) or social class (e.g., "poor"); or if they suffer from another illness that is also stigmatized (e.g., mental illness) (Mill & Canadian Aboriginal AIDS Network, 2007, p. 39).

AIDS-related stigma, defined as "prejudice, discounting, discrediting, and discriminating directed at people perceived to have HIV or AIDS" (Herek, 1999, p. 1106), has emerged as a major concern for people living with HIV/AIDS. And Chambers and colleagues (2014) found that when HIV-related stigma was associated with people's living environments, it had negative implications for the emotional and mental health of residents occupying the space.

HIV-related stigma has also been associated with HIV-specific housing, or HIV-designated housing (Stajduhar & Lindsey, 1999), which can have negative implications for the disclosure of people's HIV status. Some researchers believe that the stigma associated with HIV-designated housing may cause others to perceive social housing and HIV negatively (Chambers et el., 2014), and residents neighbouring HIV-designated buildings may further perpetuate HIV-related stigma (Derose, Domínguez, Plimpton & Kanouse, 2010; Chambers et al., 2014). However, other authors have highlighted the positive social aspects associated with HIV-designated housing, including inclusive spaces where people can be open about their statuses and connect with other people living with HIV/AIDS (Greene, Chambers, Masinde & O'Brien-Teengs, 2012). Furthermore, Robertson (2007) found that HIV-positive women living in the DTES shared a common historical narrative of hardship and survival, and as a result, women found solace and a sense of hominess in establishing relationships with others living in the designated geographical area.

It is clear from the research that access to safe, secure housing plays a crucial role in both the risk and prognosis of HIV, and the quality of life for people living with HIV/AIDS (Aidala, Cross, Stall, Harre & Sumartojo, 2005; Chambers et al., 2014). Housing has the ability to intersect with factors such as inequality and poverty, which can heighten one's risk of HIV and poorer health outcomes (Rourke, Bekele, Tucker, Greene, Sobota, Koornstra & Positive Spaces Healthy Places Team, 2012), while "[affordable], safe, supported, and stable housing can help mitigate the effects of poverty, stigma, and illness" (Interagency Coalition on AIDS and Development & Rooftops Canada, 2010). From an extensive review of the literature Shubert (2010) found rates of HIV infection to be 3 times to 16 times higher among people who were homeless or unstably housed, compared to people of a similar demographic with stable housing. Further, homeless individuals are 10 times more likely to be HIV-positive than the general population (Shubert, 2010). At the time the study was being conducted in the Greater Toronto Area, Rourke and colleagues (2012) found that 4% of HIV-positive participants were either homeless or "episodically homeless" (i.e., hotels, shelters, and couch-surfing); 63% were receiving rental assistance; and 44% had difficulty in meeting rent on a monthly basis. Furthermore, study findings reveal that 87% of participants were unable to have their basic needs met including, access to food, clothing, and housing. These findings reveal a continuum of housing tenures and living situations that are a reality for many individuals living with HIV in Ontario. The availability of housing is not dissimilar in other provinces, and the Pacific AIDS Network, who represents over 50 HIV/AIDS service organizations throughout BC, identified housing to be one of the most unmet needs for individuals living with HIV/AIDS in the province (Pacific AIDS Network, 2007).

Epidemiology

According to 2014 national HIV estimates, 75,500 Canadians were living with HIV at the end of 2014, which represents an increase of 6,700 people (9.7%) since 2011 (Public Health Agency of Canada, 2015b). Transmission statistics show that 53% of this estimated population acquired HIV through sex with another man (men who have sex with men, MSM), while 31% acquired HIV through heterosexual sex, 19% through injection drug use, 15% were people emigrating from a country where HIV is endemic, and 9% of people living with HIV/AIDS have Aboriginal ancestry (PHAC, 2015b). In Canada, 2014 estimates show a higher incidence rate of HIV among Aboriginal populations (2.7 times) and people from HIV-endemic countries (6.3 times), compared to people with other cultural backgrounds living in Canada (PHAC, 2015b). While Canada continues to have a low prevalence of HIV/AIDS overall (PHAC, 2015a), the national prevalence of HIV/AIDS continues to increase, partly due to new HIV infections and partly because of advances in treatment and testing, meaning that more people living with HIV/AIDS are living longer.

The Epidemiology of HIV/AIDS in BC

BC has the third highest provincial rate of new HIV infections (behind Ontario and Quebec) (PHAC, 2015a). In 2014, the rate of new HIV diagnoses in BC was 5.6 (261 cases) per 100,000 population, decreasing slightly from 5.8 (267 cases) in 2013 (BC Centre for Disease Control, 2015). The highest HIV infection rates are within the Vancouver Coastal and Northern Heath Authorities, with the Vancouver Health Service Delivery Area having one of the highest rates of new HIV diagnoses in 2014 (BCCDC, 2015). The rate of new HIV diagnoses continues to be higher among males than females, with the rate being the highest in the 25-39 years-old age group for males and 30-39 years-old age group for women (BCCDC, 2015). There is a disproportionate burden of HIV and AIDS among First Nations populations in the province. Between 2005 and 2014 there were between 28 and 57 new HIV diagnoses reported each year among First Nations people (33 cases in 2014); however, the rate of new infections among this population has decreased over the past ten years (BCCDC, 2015). Lastly, provincial exposure trends show the largest proportion of estimated prevalent infections was attributed to MSM. The BCCDC 2014 statistics indicate that 57.5% (150 cases) of all new HIV diagnoses were among

MSM, 24.9% (65 cases) of new HIV diagnoses were from heterosexual contact, and 9.6% (25 cases) of diagnoses were among people who inject drugs (BCCDC, 2015).

The Response

In Canada, currently there is no comprehensive, nation-wide HIV/AIDS strategy (Ticknor & Belle-Isle, 2010). Instead, strategies are province-specific, and even sometimes population-specific. In BC, there are two primary strategies that aim to reduce the incidence of HIV, and these include the Treatment as Prevention protocol and the First Nations Health Plan that was developed out of the Transformative Change Accord (PHAC, 2015a).

Treatment as Prevention

In the early 2000s, the BC Centre for Excellence in HIV/AIDS encouraged the universal access to anti-retroviral therapy (ART) through what is today referred to as the "Treatment as Prevention (TasP) protocol." The protocol continues to encourage increased testing for HIV, as well as increased access to treatment for all medically eligible persons, with the intention of ceasing the progression of HIV infection to AIDS (PHAC, 2015a). Montaner and colleagues (2006) emphasized the effectiveness of highly active anti-retroviral therapy (HAART) in reducing viral loads to undetectable concentrations in HIV-infected persons and "HAART regimens have become markedly simpler, better tolerated, less toxic, and more effective" (p. 531). The TasP protocol is supported internationally by the WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS), an influential organization with an ambitious goal that states, "By 2020, 90% of all people living with HIV will know their HIV status, by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, by 2020, 90% of all people receiving antiretroviral therapy will have viral suppression" (the 90/90/90 statement) (UNAIDS, 2014, p. 1). To extend the efficacy of the TasP protocol, the Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS) Project was developed and first launched in 2009 to better engage hard-to-reach populations in Vancouver's DTES and Prince George with regard to HIV prevention (involving screening, diagnosis, treatment, and care) (PHAC, 2015a). As a result, the rate of new infections in the Vancouver, Northwest, and Northern Interior Health Service Delivery Areas has been influenced by increased testing efforts

(BCCDC, 2015), and in BC, the number of new HIV cases a year has been roughly cut in half following the introduction of HAART (Montaner et al., 2006).

The Tripartite Framework Agreement

Along with the TasP protocol and STOP HIV/AIDS project, the province's First Nations Health Plan contains a specific strategy for HIV/AIDS with the larger goal of closing the health gap between Aboriginal and non-Aboriginal people. As such, this plan acts as a HIV/AIDS strategy specifically for Aboriginal populations and has mechanisms for accountability for both the province and the federal government through The British Columbia Tripartite Framework Agreement (PHAC, 2015a). The health plan encourages the delivery of services in a way that meets the needs, priorities and interests of First Nations communities, with one priority area including disease and injury prevention (including infectious diseases such as HIV) (PHAC, 2015a).

Both of these HIV/AIDS strategies have an overwhelming focus on increasing access to services, specifically testing and treatment, for people living with HIV/AIDS in BC (British Columbia Ministry of Health, 2012). The STOP HIV/AIDS project has added a few HIV-designated housing units and subsidies for people living with HIV/AIDS in the Vancouver area, but these housing options are not yet available province-wide (Parashar, 2014). Consequently, the provincial commitment to stop HIV/AIDS focuses on a "treatment as prevention" approach, aiming to increase access to HIV/AIDS care and treatment, promote effective screening and early detection, to decrease the number of new HIV/AIDS diagnoses (BC Ministry of Health, 2012).

With this being said, the literature tells us that an increase in testing and access to treatment is not enough to curb new HIV infections and to sustain good health for people living with HIV/AIDS. For instance, Ontario's Positive Spaces, Healthy Places (PSHP) study shows that people who are unstably housed are less likely to access medical and social services, access antiretroviral therapy, and adhere to antiretroviral medications (Rourke, Bekele, Tucker, Greene, Sobota, Koornstra & Positive Spaces Healthy Places Team, 2012). With a provincial response to HIV/AIDS highly centered on treatment and testing, there is a lack of prioritization and direction provided for HIV-related initiatives that exist beyond the healthcare system, and direction to act on the broader determinants of health that may influence people’s access and adherence to treatment.

With the effectiveness of the TaP strategy the rate of new infections has remained quite stable, both provincially and nationally (PHAC, 2015a). With this trend has come a shifting perception of HIV/AIDS in the medical community, with HIV/AIDS being more widely perceived as a chronic, episodic illness, rather than an infectious one (Chambers et al., 2014). Early discourses of AIDS were oriented around an individualistic perspective and studies primarily focused on the individual determinants of risk behaviours, such as risky substance use practices, associated with HIV prevention (Rhodes, 1997). As a consequence, the most important concern in controlling the HIV/AIDS epidemic was clinical treatment (Wright & Carnes, 2016). Since then, there have been dramatic changes in public health that have altered discussions on HIV/AIDS treatment and prevention (Wright & Carnes, 2016; Singer & Clair, 2003). Moving beyond biomedical or individualistic perspectives of HIV/AIDS, studies are now increasingly examining the disease processes of HIV by incorporating psychological, social, structural, and environmental perspectives to better understand how health problems relate to one another (Wright & Carnes, 2016; Singer & Clair, 2003). As a result, the HIV/AIDS epidemic is increasingly being considered a “socio-economic” issue rather than a biomedical one (Williamson, 2004). Building on this perspective, Parashar (2014) refers to HIV/AIDS as “a disease of inequity” because of the social and behavioural implications of transmission, together impacted by the structural inequities that exist in societies, continue to perpetuate the epidemic.

Given the numerous studies examining the relationship between housing and health for people living with HIV/AIDS, housing has been shown to be an important intervention in addressing individual and population health priorities, including disease prevention, access to and the efficacy of healthcare, the reduction of healthcare costs, and access to the broader determinants of health (The National AIDS Housing Coalition, 2005). This is especially true for complex health issues, such as HIV/AIDS. The research community has recognized that not only individual factors influence the risk of HIV transmission and disease progression, but structural and contextual factors that lie beyond the immediate control of individuals, are also a part of this causal pathway (Aidala et al., 2005). Finally, the relationship between housing and HIV has been increasingly studied, and housing has unanimously been determined an effective intervention both for the prevention of HIV/AIDS and for improved health outcomes among people living with HIV/AIDS (NAHC, 2005). However, certain housing conditions can still increase people's risk of HIV infection, as well as create unfavourable conditions for people living with HIV/AIDS (Aidala et al., 2005). Therefore, greater inquiry and intervention targeting these two causal pathways is needed to improve our understanding of the relationship between housing and health, and to improve housing circumstances for people living with HIV/AIDS.

Study Rationale

There are social, research-related, and practical reasons for conducting this study. From a social perspective, access to adequate and affordable housing is a basic human right, just as it is a determinant of health. Considerable evidence supports the claim that a person's HIV status affects their housing situation, and certain housing situations can put people at greater or less risk of HIV infection. Canada is currently without a national housing strategy that would serve to equitably and comprehensively address housing needs across the country (Ticknor & Belle-Isle, 2010). Instead, provincial and local governments have to use what resources they have to address housing issues in their respective jurisdictions. The problem with this approach is that gaps in supports and services often exist for certain subsets of the population, putting these populations at risk for other complex issues like poverty, chronic health issues, and food insecurity. People living with HIV/AIDS make up one of the populations that face systemic barriers in accessing adequate and affordable housing. In Canada, more than half of the people living with HIV/AIDS live below the poverty line (Rourke et al., 2012). Furthermore, people living with HIV/AIDS with lower socio-economic statuses are more likely to experience a progression in their HIV-status (lower CD4 counts and higher viral loads), as well as death, in comparison to the general population (McMahon, Wanke, Terrin, Skinner & Knox, 2011).

From a theoretical and research perspective, this study will explore the social phenomenon of the relationship between housing, health, and home by conducting a secondary analysis of data collected from a community-based research (CBR) study. A thematic analysis of qualitative interview transcripts was the primary technique for data interpretation and essentially followed the methods of a constant comparative coding approach from Grounded Theory methodology. While other research has explored the relationship between housing and HIV, as well as the links between home and health, past studies have overwhelmingly focused on the physical and structural components of housing and have focused on housing extremes, such as homelessness (Aidala, Lee, Abramson, Messeri & Siegler, 2007). Furthermore, housing research has primarily used epidemiological methods (Bryant, 2003), which lack the capacity to delineate the intricate relationship between home and wellbeing for people living with HIV/AIDS (Parashar, 2014). The Public Health Agency of Canada (2015a) asserted that more research is needed to understand the complexities of the social determinants of health, and how these determinants affect HIV status, and the health and wellbeing of those who are impacted by HIV/AIDS. The Agency also claims that further research exploring the impacts of living with HIV/AIDS is needed (PHAC, 2015a).

Practically, the majority of the research studying the meaning of home for people living with HIV/AIDS in Canada, to date, is concentrated in Ontario and on selected topics and sub-populations. The Ontario HIV Treatment Network (OHTN) is leading one of the largest clinic-based studies of people living with HIV/AIDS in North America. Situated within the larger study, the Positive Spaces Healthy Places (PSHP) study is a longitudinal community-based research study that began in 2005 and has since collected data from more than 600 people. Peer Research Assistants played an integral role in the sustainability of the study and the continued effort to understand the number of housing issues faced by people living with HIV/AIDS (The Ontario HIV Treatment Network, 2016). The PSHP study team members have published numerous papers examining the relationship between housing and health for people living with HIV/AIDS. Among these published studies, some have taken a deeper look of the meaningful dimensions of housing but have primarily focused on these dimensions as they intersect with issues related to motherhood, poverty, sexism, racism, immigration status and HIV-related stigma and discrimination (Greene, Chambers, Masinde & O’Brien-Teengs, 2012). Published studies have also explored the various elements of housing and how these elements can influence health-related quality of life for people living with HIV/AIDS (Rourke et al., 2012), with respect to the meaning of “healthy housing” for people living with HIV/AIDS (Chambers et al., 2014). With the dearth of research examining these more meaningful elements of housing for people living with HIV/AIDS, I suggest that HIV housing services are ill equipped to comprehensively meet the social, emotional, mental, and physical health needs of this population.

In order to capture lived experiences and explore the meaningful dimensions of people's current living situation, the literature suggests a CBR methodology be applied (Parashar, 2014). CBR approaches are increasingly being used in HIV-oriented research and authors acknowledge the instrumental contribution of CBR approaches in addressing the HIV/AIDS epidemic (Padgett, 2012). CBR approaches are built on the foundations of social justice and empowerment, and increase people's capacity to make changes in their own community through participatory approaches to research and community action. Therefore, it is practical to use a CBR approach to not only increase our understanding of the contextual and meaningful nature of people's housing experiences, but also to help influence policy and promote change to current housing supports for people living with HIV/AIDS. The PSHP study reminds us that "housing that is safe, secure, affordable and hospitable can contribute to the betterment of health for the general population" (p. 311), yet few studies have taken place in a Canadian context considering the meaningfulness of housing for the population living with HIV/AIDS (Chambers et al., 2014). Since research often sets the stage for community action, CBR can help give communities the capacity to address their own social issues by redistributing resources more equitably and by empowering communities to take part in the research process (Hacker, 2013). These characteristics of CBR are important to highlight because despite the theoretical advances made by other conceptual frameworks and research methods examining the importance of housing, significant health inequities still persist in Canada. Finally, the aforementioned contributions of CBR necessitate the use of a participatory methodologies to help address the action-oriented needs of research findings in studies involving people living with HIV/AIDS.

Primary Study: *Positive Living, Positive Homes*

In collaboration with my supervisor, Catherine Worthington, the Pacific AIDS Network (PAN) is currently conducting the Positive Living, Positive Homes (PLPH) study that aims to address the gaps in the literature by exploring the impacts of housing for people living with HIV/AIDS in three BC communities, including Greater Vancouver, Prince George and Kamloops. This longitudinal, qualitative study has included interviews with people living with

HIV in the 3 communities, as well as interviews with policy makers and service providers in each community (a further description of the relevant components of the primary study can be found in the methodology section of this thesis). My research is situated within this primary study and I conducted a secondary analysis of the research data. My study aim and research objectives are closely aligned with the original objectives of the PLPH study, which were to:

1. *Investigate PHAs' [people living with HIV/AIDS] experiences of housing, health and housing access over time; explore the personal, social and structural factors that influence housing, health and wellbeing; and examine how housing and HIV programs, services and policies have influenced (enabled and/or impeded) access to housing, and interacted with housing experiences to influence health and wellbeing; and*
2. *Document the successes and challenges of various housing-related programs, services and policies, within their localized contexts, and identify best practices for HIV and housing programs, services and policies so they may better meet the needs of PHAs.*

My role in this primary study stems from my practicum placement with PAN in partial fulfillment of my Masters of Public Health degree, and I was first connected to PAN through my supervisor's role with the organization. During my eight-month practicum I was primarily engaged in the Community-Based Research Program at PAN. Through this program I was able to develop a better understanding of the many elements of participatory research by attending CBR webinars (typically put on by the Ontario HIV Treatment Network), participating in teleconferences with PAN staff, and engaging with members of the Participatory Analysis Working Group (PAWG) for the PLPH study. Padgett (2012) claims that secondary analyses extend the life of the primary study and are an efficient use of resources. To me, the latter point is most important due to the constraints of time and funding during a Master's program.

The primary research study uses a CBR approach to explore the relationship between housing and health for people living with HIV/AIDS, and is guided by the principles of CBR.

With my own secondary analysis of the data collected from the PLPH study, it was not practical to conduct a full CBR project; however, I incorporated participatory elements where possible. I will discuss these participatory approaches in the following Methodology chapter.

Study Objectives

To address the current gaps identified in the literature, my thesis used a context-specific, CBR approach to explore the relationships between housing and health for people living with HIV/AIDS in the Greater Vancouver area of BC. Using qualitative methods, the objectives of my study were to:

1. Identify what "home" meant for people living with HIV/AIDS across a continuum of housing/living situations (including shelters and transitional housing; social and subsidized housing; supportive housing and assisted living; and secure market rental housing and homeownership), and describe the physical, social, spatial, and meaningful (i.e., the meaning attached to both tangible and intangible elements) dimensions of home.
2. Explore how people living with HIV/AIDS perceive the various elements of their housing situation, and how these elements influence their health and wellbeing.

The findings from this study can help to inform future housing services and practices to provide people living with HIV/AIDS with appropriate, supportive, and meaningful options for housing.

Terminology

This study is unique in that it examines the meaningful dimensions of home and housing for people living with HIV/AIDS in a BC context using a community-based research methodology. Therefore, it is important to define several important terms from the outset to make the distinction clear to the reader and to justify why I have chosen to define them in a particular way.

"House and Home"

Rykwert (1991) was one of the first to compare the constructions of house and home, and the languages used to determine the difference between the two, cross-culturally. Similar to Rykwert's (1991) distinction, Karjalainen (1993) describes, "House is a material object, but home is a relation...home is an emotionally based and meaningful relationship between dwellers and the dwelling places" (p. 71). From this perspective, home can be viewed as any type of existential space (i.e., a neighbourhood or a city), and not necessarily defined as a structure containing four walls (Sixsmith, 1986). Furthermore, the term "home" is intended to encompass feelings of security, happiness, and belonging (Sixsmith, 1986), and is defined as the place where social relationships are established and emotional experiences are authenticated (Després, 1991). I will continue to use the term "home" to embody the more emotional and meaningful elements of a space, and will use the term "house" to refer to the physical space, or the space defined by having a more structural composition.

"People living with HIV/AIDS"

The phrase "living with HIV/AIDS" or "people living with HIV/AIDS" is used to highlight the authentic and unique experiences that people have living with this specific, lifelong condition. By consciously choosing to adhere to this terminology throughout my thesis, I hope to limit the possibility of characterizing one person by the illness that they have and to prevent the use of one term to subject people living with HIV/AIDS to one universal experience.

I listened to a podcast recently and appreciated how the featured guest on the show described her journey of living with asthma and her reasons for not prescribing her identity to living with that illness. She explained, "I don't define myself as a sick person anymore…when I do, I become sick…what I think, I become. I have to keep reminding myself that this [illness] doesn't define me, it adds a layer to my story and that is beautiful – just like everything we experience" (Brathen & Bosnak, 2017, 23:23). Living with an illness certainly doesn't prescribe a person to a certain set of characteristics, nor does it encompass the experiences lived by people living with an illness. While disease classification systems, such as WHO's International classification of functioning, disability and health (ICF) system, may be useful in identifying disease and guiding intervention, it isn't sufficient for understanding the lived experiences of people. Rather, disease classifications often universalize the experience of living with a particular disease or illness. By keeping the terminology “people living with HIV/AIDS” I make an honest effort to consider the subjective experiences lived and felt by people living with HIV/AIDS, and recognize the array of social, cultural, economic, and historical factors that impact individual experiences. Therefore, using the term “living with” ensures that living with HIV/AIDS does not prescribe the individual to one attribute, but is rather one attribute among many.

“Community-based Research” and “CBR”

Community-based research (CBR) is a term often used synonymously with community-based participatory research, participatory research, and participatory action research. Although these research approaches differ slightly, they are commonly rooted in community engagement, democratic research processes, and action-oriented practices (Hacker, 2013). In addition to sharing these participatory qualities, CBR is also rooted in feminist theory and community organizing, which makes tenets of social justice and empowerment central to the methodology (Hacker, 2013). For the purposes of this thesis, I will use the term community-based research (“CBR”) most often, primarily because of its inclusion of social justice and community action for social change. However, I may use other participatory research terms interchangeably at times, depending on the context in which the term is used and how the term appears in the literature.

Organization of the Paper

This thesis contains six chapters in total, and following this Introduction chapter, continues with a review of the literature. This Review of the Literature chapter (Chapter II) provides a review of existing literature, research studies, and theoretical frameworks that have been used to explore the relationship between housing and health. Chapter II focuses on the meaningful dimensions of housing for people living with HIV/AIDS, as well as a more in-depth discussion about the distinction between housing and home, and how the literature has constructed the definition of “home” to date. The chapter concludes by outlining unanswered questions about the relationship between housing and health, and how both CBR and an examination of the meaningful dimensions of housing for people living with HIV/AIDS can help address these gaps.

The third chapter, the Community-Based Research and Methodology chapter, begins by providing a contextual background of CBR and how my thesis is nested within a CBR study, the PLPH study. It also provides a brief summary of the PLPH study, where the data for this thesis originates. I then explain how the data were coded and categorized into major themes using thematic analysis and participatory analysis approaches.

In the Results chapter, I introduce common themes that emerged from the data, using participants' narratives to illuminate the everyday realities of people living with HIV/AIDS. I describe the mid-level conceptual categories (e.g., kitchen spaces and housing security) I developed to more effectively organize the positive and negative elements of participants' living spaces, and to add further to the discussion of how participants define "home" and the conditions for feeling "at home". The Results chapter was organized in this way to inform a subsequent discussion of higher-level conceptual categories of themes found in Chapter V.

In the Conceptual Categories and Discussion chapter (Chapter V), I define each conceptual category and connect the major findings from the data to existing studies and theoretical frameworks that have been useful in examining the housing-health nexus for people living with HIV/AIDS. I then discuss the implications for existing housing programs and for further research to be conducted for the meaning of home.

I conclude this thesis with a final chapter summarizing the key conceptual categories discussed in the previous two chapters, and discuss their implications for the meaning of home for theory, practice, and the development of more appropriate housing options for people living with HIV/AIDS. I conclude the section by offering my own personal reflections on being involved in a CBR process and how I hope the research findings from this study will translate into a community giveback project.

CHAPTER II: REVIEW OF THE LITERATURE

To situate this thesis research, I will provide a review of research exploring the intricacies of housing and health for people living with HIV, focusing on the most prominent concepts and processes to summarize the direction of current research. I endeavoured to complete an unstructured review (rather than use a more formal, structured approach such as a systematic review) of the literature based on key findings and material to set the stage for subsequent discussion on the meaning of home for people living with HIV/AIDS in BC (Bourhis, 2017). I will place emphasis on literature examining the meaning of home and the intangible elements that define a person's living space, but I will use current housing and health research to situate this research focus. I will focus upon a British Columbian and Canadian context, and incorporate comparative research from other industrialized nations. Finally, this narrative review will provide the background information necessary to better understand the experiences of people affected by HIV/AIDS living in a specific provincial context.

In the following sections, I will describe the health implications of housing from the standpoint of housing as a basic right and a determinant of health, and the associated material (physical), spatial (social), and meaningful benefits of housing. I will then describe these components of housing in relation to the health and wellbeing for people living with HIV/AIDS. Within this section I will also describe two theoretical frameworks that have been used widely in the literature to study the relationship between housing and health among populations affected by HIV/AIDS. Lastly, I will explore the current HIV and housing policy and service environment locally and provincially. My focus will be to highlight the meaningful elements people living with HIV/AIDS attach to their living spaces, and how the various components that make up a "home" are actualized and benefit the health and wellbeing of this specific population.

The Material, Spatial, and Meaningful Benefits of Housing

The relationships between housing, health, and wellbeing have been studied widely and many researchers have reached consensus on three interrelated dimensions of housing that further explicate these relationships (Padgett, 2007): material dimensions, spatial dimensions and meaningful dimensions (Bryant, 2003).

The Material Dimensions

The material dimensions of housing provide a physical structure sheltering people from external elements (Bryant, 2003), and provide privacy and access to facilities that allow residents to maintain their physical health and wellbeing (i.e., through sleeping, washing, and preparing food) (Rourke, Bekele, Tucker, Greene, Sobota, Koornstra & Positive Spaces Healthy Places Team, 2012). Many studies have shown that features of substandard housing (e.g., overcrowding) are associated with the transmission of communicable diseases and the development of noncommunicable diseases (Krieger & Higgins, 2002). While harmful material (e.g., lead), biological (e.g., allergens), and physical (e.g., poor ventilation) exposures in the home can lead to physical health concerns for occupants, anxiety about substandard housing and the fear of homelessness can act as psychological stressors that also place occupants at risk for mental health concerns (Krieger & Higgins, 2002). In addition, issues with housing affordability can have direct and indirect effects on individuals. People challenged by the affordability of their living situations are more likely to experience negative psychological outcomes (i.e., anxiety, exposure to excessive noise and sleep deprivation), an increase in substance use (Krieger & Higgins, 2002), and issues related to food security (Rohe & Han, 2012). Researchers found that housing insecurity also created conditions in which people were less likely to adhere to their treatment regimens (Centre for Housing Policy and Enterprise Community Partners, 2007), and more likely to use hospital-based emergency or inpatient services frequently (Leaver, Bargh, Dunn & Hwang, 2007).

The physical structure of the home itself provides individuals living with chronic illnesses and disabilities the stability to successfully adhere to treatment regimens (Centre for Housing Policy and Enterprise Community Partners, 2007). Whether living on the street or in other transitional forms of housing, individuals expend a lot of energy on basic survival skills. With increased energy and time devoted to one's shelter, people are less likely to maintain healthy behaviours, such as regular doctor visits (Goering et al., 2014). These contributing factors are likely to affect the health and wellbeing of individuals, both in the short-term and long-term (Rohe & Han, 2012).

In addition to the material dimensions, or the standards of housing just described, researchers have found that the type of housing tenure can be correlated with varying levels of health status (Macintyre, Ellaway, Hiscock, Kearns, Der & McKay, 2003; Kearns, Hiscock, Ellaway & Macintyre, 2000). For instance, Macintyre and colleagues (2003) found that individuals living in social housing and rented dwellings were more likely to perceive features of their living space to negatively impact their health, including dampness, noise, and crime. Comparatively, individuals with homeownership were more likely to benefit from health promoting features in their home environments, such as access to garden spaces, which translated into improved physical and mental health outcomes. However, the authors conclude that their study could not describe the significance and influence that external factors, such as geography, culture, and historical period, had on participants' health and should thus be explored further (Macintyre et al., 2003).

There is no doubt that the physical conditions of housing and varying housing tenures play a part in determining individuals' health outcomes, but these associations do not clearly indicate how the wellbeing of occupants is affected. Moreover, "…[Since] well-being is not a purely physical phenomenon there is also a strong possibility that individuals' health outcomes are related to, or affected by, the social and psychological attributes of housing" (Kearns, Hiscock, Ellaway & Macintyre, 2000, p. 388). Public health efforts have been primarily concerned with the effects of substandard housing on health, as well as an increasing focus on the positive and negative consequences of housing in general (Padgett, 2007). Yet, the diversity of material conditions that make up people's living spaces, dependent on cost, location, and availability (Tucker, 2009), are rarely at the forefront of public health efforts and in housing literature. Furthermore, health needs, personal preferences, and the meaningfulness that people attach to their living situation may also determine the housing type they wish to occupy (Tucker, 2009). Therefore, understanding how simply "putting a roof over one's head" influences health may not be sufficient to understand the comprehensive relationship between housing and health.

The Spatial Dimensions

The spatial dimensions of housing are concerned with the environment that exists outside of the home, including neighbouring houses, community amenities, and public spaces (Bryant, 2003). Evidence suggests that the physical and social characteristics of neighbourhoods are important determinants of health for residents (Macintyre, Ellaway & Cummins, 2002). For instance, rates of chronic disease can be influenced by the quality and availability of food supplies, surrounding amenities, cultural and social practices, transportation systems, and opportunities for physical activity in surrounding residential environments (Marmot, 2005). In addition to the physical characteristics of the surrounding environment, Parashar (2014) suggests that social environments influence health and wellbeing through perceived social cohesiveness with neighbouring areas, relative standards of living, and civic engagement. Of the aforementioned social factors, Marmot (2005) claims that the social cohesion of the local neighbourhood is of particular importance. Social cohesion takes into account both the nature of relationships and social networks, as well as the quality of social relations. Through an examination of the relationship between neighbourhood social cohesion and self-reported health, Marmot (2005) concludes that measures of social cohesion were more unfavourable in deprived areas.

Other studies have explored the cultural norms and activities characteristic of certain places and neighbourhoods, claiming that cultural factors can also influence the health of residents (Stead, MacAskill, Mackintosh, Reece & Eadie, 2001). A study conducted by Stead and colleagues (2001) examined smoking rates in relation to disadvantaged communities, finding that rates were associated with individuals' place of residence, independent from individual poverty and socioeconomic status. Their study highlights a number of features of disadvantaged communities that influence health behaviours (i.e., smoking) including, "poorly resourced and stressful [environments], strong community norms, isolation from wider social norms, and limited opportunities for respite and recreation" (Stead, MacAskill, Mackintosh, Reece & Eadie, 2001, p. 333). In addition to the cultural factors that influence the health behaviours of individuals, some environments have been shown to predispose people to a level of risk or to certain risk behaviours (Rhodes, 1997). Risk can be understood both from an individual and a social perspective, but Rhodes (1997) emphasizes risk as a socially organized phenomenon that is influenced by the interplay of a number of individual and social factors, including individual behaviours, communities, and social environments.

Finally, in addition to the social, cultural, and spatial dimensions of housing, structural factors in the spatial environment, such as housing policy, can also influence the health behaviours of populations residing in specific political, geographic, and social settings (Scott, Ellen, Clum & Leonard, 2007). These dimensions also consider the social relationships and networks that are constructed as a result of larger social and structural factors. Després' (1991) review of the literature reveals, "economic, political, legal, cultural and psychological dimensions…need to be [pulled] together to understand the production and reproduction of social life and meanings" (p. 108). In this sense, social structures and cultural dimensions create a kind of window for researchers to better disentangle the more meaningful dimensions of our environments.

The Meaningful Dimensions

The third dimension of housing is the meaningful dimensions. This includes both the positive and negative feelings, and the attitudes that individuals perceive to contribute to their idea of "home". As noted in the Introduction, Rykwert (1991) was one of the first to compare the constructions of house and home, and the languages used to distinguish cross-culturally between the two. Similar to Rykwert's (1991) distinction, Karjalainen (1993) describes, "House is a material object, but home is a relation...home is an emotionally based and meaningful relationship between dwellers and the dwelling places" (p. 71). Shaw (2004) proposes to define the differences between housing and home by organizing the elements of each into "soft" or "hard" components. The "hard" aspects include the structural components of the house while the "soft" aspects include the psychosocial elements and feelings related to having a safe, secure place to sleep and eat (Shaw, 2004). People who are appropriately and adequately housed may express common feelings of ownership, stability and security. In addition to these feelings, Després (1991) categorizes several "meanings of home" to include: security and control; a reflection of individual ideas and values; modifiable; permanence and continuity; ownership; an indicator of personal status; a refuge from the outside world; and a place where social activities and activities of daily life can be carried out either individually or among relatives and friends. Sixsmith (1986) also describes home as "'a crucial site of cultural activity and cultural expression' (Gauvain, Altman and Fahim, 1985) at one and the same time, portraying a person's individuality and their ties to society" (p.282). Some of the feelings associated with home allude to the fact that “home” could exist on any level of existential space (i.e., a neighbourhood or a city), and not needing to be confined by four walls (Sixsmith, 1986). To date, several authors have attempted to conceptualize the meaningful dimensions of home and the following sections will describe these theoretical developments.

The Meaning of Home

From a study exploring the meaning of home among postgraduate students, Sixsmith (1986) defines three aspects to conceptualize the meaning of home, including the personal, social, and physical aspects of home.

The personal home

Sixsmith (1986) found that the meaningful dimensions within the more “personal” aspects of home might not be tangible objects but rather possessions that individuals knowingly associate with their sense of being. In this sense, home can be described as an extension of the person who occupies the space (Després, 1991). Such personal possessions were found to encompass feelings of security, happiness, and belonging (Sixsmith, 1986). Some individuals may also apply meaning to other tangible components of their homes. For instance, the continual renovation or additions (i.e., furnishings and décor) to complement other aspects in the home attempt to provide a space where individuals can “be themselves” and be expressive (Sixsmith, 1986). Therefore, both the tangible and intangible elements in a person’s home are associated with personal feelings of being “at home”. Furthermore, gender perspectives on the meaning of home suggest that the meaning of home often differs between men and women. Some research has shown that men consider home to be a marker of their status and achievement, while women are more likely to associate the home with family and regard it as a haven (Mallett, 2004; Kearns, Hiscock, Ellaway & Macintyre, 2000). However, a lot of the gender and home literature is critiqued with not comprehensively examining the links between gender, sex, and sexuality, and often conflates the term home with housing (Mallett, 2004).

The social home

The social aspects related to the meaning of home recognize the importance of relationships built and sustained in the home setting (Sixsmith, 1986). In this sense, “[home] is perceived and experienced as the locus of intense emotional experience, and as providing an atmosphere of social understanding where one's actions, opinions, and moods are accepted" (Després, 1991, p. 98). Additionally, Després' (1991) review of the literature revealed that social status was a relatively important element for the social meanings of home. In this regard, the home provided an avenue for which individuals could display their social status, namely their socio-economic position in society (Després, 1991). Després (1991) also found tenure status to be related to social status and as a result, individuals occupying rental units were perceived to be of lower social status than homeowners.

The physical home

Sixsmith (1986) describes how the physical structure, the design and architecture, and the space available in a setting help construct the meaning of home. Additionally, the facilities and services that a space provides (i.e., hydro) are important features of what people require, making their home both comfortable and convenient (Sixsmith, 1986). Sixsmith further explains, "[A] home is home depending on the extent to which it fulfills the person's requirements, their changing objectives and circumstances" (p. 285). To this extent, Sixsmith (1986) adds a temporal component to what constructs home, proposing that spaces defined as "home" can change over time, and can be timely to construct (Després, 1991).

Beyond Sixsmith's three aspects of the meaning of home, phenomenological research on home attempts to explore the experience of "being-at-home" rather than tying the concept of home to a particular space (Mallett, 2004). The understanding of home as a verb, rather than a noun, has still shown to include specific activities and planned events (i.e., birthdays) that routinely take place even in the absence of a static dwelling. In this dimension Julia Wardhaugh (1999) argued that home is "…a physical space that is lived – a space that is an 'expression of social meanings and identities'…the concept of home cannot exist without the concept of homelessness. Home and home-lessness exist in a dynamic, dialectical relationship. They are not, as some suggest, fixed oppositional terms. Rather they refer to 'complex and shifting experiences and identities' that emerge and unfold in and through time" (as cited in Mallett, 2004, p. 80). This understanding of home considers the social meanings and the social identities that construct the meaning of home, and defines each of these in regard to transitional and temporal elements. This understanding of home also defines people as "home-makers" who construct their homes out of the actions they perform (to feel secure and to fulfill their personal needs) and how they live (Mallett, 2004).

The meaning of home literature remains fairly consistent among studies and authors, yet these meaningful dimensions remain relatively broad and the literature is seen to have several limitations (Kearns, Hiscock, Ellaway & Macintyre, 2000). Firstly, Mallett (2004) states that the meaning of home literature is limited in that the authors expanding the meaning of home theory often do so within their own discipline (namely sociology and psychology) and "researchers generally limit their analyses to particular dimensions of home" (p. 64). Secondly, Western ideas about the "ideal home" are prevalent in the literature and tend to give preference to freestanding houses that include a yard and are occupied by a nuclear family (Mallett, 2004). Furthermore, many meaning of home studies are limited by "place-specific attitudes" and the outcomes of these studies are often specific to the context in which they take place (Dowling, 1998). Dowling (1998) explains that these attitudes influence the significance that class, gender, and housing tenure have with regard to how people describe their homes.

Despite the limitations in the literature, studies show a strong relationship between one's house, home, and health. Even though the complexity and variability of this relationship challenge researchers, Sixsmith (1986) suggests that "[a] tripartite division of home into personal, social and physical modes of experience indicates some of the interesting relations between people and places and, together with the particular constitution of the experiential modes, suggest directions for future research" (p. 294). Several authors claim that people may have more than one space that they describe as "home", indicating, "[the] interrelationships between different homes may form an important nexus of meanings through which personal meanings of home emerge" (Sixsmith, 1986, p. 285). Given the importance of studying the meaningful dimensions of the home in relation to one's health and wellbeing, some researchers have used the theory of ontological security to further deliberate the relationship between home and health.

The Theory of Ontological Security

More recently, the theory of ontological security has been used to study the social elements of a home (Padgett, 2007), and studies have increasingly examined the relationship between ontological security and housing (Kearns, Hiscock, Ellaway & Macintyre, 2000). From a psychoanalytic foundation, R.D. Laing (1965) first theorized the concept of ontological security (and insecurity) through an examination of the conditions of schizophrenia and psychosis. He referred to ontological security as “a centrally firm sense of [one’s] own and other people’s reality and identity” that arises from the experience of one’s “presence in the world as a real, alive, whole, and… [temporally] continuous person” (Laing,1965, p. 39). When considering schizophrenia and psychosis, Laing (1969) explained the challenges individuals might face in their attempt to preserve their sense of self. Giddens (1991) expanded upon the theory of ontological security by describing a person’s sense of self in relation to their surrounding environment, defining ontological security as,

> The confidence that most human beings have in the continuity of their self identity and in the constancy of their social and material environments. Basic to a feeling of ontological security is a sense of the reliability of persons and things (p. 54).

Padgett (2007) applied the theory of ontological security to her research that sought to examine the constituents of a “home” and to consider what “living independently” meant for people living with mental illnesses who were housed. She drew upon the concepts theorized by R.D. Laing (1965), Anthony Giddens (1991), and Dupuis and Thorns (1998), finding that major themes in the literature included: constancy, day-to-day routines, a sense of control due to a lack of surveillance, and a space where identities can be constructed (Padgett, 2007). Specifically, Dupuis and Thorns (1998) conducted a study with older adults in New Zealand and found that a sense of security, as well as confidence and trust in the surrounding environment, could be sustained though homeownership. While homeownership was a major element cited in terms of what makes a house a home, family and the social relationships maintained within a space also added a sense of hominess (Dupuis & Thorns, 1998).

For this thesis, I will be most concerned with Giddens' (1991) definition of ontological security, defined as the confidence in the continuity of one's self-identity and in the constancy of one's social and material environments. Dupuis and Thorns (1998) lay out four conditions that a home must meet for individuals to attain ontological security:

1. Home is a place of constancy in the material and social environment;
2. Home is a place in which the day-to-day routines of human existence are performed;
3. Home is where people feel in control of their lives because they feel free from the surveillance that characterizes life elsewhere; and,
4. Home is a secure base around which identities are constructed (p. 29).

The constructions of home developed by Dupuis and Thorns (1998) are much aligned with the three meaningful dimensions of home described by Sixsmith (1986). Through their construction of home, Dupuis and Thorns (1998) further postulated that a home was not a natural entity nor was it something that can be instantly provided, but rather a house (a physical structure) became a home through continual routine measures and social interactions. Furthermore, they explain that the complexity associated with the meanings of home is partly due to the fact that they are bound by both time and place. I will add to the findings from Dupuis and Thorns' (1998) study by examining whether meanings of home can be similar across a specific population (bound by comparable experience of living with HIV/AIDS).

To date, much of the research on ontological security has been studied in relation to homeownership (Padgett, 2007), and some authors have concluded that rented accommodations do not offer residents the same degree of security as homeownership (Dupuis & Thorns, 1998). However, homeownership might not be realistic or even appropriate for the variety of people who seek stable housing. Additionally, many researchers have described ontological security as an abstract concept (Kearns, Hiscock, Ellaway & Macintyre, 2000), which is "difficult to define, [and] even more difficult to operationalize" (Saunders, 1989). Further research is needed to explore the dynamic experiences of transient states of homelessness, as well as the more stable forms of housing tenure for specific populations, such as people living with HIV/AIDS (Padgett, 2007). Adding to the review of the literature of the three dimensions of housing, the next section will explore how these dimensions influence the health and wellbeing of people living with HIV/AIDS.

The Meaningful Dimensions of Housing for People living with HIV/AIDS

People living with HIV/AIDS experience similar material, spatial, and meaningful benefits of housing, as described in the literature. In the Ontario PSHP study, many participants described their housing as more than a roof over their head. Participants' narratives illustrated that "[healthy] housing for people with HIV should address financial and social concerns to ensure stability, attend to their physical and emotional safety, be non-stigmatizing, and foster social support and a sense of community" (Chambers et al., 2014, p. 324). Furthermore, healthy housing, or positive living environments, were shown to facilitate social inclusion and engagement. Chambers and colleagues (2014) describe these socially inclusive environments as spaces that include "social supports" (i.e., friends and family), "instrumental supports" (i.e., nearby HIV-related supports and services), and an inclusive community free of stigma. Having safe housing was also described as a health-promoting feature and allowed some people to regain a sense of mental stability. With perceived mental stability, people were able to move beyond issues related to their housing and able to focus on other things, such as their illness and health, as well as prospective employment and educational opportunities (Chambers et al., 2014). In this light, stable housing can be considered a foundational component of self-improvement, "[empowering] people to invest in their own well-being" by way of developing relationships with people in their neighbourhood, engaging with their community, returning to school or work, and by creating positive spaces for themselves and family members (Chambers et al., 2014).

The literature concludes that the physical and mental quality of life for people living with HIV/AIDS is linked to their satisfaction with the material, spatial, and meaningful dimensions of housing (Chambers et al., 2014). Even though many studies show a strong association between the health of people living with HIV/AIDS and the perceived material (shelter) and spatial (proximity to health services) benefits of housing, few studies have explored the meaningful dimensions for this specific population. Furthermore, the studies that do attempt to explore the meaning of home tend to do so within the confines of the abovementioned elements of housing and health for people living with HIV/AIDS (proximity to public amenities, community events, social belonging, etc.), with even fewer studies attempting to explore the intangible elements that help construct the meaning of home.

Housing for People Living with HIV/AIDS

Amidst the research that has examined the relationship between housing and health for people living with HIV/AIDS, housing has been framed as an effective, structural intervention influencing disease prevention, health care access and effectiveness, and cost containment. Furthermore, the research has begun to look at the meaning of “healthy housing” for people living with HIV/AIDS and how the security and stability of housing can positively impact the mental and emotional health of occupants. However, there are economic, social, and political barriers that continue to keep people living with HIV/AIDS from being appropriately and meaningfully housed. In this next section I will lay out the housing context in BC and the housing programs available for people living with HIV/AIDS.

The Housing Context in BC

The diversity of housing and shifting trends in homeownership has grown more complex in BC over the past several years. Provincial housing tenure statistics indicate that while the majority (68%) of people in BC are homeowners, over 30% of households in BC are rental accommodations (which is similar to the national average), and under 1% of housing tenures are band housing (Statistics Canada, 2017). The Canadian Rental Index (2016) estimates that approximately 6,848 people are homeless, while 23% of renters spend more than half of their income on housing and utilities. In terms of Greater Vancouver specifically, the 2016 Vancouver Homeless Count revealed that 1,847 individuals (70%) were defined as homeless with 1,276 homeless individuals living in sheltered transitional settings, including year-round shelters, transition houses, and detox centers, while 539 individuals (30%) remained unsheltered. Among the 27 shelters that reported their shelter capacity and occupancy rates, Homeless Count data revealed that all of these shelters were at full capacity at the time the data was collected. Furthermore, Lee (2016) claimed that there are approximately 4000 applicants on waitlists for social housing in Metro Vancouver alone. These statistics illustrate that there is still quite a jump in not having access to a secure dwelling at all to owning a house in the province. The definition of housing has broadened to include a continuum of housing that accommodates for a range in income levels. Vancouver's Housing and Homelessness Strategy 2012-2021 illustrates its own unique continuum of housing, ranging from emergency shelter and housing options for the homeless through to affordable rental housing and homeownership (City of Vancouver, 2011).

Even with a clearly demonstrated need for more housing options for people living with HIV/AIDS, challenges remain in meeting these needs because of individual, social, political, and economic factors. First, the housing market in BC already presents a challenging situation for persons living with HIV/AIDS because of increasing housing prices (an average monthly shelter cost of $1,156 in BC) (Statistics Canada, 2013), the significant reduction of rental housing units (CERA, 2008), and low vacancy rates (CHMC, 2012). This situation is further compounded by the rising costs of food (Dieticians of Canada BC Region, 2012), and stagnant employment salaries (Vancity, 2015). Furthermore, the few social housing units that do exist for people living with HIV/AIDS specifically are largely concentrated in the Vancouver area, and people seeking tenancy are often met with long waitlists, strict program eligibility, and a limited number of housing subsidies (Jones, 2013). In addition to the limited number of HIV housing services, it is seldom that housing strategies and supports take into account the individual experiences of persons living with HIV/AIDS, and affected populations are rarely involved in the discussions around and implementation of housing policy and programs. Secondly, individual and social challenges exist in access to affordable housing due to the high rates of poverty associated with HIV/AIDS (Rourke et al., 2012), the challenges of HIV/AIDS that make it difficult to live independently, and HIV-related stigma (Chambers et al., 2014; Stajduhar & Lindsey, 1999). Lastly, the political context in BC serves to further challenge the accessibility of housing due to the federal and provincial governments' retrenchment from social housing and greater emphasis on market approaches (O'Brien, 2011; Greene et al., 2012). While several health authorities in the province of BC are providing housing services, many are recovery-oriented services in supportive living environments for individuals with mental health challenges.

Housing as a cost-effective intervention

Homelessness and housing insecurity is a significant drain to the public system. It has been estimated that Canada spends over $7 billion annually addressing homelessness through non-preventative measures concerted by non-profit organizations, the government, and emergency services, including $1 billion per year in BC (Gaetz, Dej, Richter & Redman, 2016).

Patterson and colleagues (2008) found that a homeless individual living in BC, with both substance use and mental health issues, is estimated to cost the system an excess of $55,000 per year. However, if this individual was properly housed (and provided the appropriate services), it is estimated that their cost would drop to $37,000 per year, saving the province an estimated $211 million (Patterson et al., 2008). In a US study examining the efficacy of investing in permanent supportive housing for people living with HIV/AIDS, the intervention was determined to be cost-saving “if one out of every 19 Housing & Health study clients [clients receiving the supportive housing intervention] avoided HIV transmission to an HIV sero-negative partner” and cost-effective “if it prevented one HIV transmission for every 64 clients” (Holtgrave et al., 2007, p. S164).

There is much less debate about the cost effectiveness of providing people living with HIV/AIDS with stable housing, yet people living with HIV/AIDS still face issues with securing affordable housing. In the PSHP study, researchers found that the majority of participants were receiving some kind of governmental financial assistance, such as the Ontario Disability Support Program or disability pensions (Chambers et al., 2014). Relying on these sources of income often means that affordable housing is more challenging to attain and people are often left to decide between subsidized units, precarious housing, housing that is outside the desired neighbourhood and away from public amenities, illegal forms of housing (Chambers et al., 2014), and/or unsafe housing characterized by abusive relationships with other occupants (Greene et al., 2010). Furthermore, a study involving single parents living with HIV/AIDS indicated that all participants, to some degree, discussed the “trade-offs” in allocating limited financial resources to rent and other amenities, such as food and HIV medications (Greene et al., 2010), and this sense of “trade-offs” is not dissimilar to other people living with HIV/AIDS facing house insecurity. In the PSHP study, some participants feared losing their disability supports because of supplemental income from formal employment or pension, which further challenged the affordability of housing (Chambers et al., 2014). Even for those who chose to generate income though formal employment or were able to secure non-subsidized housing, the fear of economic insecurity and subsequent housing insecurity was often kept at bay (Chambers et al., 2014). So although the literature describes housing as a cost-saving intervention for people living with HIV/AIDS, the financial instabilities associated with housing have shown to exacerbate the emotional, mental, and physical condition of people living with HIV/AIDS (Chambers et al., 2014).

HIV housing programs in BC

In 2005, the NAHC's National Housing and HIV/AIDS Summit brought together a number of researchers and policy experts to examine empirical data regarding the relationship between housing and the prevention and treatment of HIV. Four major imperatives were brought forth during the national summit, calling for the increased availability of subsidized housing options for people of low SES living with HIV/AIDS, the promotion of housing as a HIV-prevention strategy for homeless populations, the incorporation of housing interventions as components of HIV care and management, and the continued evaluation of housing interventions for HIV prevention and disease management (NAHC, 2005). As previously summarized, the literature supports these four imperatives for housing as a health determinant and structural intervention for people living with HIV/AIDS, yet BC does not comprehensively meet all four imperatives in addressing housing and HIV concerns in the province.

As mentioned previously, many HIV services and supports are concentrated in urban centers, and in BC, these services are primarily located in the Greater Vancouver Area. Not only are HIV services and support organizations concentrated within a small geographical area, but there are also very few that address the housing needs of people living with HIV/AIDS specifically (Parashar, 2014, Jones, 2013). The small number of HIV-designated housing resources that do exist in the province are mostly made available through McLaren Housing Society of BC and Wing's Housing in metro-Vancouver, which both provide HIV-designated housing units and portable subsidies (McLaren Housing Society, n.d.; Wings Housing Society, n.d.), and ASK Wellness Society in Kamloops, which has a housing and outreach program for people living with HIV/AIDS (ASK Wellness Society, n.d). Some non-profit housing units are also made available to people living with HIV/AIDS through BC Non-Profit Housing Association, however, "…this relatively small number of HIV-dedicated units concentrated in one urban centre reflects the lack of an HIV-specific approach to the allocation of non-profit housing" (Parashar, 2014, p. 73). With subsidized housing units and portable subsidies being a customary strategy in addressing the housing needs of people living with HIV/AIDS, the next section will evaluate the implications of such.

HIV-designated housing options. As mentioned, there are HIV-designated housing units and buildings available to house people living with HIV/AIDS, as well as “portable” subsidies that allow people to choose both a neighbourhood and apartment of their own at a subsidized cost. Both of these options are made available through the coordinated efforts of the government, and various HIV and housing service organizations (McLaren Housing Society, n.d.; Wings Housing Society, n.d.). These housing options will be discussed further in later sections but are briefly discussed here because of the social implications that these housing options have on people living with HIV/AIDS. In a CBR study involving racialized, HIV positive mothers living in the Toronto area, findings indicated that mothers were often conflicted by “their concerns about disclosure, safety, community, and their experience of HIV-related stigma and discrimination” when considering living in HIV-designated buildings (Greene, Chambers, Masinde & O’Brien-Teengs, 2012, p. 124). The study also found that even in “physically safe” housing, mothers were often concerned about the emotional and mental safety of themselves and their children in housing units marked as “HIV-specific”, fearing the negative repercussions of HIV-related stigma and discrimination. In some cases, the women felt “stripped of their dignity” in having to choose between disclosing their status and acquiring affordable housing (Greene, Chambers, Masinde & O’Brien-Teengs, 2012). With fear of disclosure and the potential impact of HIV-related discrimination, many women isolated both themselves and their families from the community. However, other mothers felt that HIV-designated housing provided a safe place where they could be open about their status, feeling a sense of belonging and console with other people living with HIV/AIDS (Greene, Chambers, Masinde & O’Brien-Teengs, 2012). Chambers and colleagues (2014) conclude that while research indicates a relationship between housing stability and security and the physical and mental health of HIV-positive individuals, studies have inquired less about the ways in which these elements relate, specifically with respect to social isolation, social exclusion, and HIV-related stigma, and these relationships warrant further investigation.

HIV-specific housing and housing supports present challenges for both the HIV-positive population and the greater population in BC. Stajduhar and Lindsey (1999) found there was a sense of fear associated with the “ghettoization of those with AIDS” and the potential for worsening effects already associated with HIV-related stigma experienced by individuals living with HIV/AIDS residing in HIV-specific housing. Other challenges with HIV-specific housing involve community fear and resistance with regard to the location of new construction for supportive housing. This noted resistance primarily arises from homeowners’ perceptions that HIV-specific housing will negatively impact surrounding property values, and the fear associated with HIV/AIDS further compounds these protectionist attitudes (Derose, Domínguez, Plimpton & Kanouse, 2010). Even in the midst of these noted challenges, many non-HIV-specific housing services fail to adequately understand and meet the needs of people living with HIV/AIDS, which can further stigmatize this population (Furlotte, Schwartz, Koornstra & Naster, 2012). In light of the issues addressed related to HIV-specific housing and non-HIV-specific housing for those living with HIV/AIDS, there is still an absence of a housing strategy to address the needs of the wider population.

Other housing options. In addition to the discussion on HIV-designated housing supports, the PSHP study also highlighted a number of concerns regarding housing and services for people living with HIV/AIDS and will be used for comparison of the housing policy environment in BC. Findings from Ontario indicate that HIV housing services are not always representative of the people they serve with regard to the diversity of languages, cultures, and lifestyles of the residents being served. PSHP study findings revealed that racialized, HIV-positive mothers living in Toronto “[struggled] to navigate Eurocentric housing, [and] health and social care systems that did not address their needs as racialized and ethnic minorities” (Greene, Chambers, Masinde & O’Brien-Teengs, 2012, p. 121). Housing options were framed as having a “Eurocentric mould” that many residents couldn’t fit. Secondly, study findings revealed that HIV-designated housing services sometimes failed to address the collective needs of families housed in subsidized units, and participants experienced challenges with being able to secure appropriate living spaces that could accommodate larger family sizes (Greene, Chambers, Masinde & O’Brien-Teengs, 2012). For the mothers in this study, this created tension between choosing to tend to their own health needs, and the collective needs of their family and children.

As a result, many mothers faced ambiguity with disclosing their status for housing support, and experienced the residual effects of social isolation, and perceived HIV-related stigma and discrimination in the community.

The research consistently finds that people living with HIV/AIDS, as a collective, face similar salient concerns in terms of their health, and their requirements for adequate and appropriate housing. Such concerns include HIV-related illnesses and comorbidities, health maintenance, treatment adherence, economic insecurity, housing instability, and HIV-related stigma (Chambers et al., 2014). Chambers and colleagues (2014) found that people living with HIV/AIDS often have experiences with housing transiency – moving from stable situations to less stable ones, and vice versa. The constant transition between living situations can be stressful for anyone, but it is even more detrimental for people living with HIV/AIDS who have to mindfully balance their specific health needs and complex treatment regimes (Chambers et al., 2014). In addition to transient living situations, people living with HIV/AIDS are also likely to experience economic insecurity, especially as their illness progresses. Therefore, it is important to consider a continuum of housing in looking at housing availability for people living with HIV/AIDS because economic challenges and transient living experience render homeownership unattainable and even inappropriate for some. With the importance of housing for people living with HIV/AIDS highlighted in the literature, efforts to increase the number of social and supportive housing for this population has been on the horizon for HIV/AIDS service organizations, as well as housing organizations, such as BC Housing. Even so, many people living with HIV/AIDS in BC continue to experience challenges in securing safe, affordable and appropriate housing options.

Personal Experiences to Frame Theory

Housing assistance policies and programs can be seen as structural factors that impact the health people living with HIV/AIDS (Scott, Ellen, Clum & Leonard, 2007), as well as the greater population. Yet, there is currently no Canadian housing strategy to ensure the population's access to affordable and appropriate housing options. Instead, local and provincial governments are addressing housing issues on both a needs-based and population-specific basis (Carey, Crammond, and DeLeeuw, 2015; PHAC, 2015), which is how the needs of people living with HIV/AIDS are currently being addressed.

In a document discussing the narratives of people's pathways into homelessness, a 2015 Canadian report states, "While there is no 'one size fits all' solution, the personal narratives offer key elements of a framework in which individualized pathways out of homelessness can be crafted" (Inclusion Working Group, Canadian Observatory on Homelessness, 2015, p. 5). It is important that we shift from "policy-relevant research" to research and policy that puts people and health more central to the conversation (Robertson, 2007). Furthermore, with a greater exploration of "healthy housing" and the meaningful dimensions of home for people living with HIV/AIDS, research findings can translate into the development of housing options, practices, and polices that are more suitable for the populations most affected (Greene et al., 2012). However, we must first find an appropriate theoretical framework that can appropriately unravel the meaning of home from the greater material, social, cultural, and political contexts that confound the relationship between housing and home, and home and health. The next section will discuss two predominant theoretical frameworks examining the relationship between housing and health for people living with HIV/AIDS. These frameworks were chosen because of their attention to the wider social factors shaping the health of individuals, as well as the relationships people have with their surrounding living spaces.

Social Determinants of Health and Population Health Frameworks

As previously discussed, housing is a basic need and right, and also has the ability to influence the health outcomes of persons living with or at risk of HIV. Housing is defined as a determinant of health, along with Aboriginal status, education, employment and working conditions, food security, health care services, income and its distribution, the existence of a social safety net, social exclusion, unemployment and employment security (Raphael, 2004). With the advent of highly active antiretroviral therapy, the rate of HIV transmission and the progression of HIV have been significantly reduced in positive persons. This progression has made it clear that the health of people living with HIV/AIDS is influenced by much more than individual health behaviours and the provision of health care services (Moloughney, 2004). Thus, further attention needs to be paid to the social environments and contexts in which people live, which influences people's ability to afford and/or effectively adhere to HIV treatments (Montaner et al., 2006). Furthermore, these social implications should be explored for each stage along the treatment cascade, which links newly diagnosed persons with care and treatment so that they can reach a virally suppressed status (Aidala, Vardy & Yomogida, 2013). It is clear that giving attention to individual behaviours and the provision of health services is not enough to address the health and wellbeing of this population.

Similar to themes within the meaning of home literature, from a social determinants of health (SDH) perspective, Moloughney (2004) explains that housing is comprised of both physical and psychological dimensions, and well as the relational and social components provided by a surrounding neighbourhood and community. With this model of housing Moloughney (2004) emphasized "[better] designed studies are required to assess the relative contribution of several potential intermediate and confounding factors to provide greater insight into this association. These factors include economic, socio-demographic, and psychological factors, measures of housing condition, and the meaning of home" (p. 15). To address this need the WHO (2005) identified and examined the ways in which inter-related social factors influenced the health and wellbeing of the population through the SDH framework. Canadian health economists Robert Evans and Greg Stoddart (1990) worked with members of the Canadian Institute for Advanced Research (CIAR) to develop a model for population health from their Population Health Program. James Dunn, in collaboration with the Canada Mortgage and Housing Corporation and National Housing Research Committee (2002), later established a framework for studying the health impacts of housing using a population perspective and it is this framework that will be used to orient a description of current research on housing and health. The Population Approach to Housing recognizes the three dimensions of housing (material, meaningful, and spatial) and the diversity of experiences Canadians face with precarious living situations. In addition, the population health perspective used in this framework takes into account the political, economic, and social contexts that shape health inequities in Canada (Dunn et al., 2002).

Many studies have employed an SDH framework because of the model's ability to generate empirical evidence linking HIV to housing and health (Parashar, 2014; Chambers et al., 2014), but the framework does have some limitations. One major critique of this framework is that it is staged at the macro-level and fails to conceptually analyze determinants of health at the micro-level and in the local contexts where the health of individuals is shaped (Coburn, Denny, Mykhalovskiy, McDonough, Robertson & Love, 2003). The framework is further criticized for its finite number of categories of determinants that contribute to population health outcomes, and the model's inability to adequately quantify the impact that the determinants have on health (Hankivsky, Cormier & de Merich, 2009). Lastly, Coburn and colleagues (2003) criticize the SDH approach for "[failing] to adequately conceptualize possibilities for change" (p. 392), especially in regard to the inaction around identifying the oppressive effects that the social determinants of health can have on certain populations (Hankivsky, Cormier & de Merich, 2009).

Socio-Ecological Model

The socio-ecological model is closely aligned with the SDH framework in that it considers the social and structural factors that shape people's vulnerability to HIV/AIDS, as well as their access to appropriate housing. Socio-ecological models, therefore, do not focus solely on individual behaviours, but rather situate these behaviours within wider contexts of physical, social, and policy environments (Baral, Logie, Grosso, Wirtz & Beyrer, 2013). Over the past century there has been a shift observed for the leading causes of death and disability, moving from an emphasis on communicable (infectious) diseases to conditions that are more chronic and complex in nature. Chronic conditions, or non-communicable diseases, are often correlated with a variety of behavioural, social, and psychological determinants (Grzywacz & Fuqua, 2000). As previously noted, today in Canada HIV has been increasingly considered a chronic condition that can be managed through adherence to a healthy lifestyle, and the access to and proper management of HAART (Leaver, Bargh, Dunn & Hwang, 2007). While it may be true that with access to highly active forms of treatment a person's viral count can be almost undetectable, without access to stable housing it is less likely that HIV-affected persons will be able to access medical services and effectively adhere to antiretroviral medications (Chambers et al., 2014). Stable housing has been shown to better support adherence to healthy lifestyles and the management of complex treatment regimens (Leaver, Bargh, Dunn & Hwang, 2007). This issue points to a conceptual model that looks beyond the linear pathway between treatment and disease, and rather looks that the multiplicity of factors that influence one's ability to receive and benefit from treatment, and their subsequent health outcomes. Socio-ecological models have been shown to provide multidisciplinary and multilevel perspectives for the analysis of diseases to better inform treatment, prevention, and promotion practices that take place in complex environments (Grzywacz & Fuqua, 2000).

A socio-ecological model is equipped to "transcend the gap" between research and health practice, and is designed to analyze the conceptual linkages between a disease and its social, behavioural, and psychological underpinnings (Grzywacz & Fuqua, 2000). More specifically, the socio-ecological model attempts to explain the intersection of these wider contexts by exploring the dimensions of "intrapersonal (e.g. knowledge, attitudes, behavior), interpersonal/network (social networks, social support), community (e.g. relationships among organizations/ institutions), and public policy (e.g. local, state, national laws)" (Baral, Logie, Grosso, Wirtz & Beyrer, 2013, p. 2). Further, Fink (2013) asserts that socio-ecological models can be used to examine upstream (indirect influences) and downstream (direct influences) factors simultaneously. This feature allows researchers to examine behavioural factors of people living with HIV/AIDS, while examining community and societal-level variables that also have an indirect influence on the health and wellbeing of this population. The desired outcome of establishing the association between individual behaviours and the wider contexts in which they occur is to "employ biological and social analyses of population health to explore factors underpinning social inequalities and health disparities" (Baral, Logie, Grosso, Wirtz & Beyrer, 2013, p. 2). One major tenet of the socio-ecological model is that health outcomes are determined by the relative "fit" between a person and their environment, which gives researchers a clear point of analysis between one's perceived meaning of home and the living situation they occupy.

Baral and colleagues (2103) have used a modified socio-ecological model to illustrate the multi-level domains of HIV infection risks. Another recent study uses socio-ecological theory to explore "the potential role of community-based initiatives in individual patient's ART adherence", taking into account both the immediate household surroundings and social environments that patients occupy (Masquillier, Wouters, Mortelmans, van Wyk, Hausler & Van Damme, 2016). Masquillier and colleagues (2016) argue that people living with HIV/AIDS seldom live in isolation; therefore, the living situations in which they occupy or attempt to gain access to must take the social contexts in which they are implemented into consideration. The socio-ecological model also provides a framework for inquiry about how the meaning of home changes among differing contextual factors and in different living situations, and how the meaning of home is influenced by the social structures and relationships within a setting.

The ecological model is another theoretical framework used in health research and the model differs slightly from the socio-ecological model in that it does not focus on the influential nature of social relationships that exist in the wider context. Ecological models have proven valuable in the analysis of contextual factors shaping the HIV/AIDS epidemic because they explore the social structures and structural factors, such as housing policy, that influence the health and behaviour of people with or at risk of HIV/AIDS (Scott, Ellen, Clum & Leonard, 2007). In the US-based study conducted by Scott and colleagues (2007), there was a clear association between housing and HIV, specifically with regard to the policies, programs, and resources through which housing assistance is provided. Furthermore, the authors highlight the need to understand the wider context to identify the structural factors at play (Scott, Ellen, Clum & Leonard, 2007).

The socio-ecological model has been criticized for lacking theoretical orientation (Grzywacz & Fuqua, 2000), thus lacking the ability to develop hypotheses that can be used to explain and predict the implications of the meaning of home. Furthermore, the model is often critiqued for its comprehensiveness and critics highlight the "everything affects everything" argument implied with the socio-ecological perspective (Grzywacz & Fuqua, 2000).

The socio-ecological SDH models provide a comprehensive framework to consider the social and structural factors that shape people’s vulnerability to HIV/AIDS, as well as their access to appropriate housing. However, keeping in mind the noteworthy limitations of both theoretical frameworks, I will use several relevant principles from each model to orient the stages of my own analysis, as well as elements from a grounded theory approach to develop my analytical framework. More details discussing the implications of the socio-ecological and SDH models in this research will be provided in the following Methods and Discussion chapters.

Limitations of Current Research

While quantitative research is necessary to understand the associations between housing, HIV, and health, these methods may still lack the ability to delineate the complex nature of these relationships (Chambers et al., 2014). While epidemiological methods have dominated in the past (Bryant, 2003), these methods are not sufficient for capturing the contextual and meaningful nature of people's lived experiences, specific to their housing situations (Parashar, 2014). Parashar (2014) explains,

> Most research on the HIV-housing nexus has been descriptive in nature, generated using cross-sectional study designs with non-probability samples, and based on narrow conceptualizations of housing status that may not capture the nuances and diversity in the realities of affected communities (p. 5).

Hwang and colleagues (2011) note that the increased use of cross-sectional study designs in housing studies also prevents researchers from fully capturing the dynamic state of being housed, which often involves transitional periods of homelessness and precarious housing. Chambers and colleagues (2014) further emphasize that more evidence, specifically qualitative evidence conducted in a Canadian context, is needed to fully explore the complexities of housing and health that is specific to people with HIV. And Chambers and colleagues (2014) conclude that this research should be conducted in collaboration with people living with HIV/AIDS.

Public health efforts have seemingly focused on homelessness, which addresses only one end of the housing spectrum (Aidala, Lee, Abramson, Messeri & Siegler, 2007). This is troublesome because a focus on homelessness addresses only a targeted portion of the Canadian population and relies on a reactive approach to addressing housing issues, rather than a proactive one. The resulting emphasis on homelessness amelioration efforts has translated into the research conducted, which tends to focus on unilateral perspectives of housing. This is an issue because it narrows our understanding of what defines both homelessness and housing insecurity, and our understanding of the broader contextual factors that influence the health and wellbeing of people living with HIV/AIDS (Milloy, Marshall, Montaner & Wood, 2012). With a focus solely on the homeless or unstably housed people living with HIV/AIDS, the result may "…deflect attention from the broadly shared, fundamental need for stable and adequate housing among a wide range of persons living with HIV/AIDS" (Aidala, Lee, Abramson, Messeri & Siegler, 2007, p. 112). Canada encompasses a diverse geography populated by diverse societies, languages, cultures and traditions. This makes it impossible to apply a "one size fits all" solution to homelessness. Similarly, having only a few housing options will not suffice in adequately and appropriately meeting the housing needs of people living with HIV/AIDS. As one Canadian housing and homelessness researcher has said, "We must aspire to understand what works and for whom, and research and program evaluation must play a role in identifying issues and determining the most effective responses" (Gaetz, 2010, p. 23).

Finally, a majority of recent research in Canada has focused on the physical environments that people living with HIV/AIDS occupy, and how their housing situations affect their access to HIV services and their ability to perform activities of daily living (Public Health Agency of Canada, 2015). As a result, there are relatively few studies that explore the socio-economic dimensions of housing and health within a Canadian context (Dunn et al., 2002). Furthermore, the studies that do examine the meaning of home primarily date back to the late 1980s and early 1990s (Sixsmith, 1986; Rykwert, 1991; Karjalainen, 1993; Després, 1991), and the meaning of home data has been expanded minimally since. Just as there are limited numbers of studies examining the meaningful dimensions of housing for people living with HIV/AIDS, there are also few theoretical frameworks that have been proposed to capture these dimensions of housing in association to health. A review of the literature suggests that a contextually based, qualitative study is needed to explore the complexity in the meaning of home across a continuum of living situations. I propose that it is necessary to shift away from an understanding of home as a structural element with four walls and "towards a more holistic understanding of the social and cultural importance people place on home, and various spaces people find and make 'home'" (Parashar, 2014, p. 6).

This research will explore how the various dimensions of housing factor into people's sense of stability and wellbeing within their own unique living situations. The aim of this study was to illuminate the diversity of lived experiences for people living with HIV/AIDS, the diversity of living experiences in Greater Vancouver for HIV-positive people, and consequently the diversity of meaning that is attached to home for people living with HIV/AIDS in the Greater Vancouver area. Further, this study will incorporate participatory approaches to support a deeper exploration of housing experiences among populations affected by HIV/AIDS and promote collaborative inquiry across key stakeholders (Kindon, Pain & Kesby, 2007a). Since this thesis is situated within a CBR study and CBR is often referred to as “action-oriented research” (Kindon, Pain & Kesby, 2007a), it is also hoped that a better understanding of the meaningful dimensions of home and housing can be used to inform housing options in future studies, and help “redefine appropriate housing for [people living with HIV/AIDS] as housing that is affordable, safe and accessible to all” (Shubert, 2010). Furthermore, just as the Inclusion Working Group and Canadian Observatory on Homelessness (2015) propose that personal narratives should be vital to the development of relevant research, policy, and practice, Robertson (2007) asserted,

> Rather than “policy-relevant research”, we work outward from the circumstances and narrated experiences of [people] with whom we do research to advocate for relevant policy. The distinction is important, for too often, researchers reinforce and reproduce analytical categories that work for policy-makers rather than the subjects for whom policy is supposed to work (p. 530).

CBR will also help bridge research and practice as the methodology “aims not merely to advance understanding, but also to ensure that knowledge contributes to making a concrete and constructive difference in the world” (The Loka Institute 2008, cited in Hankivsky, Cormier & de Merich, 2009, p. 13). Through my thesis and the primary study in which this research originates, we strive to bring light to this issue with the intention to guide similar research and decision making in the future.

CHAPTER III: METHODOLOGY AND PARTICIPATORY APPROACHES

This research adds to what is already known about the health and wellbeing of people living with HIV/AIDS by examining how the many dimensions of housing influence the health of this population across a diversity of housing situations. The nature of this research topic is quite sensitive as it involved taking a deeper look into people's personal settings and where they spend a majority of their time. To investigate this topic, a qualitative research approach was applied to help unravel the elements at play in this population's home life and capture the authentic relationship between people living with HIV/AIDS and their housing situations. The aim was to capture "the lived experience from the perspectives of those who live it and create meaning from it" (Padgett, 2012, p. 17). The literature supports the use of a community-based approach in HIV/AIDS research to empower people with lived experience to be involved in various stages of the research project (Parashar, 2014).

The literature acknowledges the need for community-based and context-specific approaches to examine issues faced by people living with HIV/AIDS (PHAC, 2015a). This thesis study was nested within a larger CBR study. In this research, the primary goal was to analyze a subset of interviews from the main study through a secondary analysis of the data gathered in the larger study. As such, I did not specifically use CBR for this thesis; however, to the extent possible, I was guided by some CBR principles. For this reason, I will describe the principles and values of CBR, explain the decision to align various components of my own thesis research with a CBR approach, and conclude by reflecting upon the challenges of adhering to the main tenets of this framework within a secondary analysis. I will also outline how I undertook a thematic analysis of the interview data, utilizing the constant comparative method from grounded theory to facilitate a critical understanding of the housing situations among people living with HIV/AIDS. The SDH framework and the socio-ecological model, key frameworks used in current HIV/AIDS research (described in the previous chapter), will also be drawn upon to help provide a conceptual framework for higher-level (conceptual) thematic formulation.

Community-Based Research

Community-based research encourages researchers to think critically about the social, economic, political factors impacting people living with HIV/AIDS (PAN, 2016), and also engages the target population in the process of inquiry (Hacker, 2013). CBR has gained its popularity from its engrained principles of community empowerment, decentralized research processes, advocacy, and action. Tending to these key principles, Israel and colleagues (2008) developed an expanded list of CBR characteristics to help guide researchers when using this research approach:

- Recognizes community as a unit of identity
- Builds on strengths and resources within community
- Facilitates collaborative, equitable partnership in all phases of the research
- Promotes co-learning and capacity building among all partners
- Integrates and achieves a balance between research and action for the mutual benefit of all partners
- Emphasizes local relevance of public health problems and ecological perspectives that recognize and attend to the multiple determinants of health and disease
- Involves systems development through a cyclical and iterative process
- Disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process
- Involves a long-term process and commitment (p. 55-58).

CBR researchers also recognize the plurality of knowledge and how knowledge can be generated from a diversity of persons, institutions, and locations (Kindon, Pain & Kesby, 2007b). Furthermore, researchers of this epistemological tradition assume that “those who have been most systematically excluded, oppressed or denied carry specially revealing wisdom about the history, structure, consequences and the fracture points in unjust social arrangements” (Kindon, Pain & Kesby, 2007b, p. 9). As a result, CBR offers a means to further broaden (sometimes even counteract) the generation of knowledge from mainstream hegemonic research approaches (Kindon, Pain & Kesby, 2007b).

Justification of method for the PLPH study

As discussed previously, there remain critical gaps in our understanding of how housing impacts health for those living with HIV/AIDS, partly due to an overemphasis on the material aspects of housing (Parashar, 2014), and also because of a focus on housing extremes rather than a housing continuum (Padgett, 2007). In order to capture the lived experience and explore the meaningful dimensions of people's current living situation, the literature suggests a CBR methodology be applied (Parashar, 2014). Since the needs of people living with HIV/AIDS are not systematically addressed in the geographically based housing strategies and supports that exist in BC, communities have to fill this gap, and research often sets the stage for community action.

CBR approaches are increasingly being used in HIV-oriented research and authors acknowledge the instrumental contribution that this approach has had in addressing the HIV/AIDS epidemic (Padgett, 2012). CBR approaches are built on the foundation of social justice and empowerment and increase people's capacity to make changes in their own community through community action. Through this approach, researchers, partners, and communities attempt to equitably distribute the power and responsibility needed to carry out the various stages of the research project. As a result, CBR encourages the development of relevant research, and is likely to reveal information and interpretation that may otherwise go undiscovered by academics (Hacker, 2013). Furthermore, greater participation in the research process may encourage community ownership, and better support the sustainability of both the research and the outcomes in the long-term (Hacker, 2013; Padgett, 2012). CBR approaches are particularly useful when community partners are motivated to seek solutions for emerging issues (Hacker, 2013). Lastly, it is important to point out that being engaged in the research process itself can be just as empowering as the community's usability of research findings. Several authors note that CBR differs from other research methods in that it is "an 'orientation to inquiry' which demands methodological innovation if it is to adapt and respond to the needs of specific contexts, research questions or problems, and the relationship between researchers and research participants" (Kindon, Pain & Kesby, 2007a, p. 13). This illustrates that the process of CBR is just as (if not more) important than the research results.

Not only is CBR effectual in the exploration of the emic, or “insider’s” perspective, it also has the power to ameliorate health inequities through the establishment of community-academic partnerships, and increased engagement in policy and advocacy (Israel et al., 2010). Reason and Bradbury (2008) coined the term “extended epistemology” to describe CBR because the methodology generates knowledge to inform action. CBR also promotes the reduction of health inequities by encouraging communities to determine the social issue or research agenda. It does this in two ways: first, it redistributes institutional resources towards the benefit of the community of interest, and second, it gives communities the capacity to address their own social issues through their ability to contribute to research projects and drive policy (Hacker, 2013). These are important factors because despite the theoretical advances made by other conceptual frameworks, such as the SDH approach, significant health inequities still persist in Canada. This may be partly due to the fact that “a health determinants approach does not place explicit emphasis on power, the interactions between determinants, and the oppressive effects of these relationships” (Hankivsky, Cormier & de Merich, 2009, p. 13). Furthermore, Raphael (2000) points out that not engaging community in health promoting initiatives not only inadequately addresses health inequities, but it also withholds one of the basic principles of health promotion – community involvement. Both reasons mentioned in the literature thereby necessitate the use of CBR methodologies to address the action-oriented needs of research involving communities.

This thesis and participatory engagement

This thesis is nested within the PLPH study, a CBR study that closely adhered to the principles of CBR to guide the research. Specifically, the PLPH study is committed to genuine community-academic partnership, capacity building, democratic decision-making, the co-creation of research findings, and the dissemination of knowledge and information to community partners and organizations. As noted, the data for this thesis reflect a secondary analysis of data gathered in a larger CBR study. Since the scope of this thesis is much smaller in terms of the time and funding restrictions, this thesis did not use a CBR method. Instead, I practiced applying some of the principles of CBR that I learned through my practicum with PAN (including, involvement with the PLPH Participatory Analysis Working Group and development of a Participatory Impact Evaluation framework with PAN staff), coursework within the MPH program, and through a review of the literature, and wove participatory elements through the analysis process, in order to ensure the results were grounded in community understandings to the extent possible.

Collaborative inquiry in CBR involves various cycles of action and reflection that researchers and research teams should aim to adopt (Kindon, Pain & Kesby, 2007a; Reason & Bradbury, 2008). For example, when establishing relationships and a common agenda for the research process, the researcher should reflect on the research design, ethics, power relations, and the construction of knowledge, ensuring that the research process remain both participatory and equitable. I endeavoured to use this iterative process to guide me in the various participatory activities of my thesis and to queue key reflection points in the research process. Furthermore, to encourage the analysis process to be as participatory as possible, I set up three avenues in which participatory inquiry on the analysis process and study outcomes could take place. This involved the development of my own community advisory committee (CAC), as well as occasional meetings with members of the Participatory Analysis Working Group (PAWG) with the PLPH study, and other participatory forums on matters related to the analysis of PLPH data. In the following section, I will describe the relevant components of the PLPH CBR methodology, and explain how I attempted to incorporate participatory elements into my analysis and my eventual knowledge translation processes.

Participatory Analysis Working Group

As a member of the PAWG with the PLPH study (a working group that engaged various community stakeholders in the analysis process of the research), I was able to have a “listening ear” in discussions related to procedural elements of the CBR process and on discussions related to the participatory analysis of PLPH data. This process helped inform the various steps of my own participatory analysis process, and was useful in illuminating key themes and ideas emerging from the PLPH data in each of the three study sites (the GV area included). While involvement on PAWG was useful in the abovementioned ways, a majority of colleague/peer debriefing and participatory processes occurred though the development of a Community Advisory Committee and through continuous consultation with the members sitting on this committee.

Community Advisory Committee

Typical CBR approaches require flexibility and continuous adaptation of research processes to align with the needs of all involved partners (Hacker, 2013). As CBR is typically both collaborative and multidisciplinary, Hacker (2013) suggests the development of a community advisory committee as one strategy to create a structured relationship between the investigator and community members. Since this thesis was a secondary analysis of data collected through the PLPH study conducted primarily by me, members of the advisory committee for this project were not fully and equitably involved in discussions concerning the research design, research questions, and preliminary findings. However, I did want to include some participatory mechanisms in this research, so an advisory committee was established. Since CBR is typically both collaborative and multidisciplinary, Hacker (2013) suggests the development of a community advisory committee as one strategy to create a structured relationship between the investigator and community members.

Community can be defined in terms of geography, by condition, as well as other common characteristics (Hacker, 2013). Within the confines of this thesis, community was defined by geography – situated within the southern parts of BC (namely Victoria and the Greater Vancouver Area), and through the shared inquiry of a common issue – addressing housing issues among persons living with HIV/AIDS. Through the help of PAN staff members, an advisory committee was created and members of the committee engaged in several processes in this study. Hacker (2013) proposes that “community” should include persons that are most impacted by the research issue, as well as organizations that work with or represent the community of interest. This committee includes my Supervisor, Catherine Worthington, at the University of Victoria; my Co-Supervisor and PLPH Research Manager, Heather Picotte; Sherri Pooyak who is affiliated with the Canadian Aboriginal AIDS Network; Surita Parashar, who is affiliated with the British Columbia Centre for Excellence in HIV/AIDS; and Darren Lauscher, who is affiliated with the McLaren Housing Society of British Columbia. All committee members also have affiliations with PAN and have worked specifically with the larger PHPH study. One of the committee members has been living long term with HIV. I chose these members based on their representativeness of the HIV/AIDS community in the Greater Vancouver area, based on their previous involvement in participatory research projects, and based on their relative interest to the study topic.

Once members invited to the CAC had accepted their role on the committee, I conducted an assessment individually with each member to negotiate the various roles and responsibilities that members of the CAC were invited to take on. Within participatory research methodologies there are no concrete frameworks that guide the participatory nature of the research process; however, I developed a guideline for engagement for members of the CAC using elements from Flicker and Nixon's (2015) DEPICT model for participatory qualitative health promotion research analysis, and using the CBR guidelines developed by Israel and colleagues (2008) mentioned above. It was important to list the various roles, expectations, responsibilities, and levels of commitment early in the project so that the research process remained transparent and CAC members were aware of each other's agenda and intentions to participate (Hacker, 2013). In many cases, the roles and responsibilities of members in the participatory committee depended on the skills, expertise, and time of the members involved (Hacker, 2013).

While community involvement at all stages of the research process is ideal, the level of involvement among members of the community varied slightly, and this was to be expected (Kindon, Pain & Kesby, 2007b). The three advisory committee members (not including the two with supervisory roles) maintained a consistent level of engagement throughout the research process, participating in two teleconference meetings (in addition to the individual introductory meeting), responding to group inquiries, and providing feedback on working analysis documents. While the three members of the CAC had similar levels of participation, communication and feedback offered by those in supervisory positions was more comprehensive and frequent throughout the research process. Having consistent support through colleague review and debriefing opportunities was also both encouraging and instrumental to this research process. The way in which these mechanisms help strengthen the validity and rigor of this research study will be discussed in a later section.

With a typical CBR project, the researcher should not begin to engage members of the community with a particular research agenda in mind (Hacker, 2013); however, due to the confines of this thesis project, the first contact made with potential CAC members was with my proposed research questions and methodology in mind. Moreover, while participatory research projects typically begin with the open review of data and the collaborative development of coding frameworks among all members participating in the research process (Flicker & Nixon, 2015), opportunities for collaborative engagement began with the review and discussion of how emerging themes (and codes) could be further augmented to initiate the subsequent development of higher-level conceptual categories. The CAC members were first engaged at this stage of the preliminary analysis because of their relative familiarity with the data and coding frameworks of the primary PLPH study. The CAC continued to have a role in both the analysis stage of this research project and will be involved in the dissemination of study findings. The mechanisms for participatory analysis and dissemination will be discussed further in the subsequent analysis section.

Other participatory forums

In addition to the PAWG and the CAC, participatory forums were held at HIV service agencies to engage members of the HIV/AIDS community in the research topic. By way of "piggy-backing" on analyses underway within the larger PLPH study, I had the opportunity to facilitate a discussion in January 2016, with members of a PAN-member organization and through the support of staff on the PLPH study. Since the Prince George site coordinator with the PLPH study held weekly meetings with people from the HIV/AIDS community at the service agency Positive Living North (PLN), I was able to able to facilitate discussions around the meaning of home with PLN members attending these meetings. This process was invaluable to the analysis of study data because it provided an opportunity to engage with people with lived experience, living outside of the study site of Greater Vancouver, as well as seek verification of emerging key themes (member checking will be described further in the Participatory Thematic Analysis section). It was hoped that through the discussion with PLN members, I could corroborate emerging themes coming from my own analysis. This was a form of member checking, and is important for rigor in qualitative studies (Padgett, 2012).

The participatory forum with members at PLN involved two separate meetings during subsequent weeks, one facilitated by the PLPH site coordinator in person and the other facilitated by me (with the help of two members from the PLPH study team) by teleconference line the following week. During the first meeting, the site coordinator facilitated the open reading of excerpts (most relevant to the "meaning of home" discussion) from one transcript collected from the Greater Vancouver study site to a room containing four participants (a support manager, a peer support worker, and two members at PLN). During the reading people in the room were asked to reflect on how the interview respondent perceived the various elements of “home” to be related to their health and wellbeing, and whether these elements and relationships resonated with their own personal experiences. Everyone participating in the group discussion was given post-it notes and pens to mark up their own printed copies of the transcript excerpt in any way they wanted to better facilitate later group discussions. The second meeting with PLN members involved an enriched discussion of key themes and ideas that participants found important to the “meaning of home” subject. Some of the major themes that emerged during this participatory forum will be discussed in greater detail in final sections of this thesis and I will also point out the specific narratives I drew upon to help me further define and develop my conceptual categories.

Coinciding with the participatory preliminary analysis discussions held at PLN, I was able to participate in in a “data party” for the PLPH analysis stage. A “data party” was used by the PLPH study as a tool for participatory analysis and was held in each of the three study sites. I was able to sit in on the GV data party with other community members as participants sought to find meaning in the data relevant for their communities, identify areas to investigate further, and decide on preliminary action plans for knowledge sharing. Several important categories of data were established through this meeting and various avenues for the dissemination of research findings and knowledge translation activities were discussed. These discussions, along with discussions held in the other participatory forums, will be used to inform the analysis of research findings revealed in my own research process. Furthermore, all participants involved in any of the abovementioned participatory forums received financial compensation for their time, provided through PAN.

Thesis Study Design

There are three key design features that guided this study. Firstly, as described in the previous section, this thesis was situated within a larger CBR study, and incorporated some participatory elements (in the analysis). Secondly, this was a secondary analysis of data already collected within the PLPH study. I did not gather any primary data of my own but chose to draw upon a sample of 10 transcripts from the existing interview transcripts in the larger study.

Thirdly, in order to meet the interconnected research objectives of this thesis, I carried out a thematic analysis, using the techniques identified in the constant comparative method, as well as other analytic tools and elements commonly identified with a Grounded Theory approach as originally developed (Glaser & Strauss, 1967; Strauss & Corbin, 1999). In the sections that follow, I will describe the sampling approach and data collection procedures from the larger study, and the participatory analysis approach.

Constant Comparative Method

I used a constant comparative method, and also drew upon other elements from grounded theory methodology to help organize and communicate my process of analysis. The constant comparative method is "a method of analysis that generates successively more abstract concepts and theories through inductive processes of comparing data with data, data with category, category with category, and category with concept" (Charmaz, 2006, p. 187). The method allows researchers to discover the similarities and differences in the data by comparing narratives and incidents in the same interview transcript, then comparing these elements in different transcripts (Charmaz, 2006). This process helped me generate codes, which then lead to the development of higher-level conceptual categories that could then be compared with new data revealed in subsequent interview transcripts. The constant comparative method is central to several branches of grounded theory (Glaser & Strauss, 1967; Corbin & Strauss, 2008; and Charmaz, 2006).

Sampling

Since my thesis was situated within the PLPH study, I used existing interview transcripts and did not conduct any interviews with persons living with HIV/AIDS myself. In the original study, as previously noted, research data were collected from three primary sites, Greater Vancouver, Kamloops, and Prince George, at two points in time. For the purposes of my thesis, I selected only the first (baseline) phase of the interview transcripts collected from the Greater Vancouver study site because the area is home to the greatest number of people living with HIV/AIDS in BC and has the greatest concentration of HIV-designated housing supports in the province. Additionally, the higher migration rates from nearby rural areas into GV, the diversity of housing experiences, and the absence of HIV-specific housing policies make this city a comprehensive site for investigation. Fifty-three interviews were conducted in the Greater Vancouver area in the first round of interviews.

The intent of the primary study was to recruit study participants in the study sites to achieve maximum variation in participants' living situations. In keeping with the primary study's recruitment strategy, I purposively selected interview transcripts based on participants' housing/living situations at the time the interview was conducted. I chose to follow a maximum variation sampling strategy for my first round of transcript selection because it provided the richest data to analyze the meaning of home for people living with HIV/AIDS in various living situations. Maintaining maximum variation in the sample allowed this study to address the limitations described in other studies, where the focus was primarily on housing extremes: homelessness and homeownership. Pointing to another study exploring the "habitual lived experience of home", Sixsmith (1986) used a sample of postgraduate students in her study because students often have experiences living in a variety of accommodations. Sixsmith (1986) proposed, "in any exploratory work on the meaning of home, such unusual places [living situations] are of interest" (p. 284).

Since Greater Vancouver is home to a diversity of living accommodations, variation sampling helped this study to illuminate the heterogeneity of housing situations and experiences among persons affected by HIV/AIDS (Padgett, 2012). I was concerned with four relatively discrete housing/living situations in which respondents resided at the time the interview was conducted: 1) shelters or transitional housing, 2) social/subsidized housing options, 3) supportive/assisted living housing, and 4) unassisted market rental housing or homeownership. These housing situations were chosen specifically to reflect housing situations and types of housing that are most common in the Greater Vancouver area. This list of four discrete housing situations was intentionally designed to consolidate the larger housing continuum illustrated in Vancouver's Housing and Homelessness Strategy 2012-2021 that ranged from emergency shelter and housing options for the homeless through to affordable rental housing and homeownership (City of Vancouver, 2011). A definition of each housing situation will follow.

Shelters and transitional housing. Shelters and transitional housing options are provided with the intent of keeping people off of the streets while they seek more permanent and stable housing options (City of Vancouver, 2011). Due to the limited availability of affordable and secure housing options in Greater Vancouver, many people with HIV will live in shelters or other transitional housing situations at one point in their lives (Tucker, 2009). This situational category is meant to capture people who experience various patterns of homelessness, either chronically (living in shelters or on the streets most of the time), episodically (move often with periods of no stable housing), situational (without stable housing due to a significant life event), or seasonally (using shelters or transitional housing during inclement weather) (Report on Homelessness in Niagara, 1997).

Social and subsidized housing. BC Housing (2015a) defines subsidized housing as "all types of housing whereby the provincial government provides some type of subsidy or rent assistance, including public, non-profit and co-operative housing, as well as rent supplements for people living in private market housing." Housing tenures can also be subsidized by municipal governments and operated by independent organizations (Tucker, 2009). These housing options are often provided to individuals or families with low to moderate incomes. Financial support is usually offered on a "rent geared to income" basis, meaning that tenants pay a rent amount that is dependent on their gross household income, rather than the market rate (BC Housing, 2015a). Social and subsidized housing options tend to create more liberty for tenants since subsidies can be applied to a particular rental unit or funds can be received through a portable subsidy, allowing tenants to choose where they live (Tucker, 2009). McLaren Housing Society in Vancouver, for example, allows for this versatility through the provision of portable subsidies, allowing people living with HIV/AIDS to choose their housing accommodation in Vancouver and the Lower Mainland, as well as the provision of housing options dedicated specifically for people living with HIV/AIDS (McLaren Housing Society, n.d.). The Wings Housing Society in Vancouver also offers housing assistance to people with HIV/AIDS through portable housing subsidies and through the provision of housing for people living with HIV/AIDS in Vancouver's West End (Wings Housing Society, n.d.).

Supportive housing and assisted living. BC Housing (2015b) defines supportive housing as living situations where the tenant receives some assistance, while assisted living offers tenants a greater amount of support. Supportive housing in BC is a non-market housing option that typically involves both the provision of a rental subsidy and the provision of ongoing support services to residents who cannot live independently because of physical or mental limitations

(City of Vancouver, 2011). In 2013, McLaren Housing Society opened a 110 unit building on Howe Street in Vancouver to provide permanent housing and support services specifically to persons living with HIV/AIDS and their families. The building is staffed 24/7 and offer a variety of supports including food security, money management, and social outings for residents (McLaren Housing Society, n.d.).

Secure market rental housing and homeownership. The last prominent housing situation that exists in the Vancouver area is housing that is rented or owned through the private housing market. This means that housing is acquired through a landlord, company, or an investor (City of Vancouver, 2011; Tucker, 2009). Statistics Canada (2017) further divides this more permanent, independent housing category to include band housing (in addition to rental and owned), which can be simply defined as housing on Aboriginal reserves. It is estimated that of the 1,881,970 households in BC, 1,279,020 (or 68%) households are owned, 599,360 (or approximately 32%) are rented and 3,585 (less than 1%) are band housing (Statistics Canada, 2017).

Sample size justification

Using the 53 interview transcripts collected from Greater Vancouver, my intention was to first handpick 2 interview transcripts from each of the four housing situation categories defined above for an initial sample size of 8 transcripts. These transcripts were chosen for their richness and relevancy to the research questions, and to develop the coding framework. The transcripts chosen differ in respect to housing types and housing experiences, and maximum variation was achieved within housing situations to account for the diversity in gender, ethnicity, and shared occupancy so that a variety of key themes could be captured. The purpose of this was to find data to illuminate my predetermined living situations categories. For instance, I chose two transcripts in the subsidized housing category to compare Wings' subsidy program with the subsidy provided by McLaren; furthermore, I wanted to examine how the meaning of home changed among female and male participants, and how it differed cross-culturally.

The flexible nature of qualitative research allows the process of establishing an adequate sample size to remain inductive. I thought the housing categories that I developed at the beginning of the study might change and additional transcripts might be added, but many emerging themes remained comparable across the dataset. In their foundational work on grounded theory, Glaser and Strauss (1967) explain that accurate evidence is not always crucial to the process of creating robust conceptual categories, just as the kind of evidence and number of cases is not crucial. Thus, it is not uncommon for a study to have a smaller sample size and still generate a substantial number of conceptual categories of data. Specifically, Glaser and Strauss (1967) note,

> A single case can indicate a general conceptual category or property; a few more cases can confirm the indication…generation by comparative analysis requires a multitude of carefully selected cases, but the pressure is not on the sociologist to ‘know the whole field’ or to have all the facts 'from a careful random sample’ (p. 30).

The constant comparative method (described in more detail in the Participatory Thematic Analysis section) afforded me the opportunity to inductively adjust categories when necessary for the purposes of developing emerging conceptual categories and ensuring that the data collected were relevant to the proposed research questions (Padgett, 2012).

In the coding process, I became cognizant that my subsidized housing category was missing data that could have provided a more comprehensive picture of the subsidized housing market for people living with HIV/AIDS in Greater Vancouver. From participants’ narratives it became clear that many people go through periods of applying for and living in a variety of subsidized living arrangements. Specifically, there was a noticeable difference between how subsidized units were funded, for whom they are specified, and the various “rules” tied to subsidies. These discrepancies made me want to explore this housing category further and therefore, I added two additional transcripts to the sample. The inductive process of the constant comparative method helped guide me back and forth between data collection and data analysis as data become codes, and codes become emerging themes and categories (Boyatzis, 1998; Charmaz, 2006). The added cases allowed me to further define the relationships between and within emerging themes so that the subsequent development of conceptual categories for the meaning of home would best reflect participants’ narratives.

Once these additional two cases were added, I achieved saturation, defined in qualitative research as the point at which no more data collection is necessary, no additional codes are being added, and conceptual categories and themes are well developed (Padgett, 2012). Themes in the two additional transcripts corroborated other participants' narratives. After reviewing the sample of ten transcripts again, no new major themes emerged that were not otherwise accounted for. The discussions held with members of the CAC and PLN also confirmed key themes. Thus, with saturation reached for the core research questions, no further transcripts were selected.

Data Collection

In the primary PLPH study, face-to-face interviews were held in private offices and rooms at community service organizations after participants gave informed consent (most participants provided written consent but verbal consent was allowed). Interviews were semi-structured in nature and were audio recorded with the consent of participants. Interviews took, on average, between 3-5 hours to complete. A cash honorarium of $25 (in accordance with BC community research norms) was offered to all interview participants; childcare subsidies and reimbursements for transit fare were made available to applicable participants. The interviews were then transcribed (by a skilled transcriptionist who has signed a confidentiality agreement) using the audiotapes from individual interviews.

Interviews explored participants' housing histories, focusing on current living conditions and living conditions after testing HIV-positive. To explore perceived housing stability, respondents were asked about what makes them feel stable and secure in their housing situation and what their interpretation of the word "security" meant in relation to their living situation. Additionally, questions were asked about the neighbourhood and community that respondents were situated in, and whether they felt at home in these environments. Lastly, participants were asked about the perceived link between their health and their living situation. The above overview of the interview guide is not the entirety of the questions included in the interviews, but rather the questions most relevant to my own research questions.

To help participants construct and reflect on their current living situation, interviews included a drawing exercise in which participants mapped out their living space to better aid the researcher in understanding the positive and negative elements in the respondent's living space. Participants were asked to map their current living situations and then describe the elements of their map, specifically with regard to daily tasks completed in their living space and access to amenities. The PLPH study originally proposed incorporating the mapping exercise to augment interview data, encourage better recall among participants, attend to the diverse drawing/literacy skills of participants, and to improve the accuracy and relevancy of emerging discussions and themes from the interview data. Figure 1 provides an example of a map produced from this exercise.

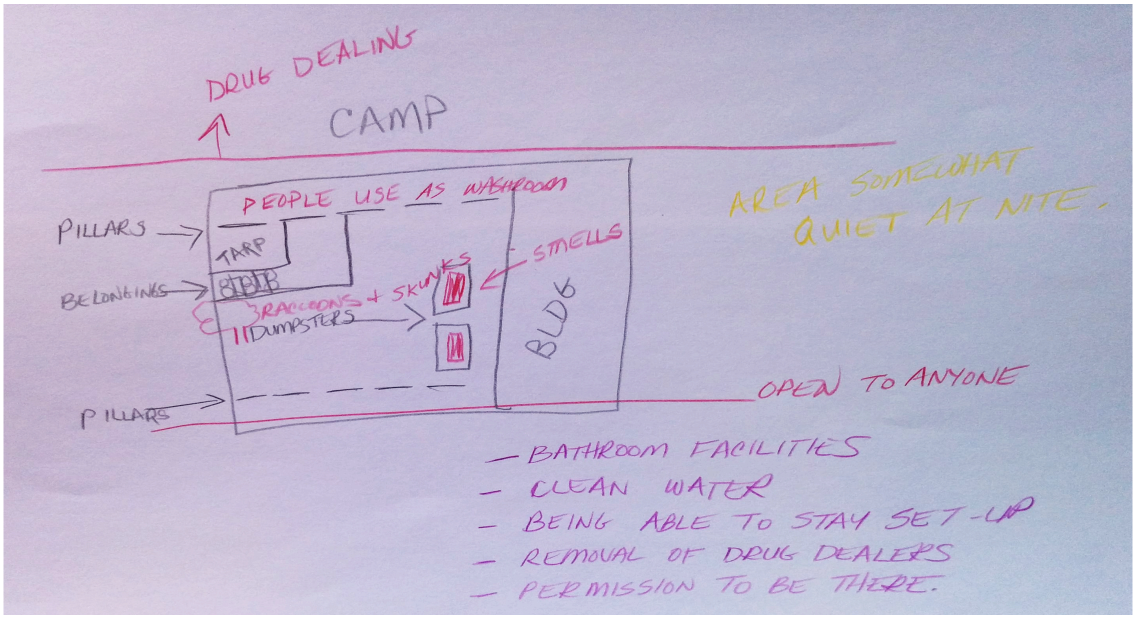

Figure 1. A visual map of space provided by Participant GV428090a.

In addition to the individual maps of space created by participants in the sample, I created two maps to geographically index where participants resided in GV in relation to frequently accessed AIDS service organizations (ASOs) and housing organizations. These maps will be included and discussed in greater detail in the Results chapter.

Participatory Thematic Analysis

Existing theories that attempt to conceptualize the relationship between housing and health are still evolving and this thesis aims to develop these housing theories further. The purpose of analyzing the meaningful dimensions of housing is to help achieve a more holistic understanding of the linkages between housing and health for people living with HIV/AIDS. A comparative, thematic analysis of four living situations (shelters and transitional housing; social and subsidized housing; supportive housing and assisted living; and secure market rental housing and homeownership) was conducted.

Parallel to the development of conceptual categories further defining the meaning of home, I endeavoured to incorporate participatory elements in the analysis process. My CAC and I, along with the participants of the various participatory forums, and I collaboratively engaged in thematic analysis through teleconferences, working documents, and email correspondence starting in October 2016. Flicker and Nixon's (2015) DEPICT model (mentioned earlier) was used as a framework to discuss participatory analysis in the sections to follow. It should be noted that participatory data analysis is rarely a linear process, but for simplicity, I will describe each phase of the process in a procedural manner here.

Phase 1: Generating data through secondary analysis

As previously stated, I conducted a secondary analysis of the data collected by the PLPH study team in the GV area. I had access to transcribed interviews through a secure shared drive available to approved students and team members through the University of Victoria, and I have continued to work with the transcripts and store data in a secure manner. The visual maps created by participants during the interview process were also secured using a password-protected folder on my personal computer (also requiring a password for access). The text from the transcripts was imported into NVivo10 software (QSR International, n.d) for the purposes of analysis. NVivo was chosen to support the analysis process because of my relative familiarity with the software and because of its ability to store data, facilitate coding and analysis, and its ability to provide these three functions in an organized fashion. Furthermore, NVivo assisted me in the aggregation of coded segments of the interview data and allowed for effortless retrieval of data during the analysis phase (Padgett, 2012).

Phase 2: Thematic coding and preliminary analysis

Thematic analysis has been used in many disciplines over the years as a way to transform qualitative data into information that can be better interpreted by its audience, yet very few researchers have described how the process is undertaken (Boyatzis, 1998). Generally, thematic analysis offers a systematic approach to comparative coding and qualitative analysis, which is suitable for examining social and structural processes and generating theoretical explanations to better explain these processes (Glaser & Strauss, 1967). Specifically, for this study, the data were analyzed in terms of the meaningful dimensions of home with the goal of identifying how these meaningful dimensions change in a diversity of living situations, how they influence the health and wellbeing of dwellers, and to contribute to existing theory and knowledge defining the relationship between housing and health. Thematic analysis is a tool commonly used in major analytic traditions, like grounded theory, and it helped guide me in identifying and recording major themes revealed in the data (Ryan & Bernard, 2000).

Thematic analysis begins with the open coding of selected interview transcripts in which researchers look at the data from a descriptive level, moving to a more analytical interpretation of the data (Boyatzis, 1998). Charmaz (2006) suggested that the process of coding allows researchers to develop “generalizable theoretical statements that transcend specific times and places and contextual analyses of actions and events” (p. 46). Through an understanding of the lines and segments of data, researchers can begin to understand what is happening in the lives of respondents and understand what is happening in the settings that they occupy. Coding is the process of making sense of the data, but it also allows researchers to recognize the need for further data collection in the earlier stages of the research process (Charmaz, 2006). This process can be broken down further into two consecutive phases: initial coding and focused coding. Ten transcripts were chosen to help develop the coding framework that was later used in coding the two additional transcripts included in the sample. As explained previously, these 10 transcripts were chosen to achieve maximum variation in terms of living situation.

I initiated the analysis stage by openly naming and coding segments of the data from 10 interview transcripts, being sure to remain open to the theoretical directions that the data may have taken (Charmaz, 2006). Line-by-line coding was the general coding practice for analysis but I did hone in on participants’ constructions of home and descriptions of healthy housing a little more closely through word-by-word coding. Charmaz (2006) asserts that word-by-word coding helps researchers better attend to the meanings, which is of particular importance for answering my proposed research questions. Line-by-line coding was used most often for two primary reasons: it helps researchers refrain from imposing their own preconceived notions on the data, and it helps researchers adopt a critical lens when looking at the data, which allows them to better identify and describe relevant processes and themes emerging from the data (Charmaz, 2006). Boyatzis (1998) refers to the initial coding process as “manifest analysis” and is followed by a latent form of analysis in which underlying or implicit meanings in the data begin to emerge.

Open coding implies that codes and major themes are developed inductively from the data itself. NVivo helped facilitate the development of “in vivo” code labels through use of word frequency queries to identify major themes and concepts that frequently emerge within the data (Padgett, 2012). I also used what grounded theorists term “sensitizing concepts”, which are relevant concepts drawn from the literature, existent theories, previous research, and interview questions from the PLPH study to guide me in coding of the transcripts (Padgett, 2012). These data-driven codes and sensitizing concepts helped populate the coding framework and were placed within larger, overarching codes derived from existing theoretical frameworks (SDH and socio-ecological). This process of “winnowing down codes” takes place through focused coding (aggregating codes) and establishing the properties of codes (Padgett, 2012). As the coding of the first few transcripts proceeded, data-driven codes were placed within the theory-driven codes based on thematic similarities and I manually sorted the codes and placed them within the appropriate categories as I saw fit. This process flowed inductively as new codes were constantly compared with earlier codes and with the emerging housing categories. The coding process occurred through the use of the analysis software, NVivo, and “nodes” were developed as relevant to the interview data. Over time NVivo nodes augmented and amalgamated into larger nodes or coded categories focusing on the dimensions of housing (specifically the meaningful dimensions) and the benefits and negative aspects of respondents’ living situations. A coding framework was eventually created to guide the coding of sampled interview transcripts and the framework remained a living document that transformed as new codes and themes emerged from the data.

The themes and major incidents that emerged became the focal point of the analysis as I endeavored to describe and organize participants’ narratives about the beneficial features of their living spaces, attempting to better understand what home meant for individuals across a continuum of housing situations (Boyatzis, 1998). As codes emerged they were organized into categories (i.e., elements of living situation) and compared to assist me in identifying participants' meaning of home. Through the coding process I remained attentive to patterns revealed in the data and employed a constant comparative analysis to highlight any similarities, as well as dissimilarities, observed among research participants and their living situations (Padgett, 2012).

Parallel to the analysis of transcripts, I kept track of study transformations and analytic decisions through frequent memo writing and journal keeping, which Padgett (2012) suggests is appropriate for documenting "the researcher's personal reactions, biases, and concerns" (p. 163). Memo writing allowed me to be reflexive as a researcher, but also ensured that any thought processes about the codes used, conceptual themes hypothesized, and any operational changes to the research were consistently documented (Strauss & Corbin, 1990). Furthermore, memo writing allowed me to continually make notes about relevant data, codes, categories, and concepts in the literature, and through the process I was able to make comparisons between each. Charmaz (2006) explains that this is an important step in explicating and filling out analytic categories, and the beginning of moving these ideas to pen and paper.

It is important to note here that since I primarily constructed the codes used to analyze the data, what was defined as happening in the data and what was defined as being significant were done so based on my own view of the social phenomenon. The importance of the coding process is to attempt to understand respondents' views and actions from their own perspectives (Charmaz, 2006), so there are a few avenues that I took analytically to better align with participants' perceptions and experiences. The mapping exercise completed during the interview process, a feature of the original PLPH study design, allowed me to gain an "inside look" at respondents' living space. In some ways the mapping exercise added depth to the conversation about people's homes because it allowed them to think more conceptually about the contents of their living space, as well as what elements were perceived as positive or negative to their wellbeing, and what elements were missing or could make their living situation better. Visualization techniques, such as mapping, have been increasingly used in participatory research to better promote the generation of information and knowledge by participants on their own terms (Kindon, Pain & Kesby, 2007b). Although the visual maps did not undergo analysis on their own, they supplemented the interview data and participant's discussions of their home respective to their health and wellbeing. Another method that was used to resolve the tension between the researcher and respondents' views was by engaging my CAC in the analysis process, as well as participating in other participatory forums that allowed me to stay close to the emic perspective.

In Flicker and Nixon's (2015) participatory analysis framework, they suggest that the research team be involved in the analysis of data as early as the coding phase (exploring raw data and developing the codebook); however, this was not the case for this thesis. Due to limited capacity for involvement among members of the CAC, I completed the coding process myself. Furthermore, the choice to leave CAC members out of the coding phase was due to confidentiality issues. Since a majority of the CAC members reside in GV and surrounding areas, there was a chance that members from the team could identify participants in the study based on interview text and visual images of their living spaces. Although participatory coding can build a deeper familiarity and a sense of ownership, as well as add to the rigor of the project (Flicker & Nixon, 2015), there were some advantages to coding the transcripts individually. For instance, because I was the only person coding the transcripts, there was better consistency in the use of codes and coding methods, better recall of important data segments, and a more comprehensive understanding of the dataset. In this specific phase of the analysis process, aggregated coding segments and emerging themes were presented to the CAC for collective interpretation, refinement, and for discussion about which key themes warranted further analysis.

To have a participatory element to the coding process, I engaged with the members at PLN in the opening reading of an interview transcript to collectively identify key themes and discuss the meaningful dimensions of home. This process was both purposeful and meaningful because it not only made the research process more participatory in nature, but it also provided a means to consult with people living with HIV/AIDS in a community outside of the GV area. Therefore, I was able to compare "what's important" in more northern regions of BC, further supplementing research data collected in more southern study site. As previously mentioned, participating members were asked to list key ideas and concepts on sticky notes, while the transcript was read aloud, and the sticky notes were later used to better define and expand existent coding categories. PLN members provided an opportunity for member checking.

Typically, researchers will seek verification of emergent study findings by consulting study participants (Padgett, 2012); however, I sought to include the voices of people whose lived experiences helped me more appropriately address the research questions, and further reduce my own bias as a researcher.

Through the participatory mechanisms described above, the codes that were initially developed were adapted for better relevance and fit with the data, but also with participants' experiences. Charmaz (2006) explains,

> Your study fits the empirical world when you have constructed codes and developed them into categories that crystallize participants' experience. It has relevance when you offer an incisive analytic framework that interprets what is happening and makes relationships between implicit processes and structures visible (p. 54).

Phase 3: Drafting thematic summaries and collaborative analysis

Once the coding was completed and major themes were identified, the CAC met a second time via teleconference. During this meeting I presented the major themes from the coding process and we collectively engaged in a critical discussion of what were the most important findings relevant to the research questions and whether these themes resonated with CAC members' own personal and professional experiences. While the number of key themes emerging from the data seemed endless, the research questions were always posted during group discussions to help ground deliberations. Flicker and Nixon (2015) agree that it is not always practical to have everyone on the study team review all raw coded data, so instead summaries of the key themes were presented to CAC members, which helped "springboard informed collaborative discussions" (p. 620) and demonstrate how collaborative inquiry lead to the development of key themes.

In the collaborative inquiry process, key themes were presented to the CAC for collective interpretation and refinement of developing conceptual categories (grouping of key themes), and a lot of discussion ensued around potential themes that could help further develop the conceptual categories. For example, in the earlier stages of analysis, I brought forward a number of emerging themes to the CAC for discussion, including themes around the need for security in one's home environment. At this point the committee and I realized the strikingly different elements in one's living environment that could provide participants with a sense of security. Collaborating as a group, we determined that participants derived security from various elements based on their most salient needs at the time of the interview and depending on their current living situation. Thus, a higher conceptual category was defined based on this temporal component for varying types of "housing security". For me, this process was influential because it helped transform the descriptive categories of data into higher-level analytic themes – summarizing the meaningful aspects of home that were commonly expressed by many people living with HIV/AIDS in the GV area. Kindon, Pain and Kesby (2007a) affirm that participatory inquiry helps researchers better respond to the "needs of specific contexts, research questions or problems, and the relationship between researchers and research participants" (p. 13), and the engagement of the CAC in the analysis of study findings was instrumental to the development of conceptual categories of data and higher levels of analysis. Therefore, the engagement of the CAC in the analysis process went beyond providing member checking and colleague review (strategies to establish rigor), but it actually redefined key conceptual categories and shaped major conclusions of this study.

Phase 4: Conceptual coding: reviewing and revisiting themes

The coding process was both iterative and reflective, and involved emails back and forth with CAC members for further enquiries on key discussions around research findings. Throughout this process, major modifications to the conceptual categories and themes became fewer and fewer, which is supported by constant comparative method (Glaser & Strauss, 1967). Glaser and Strauss (1967) also suggest that through the winnowing down of emergent themes, theoretical ideas can begin to become more generalizable to each other and to other varying concepts. For example, the theme examining the necessity for facilities to maintain one's hygiene and physical appearance could relate to the theme "filling up my space", both of which drew on overarching themes of self-identity and self-stigmatization of persons living with HIV/AIDS. These theoretical ideas became concretized through coding common themes and incidents numerous times in the data set and through their relationship to other emergent themes.

Charmaz (2006) stresses that writing and rewriting is a crucial part of the analytic process and by revisiting and rewriting major themes, researchers are better able to conceptualize the properties and relationships between their theoretical categories. Through this comparative process, conceptual categories and their properties were further defined and the relationships between categories were further described. Furthermore, through a comparative analysis of housing categories, similarities and differences between categories began to translate into higher, conceptual categories and their properties, which in turn provided theoretical explanations for the research questions (Glaser & Strauss, 1967).

As higher conceptual categories were developed to better understand the meaning of home, it was crucial for me to represent participants' lived experiences to the best of my ability. Therefore, it was important for me to continually check in with the team members engaged in the research process. This not only ensured the meaningfulness of the data, but it also ensured the validity of the research findings. I did this by reviewing and incorporating feedback from the CAC, and revising my conceptual categories to best reflect the "insider's perspective". In CBR studies, collaborative analysis aims to promote the development of relevant research and relevant information, as well as the interpretation of information that may otherwise go undiscovered by me, as an academic without lived experience.

Phase 5: Final approval and strategies for rigor

The final, revised summaries of the data were presented to members of the CAC for final approval and feedback. Having their feedback was important to ensure the appropriateness of the research outcomes. In addition to including participatory engagement in the preliminary analysis and the more analytic stages of analysis, I have undertaken various additional strategies to ensure the trustworthiness of both the research process and the research results. By aiming to uphold the trustworthiness of the study, I can better ensure that this research was carried out in a way that is ethical and fair to all parties involved and implicated, and ensure that the interpretation of the study findings are closely aligned with participants' experiences (Padgett, 2012). However, even with clear ethical intent, a study can still experience issues with accountability and rigor.

Threats to the trustworthiness of a study come from reactivity, researcher bias, and respondent bias (Padgett, 2012). Reactivity refers to the potential issue of having respondents' beliefs and behaviours influenced by the presence of a researcher in a research setting (Padgett, 2012). Since this research is a secondary analysis, I did not interact face-to-face with any of the interview respondents, thus limiting my potential for bias and reactivity with respondents. Research bias, on the other hand, results from having a researcher's preconceptions and opinions interfere with the interpretation of study findings (Padgett, 2012). It is difficult to completely remove researcher bias from any study, but I have committed to being transparent about my biases when I see them being a possible concern (these biases will be considered in the discussion of the research findings). Moreover, I have aimed to reduce my biases by committing to an audit trail, ensuring that all study procedures and decisions made are clearly documented and traceable. Lastly, respondent bias is a threat to the trustworthiness of a study as respondents may withhold pertinent information for many reasons. Because I was not involved in the interviewing of participants, it was a challenge for me to put strategies in place to limit respondent bias. However, I have employed several strategies throughout this secondary analysis to strengthen the trustworthiness of this study. These strategies for establishing rigor have been discussed in previous sections; however, I will explicitly restate and define them here. The four strategies include: triangulation, negative case analysis, colleague review/peer debriefing and support, and continuous auditing.

Triangulation. The very nature of participatory approaches in the analysis phase of my research has allowed for collaboration and collective interpretation of the data. This analytic form of triangulation has helped create a fuller picture of the data, since people from a variety of backgrounds and disciplines have assisted me in the organization and interpretation of research findings. Furthermore, the collection of visual maps drawn by respondents in the PLPH interviews has helped corroborate major themes and interpretations emerging from the transcript data. When findings are consistent among research collaborators and consistent between the two types of data (maps and transcripts) analyzed, it will create more trustworthy results and ensure that study findings stay close to respondents' experiences.

Negative case analysis. Using the 10 cases sampled, negative case analysis allowed me to test provisional theories or ideas by searching for negative cases in the dataset. For example, as I read through roughly half of the transcripts, I came to the realization that many participants experienced transitional living experiences and have lived in more than one type of housing tenure in their lifetime. With this idea in mind, I was obligated to return to the data to search for negative cases, or cases that did not align with this assumption. Negative cases in the PLPH study sample and discussions held during the PLPH data party (that examined data collected from GV) helped explain developing conceptual categories and confirm the categories of housing situations that were be created. Furthermore, negative case analysis helped refine the study's research questions by identifying research transcripts that did not fit the emerging themes and to expand the research by investigating confounding factors (i.e. the "rules" attached to gaining housing subsidies) (Padgett, 2012).

Colleague review, peer debriefing and support. The availability of peer debriefing and support is critical component of qualitative studies as they allow researchers to discuss their ideas and concerns with peers (Padgett, 2012). It was important for me to continually debrief and seek expertise from my supervisors, Catherine Worthington and Heather Picotte, as well as various members of the CAC. Debriefing allowed me to recharge though analytic processes, to seek feedback on processes that I was uncertain about, and confirm the importance of emerging theoretical categories of data.

Auditing. As mentioned previously, I was diligent in documenting my personal reactions, biases, and concerns, as well as any important logistical or theoretical changes throughout the research process. These thoughts and memos will be described in greater detail in the conclusion chapter. Memo writing was especially important with the sampling process because it allowed me to keep track of my ideas as I moved between the transcripts and analysis. Charmaz (2006) claims that memo writing allows researchers to flag unfinished categories and gaps in analysis, and guides further sampling to refine and saturate categories. This process has also added to my credibility as a researcher and to the credibility of the research project because all study procedures and issues were clearly documented and traceable (Padgett, 2012).

Community Giveback

In addition to providing consultation on the final research findings, CAC members also participated in the planning process to determine how to best disseminate research findings. I am planning to develop a community giveback project alongside this project to ensure the community can directly benefit from the research outcomes. The advisory committee will be assisting me in the development of this project so that it is deemed both relevant and valuable by the community, and I hope to leverage the personal and professional contacts of CAC members to ensure better usability of research outcomes (Flicker & Nixon, 2015).

With the study highlighting the diversity of housing experiences among people living with HIV/AIDS, the development of the community giveback project will aim to address concerns related to various housing options, as well as the process of transitioning from one living situation to another. Many participants have experienced transitional periods as well as living in more than one type of housing tenure; therefore, results from this study will be able to highlight the meaningful components of housing for a variety of people and in a variety of living situations. Housing programs and supports in the GV area were also discussed in the data, and through an exploration of the perceived meaningful dimensions of home for participants, this research will also help evaluate and recommend improvements to these housing services so that they serve the HIV/AIDS community more meaningfully and appropriately. The community giveback project will be reviewed in greater detail alongside the discussion of the study results in later chapters.

Ethics

One of the advantages of conducting secondary analysis is that gaining research ethics board (REB) approval is usually much easier because interacting with human subjects is not involved (Padgett, 2012). Since I completed my practicum with the Pacific AIDS Network, I established a close working relationship with the PLPH study coordinator and research team, specifically with the Participatory Analysis Working Group (PAWG). As a student of the academic Principal Investigator at the University of Victoria and a practicum student at PAN, I gained access to the PLPH data as a research assistant. As a research assistant I signed a confidentiality agreement with PAN and continued to adhere to the established requirements for confidentiality and data security. The PLPH study gained ethics approval through the University of Victoria's Human Research Ethics Board (HREB) before any recruitment or data collection occurred. I was required to submit a letter of amendment to the University of Victoria's HREB and have since been approved and have been added to the Certificate of Approval.

Even when institutional ethics is obtained, qualitative research runs the risk of breaching confidentiality in the processes of analysis and reporting results, so the protection of data must be ongoing (Padgett, 2012). To protect the confidentiality of respondents that participated in PLPH interviews, all identifying information was removed from the transcripts when they were transcribed and will therefore, not be included in this thesis. Furthermore, since some members of my CAC work and reside in the GV area, I ensured that members did not work with any raw data and instead focused on higher-level themes that emerged from the data. Lastly, I have endeavoured to be socially responsible throughout the entirety of the research process in considering and conceptualizing the wider structural elements of the social issue at play to better understand the data (Padgett, 2012). There is also a need to achieve a balance between accuracy in the data and the sensitivity to participants needs (Padgett, 2012), and I have remained conscious of this matter and consulted the CAC throughout the process of interpreting and reporting data.

CHAPTER IV: RESULTS

In this chapter, I will begin by describing the characteristics of the sample used in this analysis, as well as their current living situations. Then, I will highlight several key themes that emerged from the narratives given by participants concerning how the various components of their living space contribute positively or negatively to their health and wellbeing (research objective 2). This will be followed by a discussion of how participants define "home" and how the incorporation of various elements in their living space collectively constructs a sense of home (research objective 1). It was helpful to organize the results chapter in this way since a definition of home was not explicitly given by participants, but rather participants' discussion around the elements within one's living space helped them navigate what spaces they "call home" and "feel is home" (GV031130a). So to orient the reader, I will begin by exploring the data in relation to the second research question (an exploration of the elements in people's home), which will serve to better inform the discussion about the first research question – the meaning of home.

Characteristics of the Sample

At the time the initial interviews were conducted in the PLPH study, the ten participants selected for my study had a mean age of 50 years, and five (50%) identified as female, with one participant identifying as Trans-Female (10%) and four participants identifying as male (40%). In terms of race/ethnic composition, there were five (50%) who identified as Caucasian, 2 (20%) First Nations, 1 (10%) Metis, and one person (10%) identified as Chinese Canadian and another participant (10%) as an African refugee. A majority of participants relied on BC's Person with Disabilities (PWD) assistance as their primary source of income (6, or 60%), while other participants relied on other (or a combination of) financial sources, including: Canada Pension Plan (3, or 30%), welfare (2, or 20%), housing and nutritional subsidies, and financial compensation from casual work and volunteer opportunities. I attempted to explore variations in the meaning of home in relation to the differences in gender, sex, and cultural background among participants, and this will be discussed later in the conclusion chapter.

The sampling for this study was based on the type of living space participants maintained at the time of the interview; however, as might be expected (and noted in the Methodology chapter), housing status had changed several times for many participants over their lifetime. Within the selected sample, four participants lived in subsidized rental units within residential buildings at fixed addresses (with three of these buildings being designated for people living with HIV/AIDS), two participants lived in rental accommodations where they paid market value rental costs, one participant had used a portable housing subsidy for a rental unit in a residential building of their choice, two participants were housed in residential buildings that offered supportive living arrangements for people living with HIV/AIDS, and two participants did not have access to private, secure living accommodations (see Appendix A). Half of participants lived in the downtown core of Vancouver, while the other participants lived in outlying neighbourhoods, including Surrey, Richmond, Burnaby, and Maple Ridge. A majority of participants (70%) had previously lived in transitional and precarious housing situations, which allowed participants to recall and elaborate on features of past or current living spaces that they liked or didn't, and to comment on which features contributed positively or negatively to their health and wellbeing. Therefore, while this study examined a sample of 10 participants with four discrete categories of housing, the multiplicity within each category and within each participant's experiences allowed for an enquiry of a much larger sample of housing histories, in theory.

Key Elements of the Space, and Health and Wellbeing

From a thematic analysis of the data, many themes that addressed the original research questions proposed by the PLPH study emerged. There were many themes that emerged strongly from the data, but some were not directly related to the research questions proposed by this secondary analysis, and will not be discussed further. Instead, I focused on a smaller number of key themes that I believed to describe what "home" consisted of and that highlighted how various elements within a diversity of housing situations specifically influenced people living with HIV/AIDS. The themes that were focused upon were the subjects that consistently emerged in participants' narratives, as well as the themes that were further acknowledged by members of the CAC. For example, one space in the home that had a great impact on the health and wellbeing of participants was having a kitchen to store and prepare food, and the significance of a kitchen space will be discussed in greater detail in following sections. The several key themes that I chose to focus on are instrumental to the subsequent discussion about how themes emerging from this study compare with the literature and the theoretical frameworks (socio-ecological model and population health framework) that are currently being used to describe the relationship between housing and health. Participant identification numbers (i.e. GV031130a) follow each quote, and corresponding information regarding participants' housing status at the time of the interview can be found in Appendix A. The choice to use participant identification numbers instead of participant pseudonyms was to keep the process of this research aligned with the primary study, and to allow the PLPH research team to integrate the findings from this study back into the larger study. I also decided to keep the names of specific ASOs and other housing organizations in direct quotations when the inclusion of organizational names did not compromise participants' confidentiality, because CAC members indicated that this was important and it added a rich, contextual piece to participants' narratives of their home environment. The decision to include organizational names also had broader implications for the PLPH study, as well as for the community members and organizational partners who will be involved in subsequent knowledge translation processes.

ASOs and housing organizations

Many participants discussed their living environment in relation to nearby (or not so close by) amenities, such as grocery stores, recreational and social activities, and health care services. Due to the nature of the research questions, it was beneficial to create a map with commonly noted housing and HIV service organizations and supports in geographical reference to where participants reside to help facilitate the discussion about access (see Appendix B for a reference list of map points). While there were some public amenities noted in the data outside of the context of HIV and housing service organizations (i.e. public markets, transportation hubs, and grocery stores) the dialogue surrounding these amenities were often non-specific and a majority of participants enjoyed a myriad of these services and supports from HIV and housing service organizations on a daily basis. For instance, in terms of access to food, participants referenced several HIV/AIDS service organizations (ASOs) and housing drop-in centers that offered hot meals. Additionally, social and recreational activities, as well as health services were frequently housed at ASOs. I will discuss the types of services offered at ASOs and housing organizations in further detail throughout this chapter, but first, I would like to point to the geographical locale and dispersion of said services in the GV area. In the geographical maps to follow, ASOs have been labelled using a red pin, while housing organizations have been noted using a green pin, each with numbers (in no particular numerical order) corresponding with the name and address of the organization. The blue pins represent the location that participants referenced as their living space using postal codes to highlight their geographical proximity to the organizations visited and services used on a consistent basis.

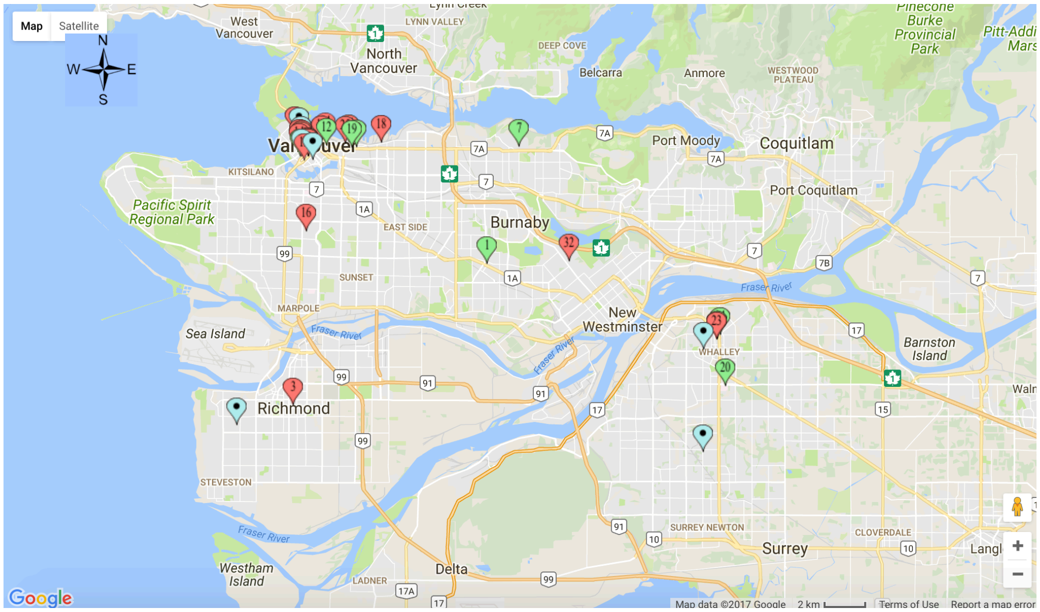

Figure 2. Location of ASOs and housing organizations in Greater Vancouver

Legend	
Point	**Label**
●	Participant living space
16	AIDS service organization
1	Housing organization

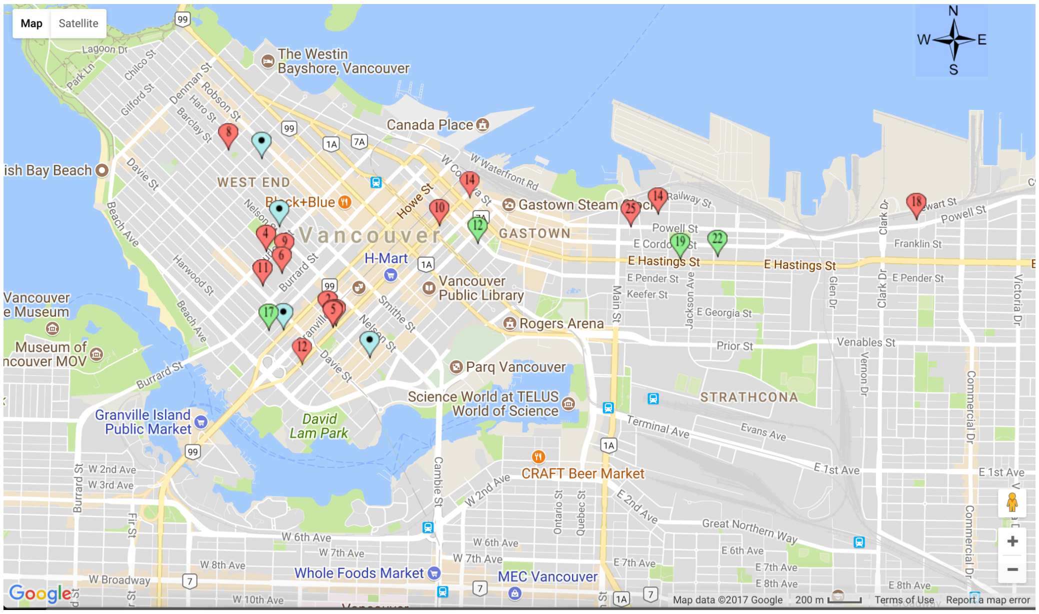

Figure 3. Location of ASOs and housing organizations downtown Vancouver

Legend	
Point	**Label**
●	Participant living space
16	AIDS service organization
1	Housing organization

Figure 3 illustrates that participants live in several different neighbourhoods in the GV area, including Richmond, Burnaby, Surrey, and Maple Ridge, yet there is a congregation of both housing and HIV services in the downtown region (shown in Figure 3). For a participant living in the West End of Vancouver, he described the location of his living space as:

> …[A] great neighbourhood. Everything, that, one could need is accessible. There are grocery stores, there's a pharmacy. There are shops. Markets…I don't need a car. I can go anywhere in the West End and elsewhere by bus, and sky train. So I can go as far as Surrey with little to no problem at all (GV020101a).

Many participants living in the downtown core of Vancouver noted the convenience of accessing the abovementioned services and amenities, while the participants that resided in outlying areas of GV had to navigate access to necessary services in slightly different ways. Even though a majority of HIV and housing service organizations are located in the downtown area of Vancouver, residents in outside neighbourhoods (except for one) were seemingly content with the proximal geography of their living space to said services, and reported no serious concerns with accessing them on a regular basis. Several participants mentioned other types of supports that helped them access services and amenities. For example, participants mentioned that both the BC Ministry of Social Development (through the Person's with Disabilities designation) and AIDS Vancouver provide financial support to those needing bus passes, which helped to address the cost of transportation through promoting the use of public transit at a subsidized cost. Another method shown to increase participants' access to HIV and health care was the establishment of satellite clinics and site locations in neighbouring communities. One example of said organizations is Lookout Emergency Aid Society, which had several services and locations scattered throughout the GV area, including Positive Haven in Surrey. The capacity for outreach among housing workers and health care workers was another important mechanism for helping participants receive services where they were geographically, as well as where they were in terms of their physical capacity. However, not all participants had access to these supports. One participant residing in GV did not have access to a method of transportation and noted the inconvenience of needing to travel to the downtown core to have her health needs met.

> I'd like to make it the downtown one, the center, a lot more. But-they have all kinds of acupuncture, different alternative medicines that I'd just like to look into. But because I don't have disability I'm always stranded and can't get anywhere. Never get on the bus to get here. Just getting to St. Paul's [hospital providing HIV care], twenty minutes is a challenge on such limited funds (GV428090a).

While the number of ASOs and housing organizations remained concentrated in the urban center of Vancouver, most participants were able to navigate access to necessary services in alternative ways that allowed them to be content with their home environment.

While it was convenient for most to live close to public amenities and to be in walkable distance to fulfill service needs, not all participants autonomously chose to live in the areas where they lived. Participant GV421101a explained, “Well if I didn’t have HIV, I would have my career and I could live wherever I wanted…it limits me to where I live, you know.” This quote highlights the necessity of living close by to healthcare and HIV supports to ensure that participant GV421101a’s illness is effectively managed and good health outcomes are maintained. However, this quote also hints at the financial vulnerabilities associated with living with HIV/AIDS and how many participants opt for subsidized units in HIV-designated buildings to lessen housing costs. For participant GV428090, she had chosen to set up camp recurrently in specific geographical locations of Surrey because of the camp’s access to nearby amenities. “My supports are here, like this. Like where else would I shower? Where else would I eat? Use the bathroom? You can’t use a bathroom anywhere in Surrey. And like, all the food services are right here” (GV428090a). In a similar case, Dr. Peter’s ESL housing helps to ensure close proximity to necessary services by offering residents furnished suites within the footpath of the Dr. Peter Centre. This housing program is best suited for people transitioning out of residence at the Dr. Peter Centre and into the community, being mindful of keeping necessary supports in close proximity. Participant GV910121a, who lives in this supportive housing arrangement, claimed, “I mean…if I hadn’t been living in Nixon Towers [transitional housing], so close to the Dr. Peter’s Center, it wouldn’t have been so easy to get my medications, and my food.” From participants’ narratives it became clear that the location of housing and HIV supports was an important determinant of where participants lived. However, while it was necessary for participants to be close to their supports, it is important to note the difference between autonomous choice and constrained choice, and how each may affect the health and wellbeing of participants differently.

Portable housing subsidies were a form of housing support offered by McLaren Housing and Wings Housing Society to some participants sampled in this study to help them afford market rental costs in locations of their choosing in Vancouver and the Lower Mainland. The portable subsidy allowed for more autonomy around housing choice, and with the support of a portable subsidy, participant GV421101a explained that the house had “everything I wanted.” Even when his housing stability was threatened, he said, “I had a couple friends who helped me with my rent when it was being increased, because they didn’t want to see me back in McLaren house…They saw- they said I was more happier outside. Like, with portable subsidy” (GV421101a). Even though the portable subsidy afforded participants greater choice in where they wanted to live, as well as what kind of living space was most suitable for them, not all housing options could be made affordable with the use of the subsidy.

In consideration of the important spatial dimensions (essential features in the environment that exists outside of the structurally defined “home”) of participants’ living spaces, the home mapping exercise supported an increased understanding of where and how participants lived through the visual depiction of the contents of their space. In one noteworthy map, participant GV421121a drew and labeled contents of her environment that were external to her living space. Participant GV421121a, residing in a three-bedroom rental unit in a Wings Housing building, drew the floor plan of her living space in relation to the other floors in the building (including the building entrance, lobby, and shared laundry facilities) and the building was sketched as being in close proximity to St. Paul’s Hospital. Labeling a hospital or public amenity suggests being of certain value to the participant; however, there was an absence of further explicit dialogue around the importance of St. Paul’s for participant GV421121a, except for noting frequent disturbances from nearby ambulances and regular visits with her practicing HIV specialist.

Even though not all participants spoke explicitly about the advantages of living nearby ASOs and housing service organizations, it was evident that there were in fact some positive aspects articulated. The social benefits offered by ASOs can be just as important as the physical support offered. Participant GV421101a explained,

> I know who and how and when, the date, how I was infected. So I usually dwell on it. But then I just got, with the help of Living Positive, and AIDS Vancouver, and McLaren, and Loving Spoonful, I got help from being…scared and being more positive.

This quote highlights that the types of support offered can have a significant impact on the emotional and social wellbeing of people attending these organizations. The social environment created through the congregation of staff and peers at ASOs will be elaborated on further in subsequent sections.

Another component of ASOs and housing organizations were the staff that worked there.

Staff members within these organizations often take on multifaceted roles and help people find affordable housing by assisting with housing applications and acting as an advocate in landlord-tenant relations, and help with the upkeep of positive health practices, such as staying on track with treatment regimens and regular trips to the dentist. For a few participants, housing outreach workers were supportive of their efforts to find appropriate housing options, and participant GV031110a explained,

> So I went to one of them and they drove me around to look at a place. And sometimes they're good. You know, especially with me, like I feel sometimes I'm being discriminated against for being a single woman. They can talk a little bit better on the phone to a landlord, yeah.

In this example, an outreach worker helped facilitate discussion between landlords and potential tenants, as well as alleviating some of the tensions brought on by preconceived notions. There were some also some cases where staff at these organizations presented challenges for participants. Participant GV3211101a explained,

> …Went from getting to know everybody and getting comfortable with everybody, and then all of a sudden they're not there anymore. And I'm not good with change. Especially with major things. So having to sit there and explain everything over again to people, like over and over again when really I just got used to somebody.

Not only were staff changes troublesome for participants in having their immediate needs met, but it created a social environment that made it difficult for participants to meaningfully engage.

In addition to issues with frequent staff changes at organizations, housing services were also criticised for having long waitlists to get into secure housing options, needing references to submit housing applications, and the onerous process of having to keep up with housing applications (i.e., frequent phone calls to housing agencies). Even though some ASOs and drop-in centres permitted the use of phones and computers on site, there were often long wait times also associated with these amenities. Finally, even though housing organizations promoted access to their services by increasing their hours of operation, they were sometimes still perceived as inaccessible due to their location. For example, participant GV428090a explained that although Front Room was open all night, she was apprehensive about using the service because "…it's scary coming down here, like right on the strip at night. It's very scary."

Another participant commented that her residence in Richmond lacked nearby recreational activities and community amenities for physical activity, and she explained,

> I feel I'm not doing anything, there's nothing to do. There's nowhere to do anything there. There's nowhere to work out or anything, and you know, it's just stupid. Whatever. I've tried to go and lose weight, and then- but it's affecting other things (GV321101a).

This quote highlights participant GV321101a's discontent with her environment being able to meet her health needs, as well as the lack of opportunities to keep her socially engaged within her community. This quote also suggests that not having access to these necessary amenities has played a role in participant GV321101a not feeling at home in Richmond and for her to conclude: "Even though I was born and raised in Richmond, I have like one friend out here, but like, I met her living in Vancouver. Like I don't know anybody out here. I hate it here. Richmond's retarded."

Kitchen and access to food

A kitchen space where one could prepare and cook food, store their food items, and "break bread" with others was a significant feature of participants' described living spaces. Due to the nature and extent of participants' living situations, a "kitchen space" was defined in different ways. For many, a kitchen space was defined as having access to useable appliances (i.e., ovens and cooktops), and included areas to prepare (i.e., counter tops) and store food (i.e., refrigerator and cupboards). Some participants had contained kitchen spaces within their own living accommodations, while others shared spaces with others in the form or communal kitchens and eating areas. Participants talked about having their own kitchen space in relatively positive terms, while shared kitchen spaces had a mix of positive and negative elements.

Several participants noted a sense of autonomy and choice when they had access to their own kitchen space. Participant GV011110a explained: "And so my kitchen suite, I really enjoy it because it gives me the power to eat stuff that's more healthier so I can go across the street and just make a meal, and it's filled with healthy options." Participant GV01111a also explained that being able to cook her own meals was an empowering process for her to not only take control of her food choices, but also her health by ensuring her nutritional needs were being met and that medications are being taken appropriately with food. She explained further by claiming,

> Having that option to cook whatever I need, so I know that I have nourishment in my body, and, so far my numbers have stayed up, at least around eight hundred. So seven to eight hundred, so I know that- what I'm doing is working for me [inaudible 51:03]. That's why I keep- that's why I keep inspiring myself to cook more, just to see those numbers higher. So it's a huge inspiration and especially to have that kind of power over my own health. It's nice. So I don't rely on anyone, and no one has to worry about taking care of me (GV01111a).

In addition to having the space to allow for decisions about what to eat and when to eat, food vouchers were also given in some cases to compensate participants for volunteer hours, which enabled greater autonomy in food choice since the vouchers could be used at local grocers.

Some participants pointed out that the process of preparing and eating food could also have benefits for their mental and emotional wellbeing. For example, participants expressed enjoyment in the routines of shopping for food and preparing food with others. Participant GV412110a, a refugee from Africa, discussed the importance of cooking foods from her home country in company of family members: "…when you eat with two or three people you can enjoy. The food again is good." A kitchen space becomes a gathering place within the home where people can convene and share a meal: "…inviting people to have a snack at my home, they just can come over. So it is really nice just to have that option of community" (GV011110a). For one participant, having a kitchen provided the space to rekindle her relationship with her mother, as she was able to invite her mother to a place that was hers and partake in the joint activity of cooking and eating.

For people coming from transitional housing periods, having a place to store food items enabled them a sense of constancy in their living environment as well as their eating routines, rather having to rely on outside sources, such as soup kitchens and food banks. For participant GV031130a, being housed and having access to his own kitchen provided

> [just] a sense of security. The fact that I could eat regular, you know, because there was a place to put the, you know, your groceries and stuff and that […] Because that way I can buy my groceries, I can maintain my eating habits, and everything. So as long as my housing is stable, I feel that that's a big impact on me (GV031130a).

Consistency in meal times was an important factor for many participants who were on regimented anti-retroviral (ARV) treatments. Constancy can be an issue for people living in transitional housing situations, where access to food at specific times during the day can pose a challenge.

> [I need] to take [meds] with food, so I always take them at dinnertime. And sometimes that's been a little later, lately, like when I kicked- don't get in the dinner line up because of my bully, I have to put something in my stomach with them, so I always have to try and save some- or sometimes it'll just be a little later before I can access food, because I couldn't stand in the dinner line up, but yeah, it's been pretty good (GV428090a).

Participant GV428090a cites her "bully" as an impediment to accessing food at necessary times. Like participant GV428090a, other participants discuss challenges with accessing food from public spaces making reference to the cleanliness of these facilities, negative interactions with other attendees, and litter from drug-related paraphernalia in the environment.

The lack of storage in communal kitchen areas was another perceived challenge for those accessing certain food services in GV. For participant GV428090, who is without her own secure kitchen space, the food bank wasn't a resourceful way for her to obtain food because many of the food items available needed proper storage and the proper means to prepare the food (i.e. a stovetop). In another type of transitional living environment, a lack of secure storage presented a challenge for participant GV011110a, who had to share a kitchen space with other residents at Covenant House. She claimed,

> It was a great place to be at. They served food like twice a week I think, and then we had to cook the rest of the food for ourselves, we had to buy it and actually put it in the fridge. But sometimes food would get stolen, so I didn't really put anything to eat (GV011110a).

While shared spaces posed challenges for some participants, others noted the positive aspects of sharing communal spaces with other residents and the positive aspects of attending service organizations that offered attendees a hot meal. For example, communal kitchens, often located within drop-in centres, offered the means for socialization among residents. "Like sometimes I'll even just go out to the temple [Akali Singh Sikh Temple] to eat just so I'm around people" (GV031110a).

Some supportive living buildings, such as Dr. Peter's ESL building, offered residents the convenience of prepared meals, as well as, comprehensive nursing services that help participants maintain highly active anti-retroviral therapy (HAART) regimens. Even though residents had access to their own private kitchen spaces within their residential suites, the provision of hot meals in a more communal type of "kitchen space" within the building helped ensure the intake of food went hand-in-hand with medication. In similar transitional housing accommodations, such as Covenant House, residents were also provided with meals at scheduled times; however, they were also given the capacity and encouraged to prepare their meals independently. Participant GV011110a described her experience,

> [But] even at the shelter that I was living at, we always had two meals at least, we had to make our breakfast. So, that's what was like inspiring me to start like cooking more and cooking differently and having stuff that I cook in my own oven. Especially for sandwich meats or anything. Just so that I have the option there, right. But it's definitely made an impact on my life because once I was living at the shelter, my numbers had like nearly doubled at one point. I remember at one point, it was like one thousand. […] My CD4. It just jumped right up and it was there for a long time. So it really- I could really feel, like

> having that access to that food, and that food inspiring me to move on my own, eventually start taking care of myself.

While Covenant House didn’t offer residents the same level of support with their medication regimens as in the ESL program at Dr. Peter’s, consistent access to food still helped participant GV011110a gain control over her HIV care and increased her CD4 count over time. In addition to managing participants’ HIV care, the transitional living arrangements in the abovementioned examples encouraged a gradual transition for residents in beginning to prepare their own meals independently; thereby increasing their ability to maintain better practices to sustain good health outcomes.

Washroom, toilet, and washing facilities

For many participants, access to washrooms and laundry facilities were critical features of their living space, and allowed them to carry out their daily routines. Some participants talked about the serenity of hot bath, while others mentioned needing immediate access to washroom facilities in the case of negative side effects from their medications. Most noteworthy were the features in the home that allowed participants to maintain hygiene and look after their physical appearance. For instance, a shower was important “…because it helps keep me clean and fresh so I can present myself well at work” (GV011110a), and a mirror was necessary, because “[well], I mean, okay…like I said, once you got diagnosed, the last thing you want to do is look like it” (GV910121a). Having access to a shower and laundry seemed to provide the necessary amenities to allow participants to look their best selves, and to put their best foot forward. One’s external self-image seemed to be important for several participants who felt that their exterior appearance didn’t always convey an image to others that was reflecting the self. Aware of this, participants explain their methods for ensuring that their physical appearance didn't feed into any negative and unwanted stereotypes. “Like…people didn’t know that I was homeless unless they see me sleeping on the street. I always made sure I had a shower every day, kept my clothes always clean” (GV031110a).

Living on the street presented some obvious challenges for maintaining hygiene and obtaining access to necessary washing facilities. GV428090a describes her routines around using such amenities:

> …[Normally] I will come into the Front Room to clean up. Sometimes I'll come here depending on…so a lot of times it's easier to just come here to clean up in the bathroom. Brush my teeth, throw some water on my face, and just kind of feel alive. I never used to leave my house without a shower. This is so not me. […] You know, I always had a roof over my head and shower facilities, laundry. And…take those things for granted when you don't have them, I tell you. Even running with just a couple of outfits, and having to wash every other day and…just- I always feel dirty (GV428090a).

In addition to not having access to a private space for washing up, the wait times and cleanliness of washroom and laundry facilities in drop-in centers can make these conveniences less accessible. Participant GV428090a talked about waiting upwards of eight hours to do a load of laundry or to have a shower because of the number of people on waitlists. She further explained how she managed her living space in spite of having access to her own washing facilities:

> Well yeah, I have to buy- I always have to make sure I have a moisturizer and bleach, you know what I mean? I buy cleaning supplies to clean next-door at the shelter because it's horrifying. And I'm just- I'm very cautious about where I shower and what I expose myself to. It's all going to come back on me, always. They come off as like misinformed, they think we will get them sick, but the reality of it is we're going to catch everything going around. And the public doesn't really understand that all. They…they always give you different plates to use (GV428090a).

Maintaining hygiene comes up repeatedly in reference to living with HIV/AIDS in several interviews. In the abovementioned quote, participant GV428090 described the risk of being exposed to harmful pathogens in unhygienic washroom facilities and referenced common misconceptions about the risk of HIV transmission from person-to-person through the use of such shared facilities.

Possessions, furniture, and storage

Empty spaces were described as encouraging the desire to fill them. For many participants, having possessions and furniture, as well as having a place to keep them secure, gave people a starting point, a foundation, to build from.

> I think what would've helped me is like having a space where I can start filling it with my own belongings. So I can collect things along the way and just create a better lifestyle because I think that's what helped- what is helping me right now, is the idea that whenever I look around in my place, I still see things that I have to get and I always see these small little things as goals, because I am a goal oriented person (GV011110a).

Not only did such spaces create a foundation and place to make their own, but they also supported growth and the development of goals that hadn't been thought of before. For example, one participant noted having bike storage in her residential building, which prompted the possibility of one day getting a bike. Just as spaces were encouraging for participants to fill them up and idealize future goals, having furniture and other belongings already in possession created the need to find secure storage and secure housing accommodations. "I have stuff, now. And it's exciting having new stuff. Like, when you actually have absolutely nothing, you know, you're not really going to be all that motivated" (GV321101a). However, just as participant GV0321101a's possessions kept her motivated to find housing, the loss of her possessions created a feeling of despair when trying to find a suitable accommodation.

> I've been looking for places and….it's just ridiculous why I don't a- my own place. Well then I kind of stopped looking after I lost my stuff because…I didn't feel like- if I did find a place what would I move in with? Like I didn't even have a bed, or dishes, or anything. I had nothing. So I kind of gave up (GV32110a).

Other participants' narratives were consistent with participant GV32110a's experience, and in the collaborative session with participants at Positive Living North, one participant concurred, "There is no point wanting to own anything" while living in transitional housing situations, such as shelters. Participants attributed a higher risk of losing their possessions to a lack of storage in housing shelters, as well as municipal rules that restricted residents from keeping an eye on their belongings.

Of particular importance to people living with HIV/AIDS, these at-risk belongings may have essential health functions. As one participant said:

> Both months- the last two months I picked up my HIV meds, the first time I just left my ex, so they were gone and this time I picked up my meds, my purse got stolen the same night, so I had to come in and say, "I've lost my meds again." So they're going to give me weekly- which works for me, too. Weekly, instead of like, month and two month. Which I never had a problem with when I was housed, because you can hang on to your stuff (GV428090a).

Participant GV428090a expressed that not having security over her meds, and by extension stability over her health, stressed her out. As participant GV428090a and many other participants described, having secure options for housing allowed people to store valuable possessions and health-necessary assets, and provided a space where people could build up both the quantity and quality of items that helped them turn a house into a home. While the need to have access to secure storage spaces was undisputed, options for furnished rental suites and unfurnished suites seemed to be determined by the individual preferences participants had for their living space.

Housing security

The discussion about the security of participant's belongings structures the following discussion about what housing security meant for participants, as well as what feelings of security fostered in terms of their emotional, mental and physical health. The interview included questions about what housing security meant for participants in an open-ended format to allow for individual interpretations. The terms 'safety', 'stability', and 'security' seemed to go hand-in-hand for many participants when asked what is important about their current housing. For some, a sense of security was established through the formation of a locked entrance, and though the presence of cameras and 24/7 supervision of building staff. For others, security meant assurance that they would get to live in their current living space for years to come. The section that follows will further discuss these two definitions of housing security and the implications of each.

Security meant many things for different people, but for people living in a somewhat precarious living situation, or who had recently transitioned from unstable living situations, security was often defined within the parameters of feeling safe, protected, and having their belongings contained. In the mapping activity participant GV428090a drew her outdoor living space (see Figure 1. above) and referenced the building walls, pillars, and garbage disposal bins where she frequently set up camp next to, as well as a tarp that was used for additional concealment. Rather than focusing solely on the structural components in her outside living space, participant GV428090a highlighted the types of activities that occur in close proximity to her living space, suggesting the negative connotations that they have for her health and wellbeing. For example, participant GV428090a made reference to pedestrian traffic, animal sightings, and smells from nearby disposal bins, as well as areas that were used as washrooms and sites for drug-related activity. "We're a little vulnerable to whoever wants to walk in there; it's cold; and just plain dirty" (GV428090a). Participants with experience of living in street or shelter settings described their inability to put their mind at ease if they were to put something down. They explained that there is a need to be overly cautious and attentive to ensure that their possessions don't go astray.

> Like to take your shoes and socks off and…it's just, yeah, something I never ever dreamed of, ever. You can't take your shoes off at Front Room anyway, they'd steal them. Like to sit for a little while. If it isn't attached to you, it's gone. They'll take it. Steal it. It's gone (GV428090a).

People with access to stable housing may not realize the security that having locked storage and a locked door provide. The abovementioned quote illuminates the sought after feeling of being able to take their shoes and socks off, and to feel the comfort and relaxation that that entails, without having to worry that they will go missing.

After experiencing a period of transitional housing situations, some participants still possessed the fear of losing their belongings even when they were stably housed. Participant GV910121a explained that whenever he is away from home, he has a perpetual fear that his possessions will be stolen.

> All of a sudden it was just like, wow, you're here in [hospital room] ten C, and it's a very scary place. And you go, what about my room? That's all my stuff, right there. That's all my stuff. If somebody gets in my room- so it kind of freaks you out. […][The main door] Is kind of good, because when it's locked, I know I'm safe. But when I leave, because I'm kind of paranoid, I have to check it six times to make sure that it's locked (GV910121a).

In many instances, possessions and carts (used to transport possessions) are routinely taken away when found in public areas unattended. This kind of transient living can instil a conscious awareness of where a person's belongings are and constant need for protecting possessions from loss. The need to be attentive and cautious do not necessarily resolve immediately after a person has been housed. Participant GV031110a explained the need to be on guard in transitional living situations, not only to protect your possessions, but yourself: "Like, attitude-wise, too. Your attitude totally changes when you're homeless, you got to put up that defense" (GV031110a). On top of having to put up a defence, participant GV428090a claimed, "I go days without sleeping. Before I actually, like decided to camp because you can't put your head down or they'll steal everything from you. Everything. It's crazy down here."

With transitional living periods and struggles with mental health issues, GV421121a reached a point in her life where she could no longer stay indoors, let alone stay housed. She explained,

> I was like…feeling really hopeless and lost around- and I wasn't even using. It was like my substance use brought me to a point of where I was kind of stuck in that fear and paranoia, state. So I couldn't be indoors at a place. Like I tried a couple transition houses for women, but I couldn't even last there a night. It just didn't feel safe. I was feeling always unsafe, right… it's a fear inside you. It was. And it was probably a pretty deep depression (GV421121a).

Participant GV421121a noted the need for pharmaceuticals to regain feelings of safety and to take advantage of indoor housing situations. Participant GV031110a also discussed a similar situation in which she compared her relative comfort in visiting a particular neighbourhood downtown Vancouver during two different instances: one when she was using substances and one when she was not. She explained: “If I’m on drugs I don’t really care where I am, but when I’m like how I am now, yeah, I’m very aware of what’s going on” (GV031110a). So while the use of substances (pharmaceutical or illegal) was not necessarily framed as a method for increasing one’s feeling of security, it did influence people’s relative sense of comfort and safety in housing situations.

Drawing again on the issue of risk related to living with HIV/AIDS, it had been said that having a clean living environment is one aspect of “safe, secure housing.” When asked what security meant in relation to housing, one participant responded: “Safety…safety…healthy environment…It’s clean. Like it’s really clean. They clean it every day. It’s well kept” (GV421101a). Participant GV428090a, who did not have access to her own washing facilities and had to use public amenities, also defined security in relation to her physical health and the need to clean these facilities herself to decrease her risk of exposure to harmful contaminants.

There were various elements in the home that participants described to positively contribute to feelings of safety and security, including having a lock on the front entrance of their living space, a locked storage area, cameras, block watch, and 24/7 building supervision. Having a locked front entrance was the most commonly cited factor to ensure the security of one’s living space.

> I’m the only one that has the key, for one, other than the landlord, in case anything did ever happen. You know? Just that it’s kind of a crime-free area…that I don’t have to worry about people breaking into my place when I’m gone (GV031110a).

A locked entrance ensured the safety of participants, but also the confinement and security of their belongings when they were not home. For one participant, having a front entrance without a glass partition would have added to her sense of safety by providing privacy from next-door neighbours. Another feature that added a sense of safety and security in participants’ living spaces was the presence of cameras. However, some participants reported feeling “monitored” when cameras were present and others commented that the provisional security offered by camera was not sufficient to ensure the safety of their possessions from theft, in comparison to locking them up in a storage locker. Another feature was to have a block watch in place to ensure the safety of the area surrounding participants' living spaces. Some participants felt that their proximate neighbours and people living in the same building had an impact on their sense of security in their home, since they could jointly keep unwarranted visitors from entering the building. Participant GV421121a explained,

> They…it's kind of like…like a block watch. So everybody upstairs keeps an eye out. Nobody's allowed to let anybody in that doesn't have a key. Like we have FOB [a component of a keyless entry system] and if there's somebody out there, you don't let the person in, you let them buzz. It's- we go through that process…Sound and secure and stuff, yeah. The management's excellent.

Another participant explained that the presence of staff (or management) onsite in residential buildings reinforced feelings of security. Lastly, travelling and camping in small groups helped add to participant GV428090a's perceived sense of safety for herself and her belongings while living outdoors: "Like in a group like this, we do- we can sleep at night time. Whereas if you're here by yourself, lots of times you just don't because it's paranoia, you could lose all your stuff" (GV428090a).

Other dimensions of housing security. Along with the feelings of safety and reassurance conjured by having a locked door, other features related to participants' living spaces were associated with feelings of security and stability in the long-term projections of their housing status. In this context, housing security "…would mean that I'd be able to live there as long as I need to" (GV011110a). It also meant "…just being secure, it's like you know, when you don't have to worry about, you know, where you're going to be" (GV321101a). These descriptions of housing security were often linked to the reassurance that their living situation would not be altered unless consensus was obtained.

Having a stable housing situation provided many participants with a necessary foundation to develop positive practices essential for maintaining good health (i.e. scheduled mealtimes and taking medications). Participant GV031130a explained that housing was a instrumental component to helping him stay sober, and to helping him maintain healthy eating habits at home: “Especially with the housing that, as long as that maintains itself, everything else seems to just…go along with it” (GV031130a). On the other hand, participant GV428090 found it difficult to establish long-term living arrangements when living on the streets: “Because they keep kicking us from one place to another. You can’t set up anywhere for any length of time so we just set up and take down every morning, there’s no other way around it” (GV428090a). In addition to having to constantly set up camp in different locations and carry her belongings with, GV428090a was at the mercy of external sources, such as service agencies, to have her daily needs met (i.e. washing and eating). Participant GV428090a lacked constancy in her living space and as a result, her day-to-day routines were subjected to change. Therefore, a majority of her time and energy was consumed with meeting her immediate needs, rather than devoting time to maintain and develop practices for good health, as was the case with participant GV031130a. A member of the CAC summarized participant GV428090a’s experience by claiming her living situation compelled her to “survive, rather than thrive.”

For people wanting to be in control of how long they lived in a specific living situation, rental agreements and housing leases provided a means of legitimately negotiating their housing stability. Some participants claimed that short-term lease options granted them autonomous decision-making about how long one would need to stay in the same living space, while for others, long-term leases ensured greater stability in their housing situation: “I would really like, like, a twenty year lease because I never wanted to move again” (GV031130a). Even though rental agreements were described as providing some legitimacy for those in rental accommodations, participants still feared that landlords could break the lease at any time. Participant GV031130a explained, “The only concern that I have about any place that I will live in is that I can be removed.”

Housing security was also described as being associated with feelings of financial security. This was especially true for participant GV020101a, who had to rely on the income of his partner to share the cost of rent: “I’m…not feeling secure about the months ahead, right now. What’re you supposed to do when a partner loses their job and changes jobs and isn’t making the same money?" For participant GV020101a, the loss of his partner's job had threatened the stability of keeping their home. Participants' employment status also operated as a barrier in negotiating rental contracts with potential landlords. Participant GV321101a claimed: "If I had a job, and if I didn't have to be on disability, then I'd probably have a place. Like it wouldn't be so hard to find a place. Because they want people who are working" (GV321101a). Many participants rely on PWD, as well as portable housing subsidies from ASOs and other types of income assistance, to help make housing costs more affordable. Participant GV031110a explained,

> But now I always get my rent sent direct, and it's like as soon as they [landlords] know that you're on disability or you know, Ministry assistance, it's like, "No." And I'm thinking that's kind of crazy because you're guaranteed your rent money. You know?

Although having rent paid directly through these sources was a reliable way of paying housing costs on time, participants expressed challenges with landlords accepting this payment method, and it could be perceived as a barrier for both acquiring and maintaining rental accommodations.

Just as financial insecurity and certain income sources were perceived barriers to housing security, individual factors were also perceived by participants to affect long-term housing stability. Two participants mentioned the notion of ageing in place: "So here I am now, I'm sixty-three years old. What's going to happen when I can't afford this place?" (GV020101a). It seemed that at a certain age, people began to think more about the future and had some reservations about living situations more suitable for senior living. Another participant commented: "Especially as you get into -- I'm, I'm sixty-two in January, and that being said, one doesn't want to move very often [laughs], you know? So, that does become a big concern" (GV031130a). In addition to concerns about age, several participants perceived individual behaviours related to substance use, partying, and disruptions from domestic disputes, to threaten the security of their living space. A few participants also discussed ambiguity around disclosing their status to potential landlords and building managers, and one participant questioned whether disclosing her HIV status to a current landlord would have negative repercussions for maintaining housing.

> [The] [fear] of losing housing because of my HIV, or like…you know, even my partying, I didn't even think that was a bigger problem than my HIV, I actually thought my HIV was the reason why I would get evicted, if I told anyone (GV011110a).

The long-term stability of one's living space did not only have to do with the risk of losing their home, but was also associated with the perceived risk of losing one's life. At the time of diagnosis, participant GV020101a was told he only had six months left to live. Like many others living with a chronic illness, he was required to endure a level of uncertainly that his illness would significantly reduce their quality of life, and may even lead to death. Participant GV020101a explained how his feelings towards his living space changed after given a prognosis of six months: "I had a place- an apartment, but it wasn't a home. I never made it a 'home' because it was just a place where I was waiting to die" (GV020101a). This quote illustrates that the security offered by a stable living space may not be sufficient for those experiencing uncertainties about their health and prognosis. Therefore, it was important to consider the housing trajectories and lived experience of participants' to better understand what housing security meant for them, and what features were used or could be used in their living environments to enhance feelings of security.

Social environments, social circles, and cohabitants

The social environment within and external to participants' individual living spaces was quite complex and diversified. Some participants lived by themselves and their social circle, therefore, remained mostly external to their private living space and socialization occurred within their neighboring community. However, some participants shared their dwelling with other people, including members of their family and roommates. In some cases, living with others was seen to positively contribute to one's health and wellbeing, but in other cases, shared living spaces affected participants negatively.

Positive features. Having a roommate was described as a positive feature for some participants because they were able to share rental costs to make housing more affordable, and they offered some participants a sense of safety in their living environment. For participant GV031110a, the security provided by living with another person was two-fold. For one, living with a roommate was a sensible way to mitigate the residual effects of traumatic experiences that threatened the sense of security that she had in her living space, and secondly, living with a person served a functional role in having someone accessible to respond to an immediate threat if necessary. Participant GV031110a explained,

> Because you know, once in a while I'm prone to black outs for some reason, so I told them because, you know, I live alone and nobody ever checks on me so I can be dead down there and nobody would know until the place started smelling.

For participants experiencing episodic health issues, roommates ensured that their immediate concerns could be addressed if necessary.

People in shared living spaces were also said to positively influence participants' behaviours. For instance, participant GV321101a moved from a previously unstable living situation into a house with her mother, grandmother, aunt, and two daughters. With her new living arrangement, she had taken on new responsibilities with cooking and getting her children to school each day. Not only did participant GV321101a find herself occupied with new, consistent routines, her daughter's HIV positive status kept her engaged in her own HIV treatment regimens, becoming an important component of her daily routine. When asked what helped her stay on her medications, participant GV321101a responded,

> Maybe not the housing, but maybe, being around my daughter because my oldest daughter has to take medication every day. So maybe that. And being locked down. Like not being able to go anywhere all the time, so I'm always there. Like when I lived on my own, I could literally just do whatever I wanted, and, yeah, so…maybe that's why. It's like I'm just there all the time to be able to take it, and…and…stuff.

Having accountability to people sharing the same dwelling was an important factor in maintaining certain behaviours and for achieving desired health outcomes. Similarly, participant GV031130a shared a house with his landlord (who also doubled as his addictions sponsor) and his landlord was commended for helping participant GV031130a remain stably housed and in recovery.

Having a living space encouraged some participants to reconnect with estranged family members, and allowed them to provide a space for their children to live as well. A few participants mentioned that their intention to seek stable housing was often because of wanting to fulfill the needs of others – to make a home for children and for partners. For other participants, being stabling house served to represent the status and wellbeing of participants, and a way to indicate to others that they were in a good place in life, that they were doing well. Participant GV011110a described that when she was unstably housed, she didn't want to connect with her family because she felt that her family would not be impressed by what she owned and by where she lived. However, when she got herself settled in a stable housing situation, it created an opportunity to invite her mother and reclaim that relationship with her: “And connected with my mother more often, I find I’m cooking her a lot of meals too. So, I actually get to enjoy her company more often now that I have my own space” (GV011110a). Not only does this quote reveal that how one lives can be a socially construed depiction of one’s self, it also highlights, again, that the kitchen is often designated as a social sphere where activities of cooking and eating food can be enjoyed in company of others. How participants constructed their living space often had to do with the people they lived with or wished to share a home with. For example, participant GV020101a moved to BC from Ontario in search of HIV services and supports after his diagnosis; however, his desire to be close to his HIV supports changed over time and he then sought to be close to other kinds of support. Participant GV020101a explained,

> …You see people all the time who have lived where they’ve lived and then when their family is getting older, or they’re getting older, they feel they need to move home. I never had that feeling before, but now I’m getting old. It’s crept in. But how come I’ve spent so long here when now I’m feeling like I wish I was there. I don’t really wish I was there. I would like to be closer.

Home in this context was concerned less about a specific style of living arrangement and more about who participants live with, and in some cases, the geographical proximity to where family members resided.

There were also important features in the surrounding neighbourhood that made participants feel more at home, and had positive effects on their health and wellbeing. One participant favoured mixed residential living spaces that accommodated people of all different ages, experiences, and social statuses. She explained: “And I have…great neighbours. And like, even though that we’re all in like different areas of our life and like living in different situations, it’s nice to like come out and just see a mixture of people” (GV011110a). She later added,

> So it’s really nice and everyone just seems happy, especially on the street that I live on. Anytime that I walk down to go downtown or to work, I just see people like being social and happy and they’re not- they’re not [inaudible 23:28], so they’re just enjoying the community spaces also. And it’s really nice to see (GV011110a).

Several participants have cited the presence of an “HIV community” that developed in part by coordinated efforts from ASOs and designated residential buildings, and the community is said to be, for the most part, both supportive and respectful. Within these communities, participants have engaged with other peers through attending events and programming, and through volunteer opportunities. Participant GV020101a highlights her experience by claiming,

> And so that’s why, too, when I say “community”, you know, back then and since have been involved in all those things- but back then, when I went to one workshop there might be twenty-five people, the next one a hundred, and then fifty, or twelve or whatever. But over the course of a month, I was seeing some of the same people, getting familiar. By the time I actually had to go back home I’d already felt like I had made life-long friends and those people still are my friends today, so they were like life-long friends. But the community is important for a lot of different things, not just social, but it feeds my spirit; it helps me to stay healthy, and in many ways, not just physical, but also physical (GV020101a).

In this respect, a sense of community was established through the development of programs and activities devoted to people living with HIV/AIDS; therefore, community for some people wasn’t geographically defined but rather socially and experientially, and as one participant puts it: "we're kind of like, in the same boat" (GV031110a).

Another advantageous component of ASOs was that a few of these organizations offered housing accommodations to those living with HIV/AIDS, and thus this social engagement component becomes engrained in the residential life of people living in such buildings.

> Well, I mean, it's good to be living in an HIV positive building because I have peers in there. And it's really nice to come home and- you know what I mean? […] Our neighbours can be really friendly and everything in other places, but you know, you've got that…we have that same thing in common. Nonjudgmental. It's pretty cool (GV421121a).

Furthermore, in supportive living environments designated for people living with HIV/AIDS, the staff played a pivotal role in reintegrating residents socially.

> …[When] I first came to the Dr. Peter Center, a recreational therapist named [therapist' name]- at first it was kind of bothersome. But she was like right on me, you know what I mean? Getting in there and talking to me and, and I said, "Yeah, yeah, okay, we'll go bowling", and I hate bowling. But we go bowling, and we go to a movie, and we- all of a sudden, all of a sudden I wasn't in bed anymore. I was up, I was out. It was like this is what this whole place is about (GV910121a).

Being in a more supportive type of living environment was shown to be not only beneficial for addressing immediate health concerns, but also for supporting the reintegration of residents into social activities.

Negative features. Living with family members and roommates described by several participants as a positive feature of participants' living spaces; however, some participants were constrained to find affordable housing options and needed to share a dwelling with others to bring down the cost of housing. Participant GV321101a, who was living under her mother's roof with other family members, explained: “I guess it sounds like I’m being selfish because, at least, I have roof over my head. But, it’s…it’s just not…it’s not…I don’t know how to say it. It’s not…it’s just, I know that I’m truly like, unwanted there” (GV321101a). This quote illuminates that the social aspects of one’s living space are just as important as the structural aspects (a roof over one’s head). Many participants commented that they endured the negative effects from poor relationships with family members and roommates in order to access to affordable housing. In one case, one participant even chose to move into a shelter accommodation – traditionally known as being a less stable form of housing, to move out of a socially negative environment. Not only did living with others put a strain on the social wellbeing of residents, it also had negative connotations for people living with chronic illnesses, specifically, because that meant they were are often needing to manage symptoms and side effects from medications. “Sometimes I need my [own, personal] space, right. Especially when I’m not feeling good” (GV421121a). In this situation, having a space of their own was an important factor for participants to maintain positive health and wellbeing.

On several occasions participants discussed the challenges associated with not having a suitably sized living space to accommodate the number of residents living under one roof. For participant GV321101a this caused a strain on other members in the household because family members needed to share bedrooms because there were not enough bedrooms to accommodate the number of family members: “…and the fact that I don’t have any space. Like I don’t have anything there. I can’t do anything there, my daughter doesn’t have her own room” (GV321101a). Other participants complained that there were rules in their residential building that barred them from having their social needs met. For example, participant GV412110a, who was sharing a bachelor suite with her granddaughter, was told by building staff that she needed to have a boyfriend or get married to secure a larger rental suite. In another case, shelter rules disallowed couples from sharing sleeping quarters, which made sleeping in other precarious spaces the only alternative option for staying together overnight.

Building rules were often described as impinging on participants’ ability to create socially inviting spaces in their homes. Building management and landlords imposed rules for having visitors, such as requiring visitors to sign in at the front desk of the building with their personal identification (which not all visitors had). Furthermore, some residential buildings lacked visitor parking that made it increasingly difficult for participants to invite guests to their home, which could have further implications for the development of their social network. For participant GV321101a, living again under her mother's roof meant that she had to abide by house rules, "Like, I have a curfew. I'm thirty-two years old, and I have a curfew…I have to be in the house by ten o'clock, otherwise they lock me out." Since house rules limited participant GV321101a from going out in the evenings and from having friends visit, she felt like she no longer had control over her own social engagements in her living space. Finally, supportive living environments were not always conducive for building supportive social environments. Because of the type of health and social supports offered in these living spaces, participant GV910121a said that the severity of issues that some residents were dealing with challenged his sense of feeling at home, as well as his transition to independent living.

People in shared living spaces were sometimes said to influence participants' behaviours negatively. Specifically, issues related to substance use were commonly cited and participants discussed the implications of living with roommates that used substances. A few participants concluded that living in an environment where people encouraged the use of substances did sometimes increase their own use. Additionally, one participant noted the perceived trustworthiness of living with people who used substances: "…I've had lots of offers, like, 'You can come stay at my house' but it's people I don't know very well or they're drug users. They're not- not somebody I really trust" (GV428090a). Overwhelmingly, the use of substances in residential living spaces was thought to affect participants negatively, and was clearly described as a safety concern in residential buildings that permitted the use of substances.

The harm and risk associated with substance use was also attributed to specific geographical areas and social networks. Participants commonly referenced the DTES in Vancouver as an area with widespread substance use, but one participant also described a similar situation in a neighbourhood in Surrey where she was living: "Drug addiction is running rampant in this neighbourhood. It's an epidemic. There's a lot of mental health people mixed in…I think they fall into the addiction because they're down here" (GV428090a). Not only did substance use in these areas create safety concerns, but it also created a social pressure to reengage in substance use. Participant GV031190a further explained:

> So, it was either…I want to say crap or get off the pot. It was like you had to do something or slide even further into this system. Like the Downtown Eastside, or whatever. There was a point where you either had to jump in, or jump out. And jump out would put you back on the streets and out of touch with everything because there's nothing to do out there (GV031130a).

Participant GV031130a highlights the cycle of transitional living in which social circumstances can influence people's ability to secure stable housing, but without access to housing, the cycle is perpetuated.

Issues with disclosure and discrimination. Living with others in confined living spaces, as well as interacting with people in residential areas on a day-to-day basis can raise issues about disclosure and perceived discrimination for people living with HIV/AIDS. Several participants commented on wanting to conceal their HIV medications from roommates, visitors, and from people in shared spaces in transitional housing situations, as a means of not disclosing their positive status. The concealment of HIV medications could be a point of contention for people sharing kitchen spaces with others since they often require storage in a refrigerator.

> And after I started taking the pills again, there was one pill I had to keep in the fridge. […] Because I wasn't open with my HIV then, I was kind of ashamed, and it was in probably only my third or fourth year of being HIV positive, so, it was…it was difficult because I didn't feel comfortable because I was a person who was not living on my own (GV011110a).

Some participants discussed the implications of hiding material from the people that they were living with and suggested that it might hinder the development of genuine relationships with others. Participant GV428090a found it difficult to form a positive relationship with her roommate while she was managing noticeable side effects of her medications. Participant GV428090a explained,

> Yeah, it became a little bit of a problem, like with this last roommate, because after I started meds, I don't know what happens, I get these boils on my eyebrows, and I don't know if it's Alopecia or whatever, but she…I know it freaked her out, the big boils and…I don't know, she just got a little weird.

Participant GV428090a further explained, "Living with a roommate who is uneducated [about HIV/AIDS], just…I don't know, it just…makes me feel like I have leprosy" (GV428090a), highlighting that it may not just be about issues with disclosure, but rather the negative ramifications associated with disclosing to someone without a comprehensive understanding of HIV/AIDS.

In addition to the issues of disclosure associated within the living space, the building or area in which participants reside can also have implications for disclosure. For example, participants discuss the implications of using HIV-designated housing supports that could make their positive status explicitly known to visitors and the community due to the type of building they reside in. Participant GV421101a explained, "…When it was my first time at McLaren House, I didn't want to bring any guys back home because they know that's an HIV building, and I didn't want to…let them know." Similarly, the use of a portable housing subsidy that is linked to an ASO (i.e. McLaren Housing) can also allow for inferences about a person's status: "Usually when you get outside portable subsidy, you either go find your own apartment, and sometime people find it frustrating because they don't want- they don't want to tell the potential landlord they're positive" (GV421101a).

Even though the above section examines issues related to disclosure, many participants were quick to note that they have not felt discriminated against when seeking housing or in particular living situations due to their positive status. However, participants did note instances where they did feel discriminated against and it was perceived to be in association with their profession (or lack of profession), source of income (i.e. welfare cheque), their sexual orientation, and individual behaviours (i.e. partying and substance use). Participant GV011110a defended,

> I would meet managers in buildings and try and get a place of my own for myself. But I just don't think that they…I don't know what it is that they saw, I just know that when I left there, I'm like, "Ugh, I feel like I'm being judged" and not even in a way that I want (GV011110a).

Many participants felt that landlords and building managers were in a place of power and were arbitrators that decided who could gain access to rental accommodations. As mentioned above, some participants found that housing support workers could help remediate tensions between landlords and potential residents by providing references for potential tenants and by sustaining effective communication between both parties, and could therefore be used as an effective strategy for access to housing.

Other elements in the home

There are other commonly discussed elements in the home that will not be examined at length in this thesis as they are not central to the research objectives; however, I will describe them briefly to consider their potential implications for people living with HIV/AIDS, and for potential topics requiring further inquiry. These themes are listed here to provide a more complete picture of how participants in this study described the components of home, but they will not be used as examples in the discussion to follow regarding the conceptual categories created to further explain the feeling of home.

Participants often described home as a place to rest and a space to feel comfortable, and common elements that contributed to these feelings included: a television, a computer, a bed, and a couch. Many participants reported that managing the side effects from medications and symptoms from other co-morbidities often left them feeling drained and unable to energetically undertake daily tasks and responsibilities. Participant GV020101a explained, "…my days seem like there's not a lot in them. But…that's because of some of the health issues that I have. So…a lot of time is just spent…relaxing either in bed or on the couch or…you know…preparing food, making food, eating." For participant GV428090a living in precarious, transitional living spaces, she reported: "I'm always tired. I'm always- I just feel like a zombie. Never get enough sleep", and a place to put her head down at night was important for her own sanity, as well as her physical and emotional wellbeing.

Outdoor living spaces and fresh greenery indoors also provided a sense of refuge for participants who didn't feel well enough to go out. The outdoor space offered by private or shared balconies provided an extension of the home where participants could sit and ponder, read, and relax. For some, having plants and living foliage was accompanied by a sense of responsibility and encouraged participants to work with their hands and to leave one's mark on the Earth. In addition to physical outdoor space, having windows that let in natural sunlight and fresh air was also commonly cited as a positive feature in participants' living spaces. However, poorly insulated windows left people vulnerable to temperature extremes, and exposed to allergens, such as mold, which had negative effects for participants' physical health. Furthermore, basement suites and other similar spaces were associated with a lack of natural light that was perceived to negatively affect participants' mental and emotional state: "…the gloominess of the suite. And it affects the depression, right. Especially if I'm in that kind of glum mood, it just brings it on more" (GV031110a).

Like outdoor living spaces, workspaces also provided participants with feelings of enjoyment, as well as a sense of duty and accountability. Workspaces could be more structurally defined as a place in the house where a desk and computer was set up, or more simply defined as a portable laptop. For people not feeling well, computers created an opportunity to contribute to the formal workforce from the comfort of their home. For example, participant GV428090a explained,

> I can get the jobs, it's just…I end up being off a lot. With the flu or an infection, it's on and on. Even though I'm undetectable, I still will randomly get different infections and…bosses don't like it when you can't make it to work.

Several participants reported on the utility of having a computer in their living space to actively engage in both paid work and volunteer opportunities that they find to be meaningful, such as involvement with advocacy or research projects.

The mapping exercise used during the interview process was another resourceful way to understand the types of elements that were contained in participants' living spaces, as well as their utility. The mapping of key features, such as a bed, a television, and a computer, helped facilitate the discussion about how features each feature helps them function in their home, how each element is associated with their health and wellbeing, as well as the sensations and emotions they provoked. While it was common for participants to map the structural layout of their living space (i.e. distinguish the living room from the kitchen) and to map utilities (i.e. kitchen appliances and windows), it was less common for participants to draw and label specific possessions, such as a televisions and stereo. To understand the reasons why some participants chose to include certain items in the drawing of their living space and not others, it is necessary to listen to how participants described their living space in relation to the features it has. For instance, participant GV910121a described how he managed his living space with living with debilitating periods of his illness where he was battling the toxic effects of regimented ARV cycles that kept him in bed for a majority of the time. He talked about receiving a gift from the Dr. Peter's Center that helped get him through his health issues.

> I mean, like one year, they [staff at Dr. Peter's] asked me if- what I wanted for Christmas, because they were getting Christmas gifts and they said they had a fifty dollar limit, or whatever, like that. I said, 'Get me a little tune box' and they got me a little radio. And then all of a sudden I had a radio in my room, so if I had to go to my room and just be alone I could listen to music. Or if I wanted to wake up to music I could do that, and all sorts of really crazy stuff like that started happening for me…Well all of a sudden, because I was very much into music, and all of a sudden, there was sort of an energy (GV910121a).

To participant GV910121a, this radio was more than a mere possession – it was form of solace and therapy provided in times of solitude, thus illustrating that tangible items in one's home can have meaningful dimensions.

Things that were described as negative in the home were aspects that created excessive noise and disturbances, such as nearby ambulances, Kindergarten playgrounds, fire alarms going off in residential buildings, and pedestrian traffic near outdoor camp at night. The absence of disturbances created a more positive environment for participants, and participant GV412110a explained, “Yeah, when I’m alone in my house- everything in my house- no noise with the people, I feeling safe.” Lastly, while pets provided an important source of companionship for participants in their living spaces, they also created challenges in seeking suitable living accommodations since pets were not always welcomed in residential buildings.

The Meaning of Home

Shown from the results thus far is the complexity of the relationships between what elements in the home that seemingly benefit or negatively affect one’s health and wellbeing. We can also appreciate that one person’s living space is not the same as another’s, indicating that housing situations are less categorical, and more fluid and transitional (and even cyclical). A home can be described in many ways, and although not often articulated directly, I have summarized some key narratives to add to the discussion about the meaning of home.

Home is where the family resides and friends can gather. Feeling at home in a particular living situation was often in reference to the people participants lived with. Participants shared their experiences of living with roommates for a sense of security, and the support they felt when living in residential buildings and communities with other peers. Discussions with the group at PLN also conveyed that the desire to live with significant others can take precedence over the type of living environments that people are willing to tolerate. For example, one participant thought living on the street or in other precarious living situations might be more accommodating to romantic couples than shelters. Home was also depicted in geographical reference to where other family members resided, as well as being a space that allowed family and friends to congregate.

Home is a place where people can have their needs met. In the sections above, participants have described the many features and amenities of their living space that enabled them to complete day-to-day routines and to have individual goals attained. Within the living space, such features included a kitchen space for food storage and cooking, washroom facilities, and a place to rest. Participants also discussed requiring nearby public amenities to have their social and recreational needs met, as well as proximate clinics and grocers to have their physical needs met.

Home is a place that I have lived for awhile, "[because] it's a decent size and I've been there a long time. I've come to love that apartment" (GV020101a). This quote illustrates that an impression of home might not come instantaneously for all people, and that a house can evolve into a home over time. Another participant comments on how having her own space to fill up with her belongings over time made her place a home. She explained,

> [When] I was living in other people's spaces and I just couldn't see anything of mine around me, and what I did see around me, it was just like small little items. It wasn't really enough to call it my own home, so I think what would've helped me is like having a space where I can start filling it with my own belongings. So I can collect things along the way and just create a better lifestyle because I think that's what helped- what is helping me right now, is the idea that whenever I look around in my place, I still see things that I have to get and I always see these small little things as goals (GV011110a).

This quote highlights the meaningfulness of the accumulation of material aspects within one's living environment that help create a feeling of home. For participant GV011110a, it was not only important to have a space were her individually accumulated belongings surrounded her, but the accumulation of personal items was also a reminder of her own personal growth, and provided the motivation to continue the activities that were positive for her health and wellbeing. That being said, it seems important to consider the various factors that influence participant's long-term stability in their living situation, as well as the security of their belongings, to ensure they have the means necessary to provide a secure foundation for which they can make a living space their own.

Home is a place that is mine, "A place to come home to. That I can call home. That I *feel* is home" (GV031130a). Several themes discussed above contribute to a feeling of ownership and control over one's space. However, without these key features, participants were less likely to feel at home in their living space. Participant GV321101a's living situation was most noteworthy in addressing this point. She disclosed,

> It's ridiculous. Like I don't have anything. Like I don't. It's stupid. I don't know, like…being comfortable- like being- having, I guess, like…I don't know, having people around and, like…that you can trust, I guess. Like people that you're safe around, or comfortable around or that makes you smile. I guess, like, stability where you can go use, like, the bathroom, you know? Your own bathroom. Not getting bitched at because you're in there too long. Stuff like that [cries]. Just mentally, it's draining. Like it's just too much (GV321101a).

A private space afforded more autonomy and constancy for participants to live in the space and participate in day-to-day activities in ways they found suitable. Additionally, having a keyed entrance to the home or locked storage area allowed for participants to maintain their living space and belongings in a confined, secure area defined as theirs. This spatial independence was also important for participants in setting boundaries for their own self care (taking care of their mental, physical, and emotional health) that allowed them to create a space of refuge from the outside world when necessary.

Concluding Remarks and Summary of Key Descriptive Themes

The key themes described in this chapter are in no way meant to summarize the lived experiences of people living with HIV/AIDS; however, they are meant to promote discussion and describe the types of features in people's living spaces that are perceived as positive and negative, and how these features make participants feel more at home. Secondly, these summaries provide participants' reflections around how various living situations operate, which provides a foundation for developing some best practices and will be discussed in the following chapters.

To visually summarize how the key descriptive themes fit within higher-level conceptual categories of home, I developed a figure (see Figure 4). This figure links the descriptive themes to the conceptual categories to be presented in the next chapter, and will be used to guide the discussion of the higher-level conceptual categories that define the meaningful dimensions of home. The key elements that contributed to participants' definitions of home, as well as the described elements that helped participants transform their current living space into a home, are represented in the interior of the drawn house structure, while the four primary conceptual categories defining the meaningful dimensions of home surround the exterior of the housing structure. Elements listed in the interior of the house relate to the conceptual categories listed in the exterior. For example, locking a front door helped some participants attain and maintain security in their home environment. Conceptual sub-categories are also indicated in the figure, as they pertain and the surround the larger four conceptual categories (autonomy and control; constancy and routine; security and privacy; and construction and strengthening of identity). While the descriptive themes and conceptual categories are highlighted across participants' narratives, each participant experienced and/or attained these elements in slightly different ways. Thus, it is important to consider the context in which these elements are situated, including participants' past experiences, housing histories, and current living situations.

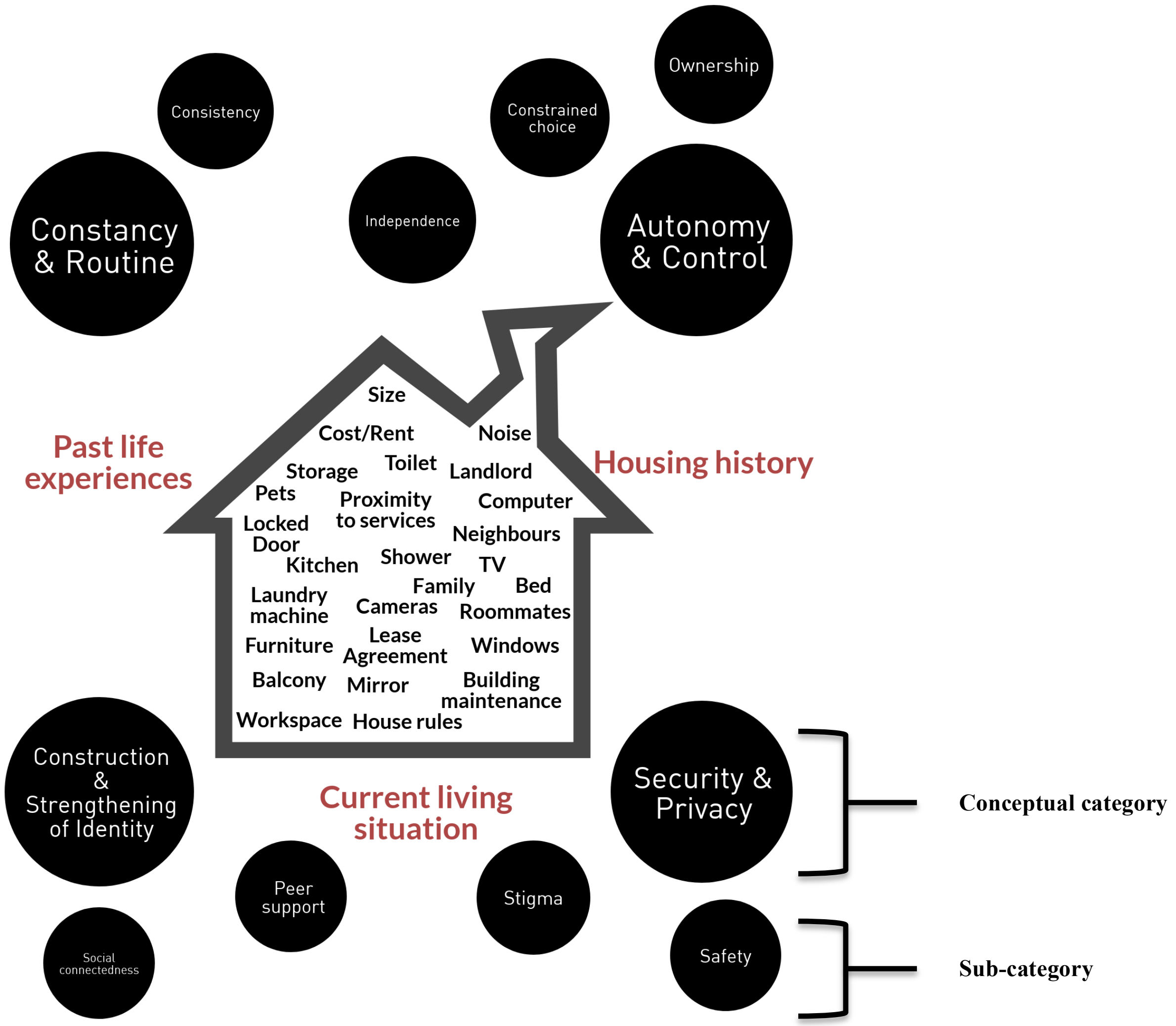

Figure 4. A visual depiction of key themes and conceptual categories

The following chapter will describe the conceptual themes and explore how these themes relate to other literature and theoretical frameworks used to help explain the relationship between housing and health for people living with HIV/AIDS.

CHAPTER V: CONCEPTUAL CATEGORIES & DISCUSSION

While the physical attributes within participants' living environments discussed in the previous chapter helped participants construct narratives about how they define home and what they feel is home, this section will organize the abovementioned themes into higher-level conceptual categories to help develop these concepts. This section will explore how the physical and material dimensions of one's living space create meaningful dimensions of home. I will further explore common themes running through each of the six categories of narratives described in the previous chapter. The themes include autonomy and control; constancy and routine; security and privacy; and construction and strengthening of identity. There will be some overlap between discussions of each theme, as many of these themes are interrelated; however, I will discuss each theme separately for clarity. I will then discuss how these narratives can be used to expand the conceptual frameworks commonly used to explore the relationship between housing and health (population health framework and socio-ecological model). I will conclude by summarizing key findings, and identifying potential areas for future research and program design.

Autonomy and Control

The themes autonomy and control spanned several narratives when participants described various features of their living space. Autonomy was described as being able to independently make decisions about how to conduct daily activities, as well as how people utilize and manage their living spaces. While autonomy allowed participants to make decisions independently, having control gave participants power over daily decision-making, empowering them to make choices appropriate for their own health and social needs. The themes of autonomy and control were expressed when participants had access to their own living spaces and amenities, as well as in certain living arrangements that either enhanced or restricted participants' sense of independency and choice.

Several participants noted an increased sense of autonomy and choice when they had access to their own space, such as kitchen spaces and washing facilities, as well as control over the entry of guests into their living spaces. Having access to a kitchen space gave many participants a sense of power in making decisions about when to eat and what to eat, and provided necessary storage to take stock of healthy food items to be later enjoyed at their convenience. While shared (or communal) kitchen spaces gave participants access to the facilities necessary to prepare and cook their own meals, participants were unable to exercise the same degree of control over this space, and cited negative interactions with other residents and stolen food as barriers to using these amenities. Similarly, having access to washrooms and washing facilities were important for participants to autonomously carry out washing routines. Some participants noted that being able access washroom facilities in a timely manner when experiencing negative effects from medications was also a priority. Without access to stable housing, participants often had to rely on public facilities to have their washing needs met and could be met with a number of challenges, including a limited number of accessible washrooms in certain areas, long wait times, and unsanitary conditions. Even with access to stable living arrangements, some participants still felt as though they could not fully perform her day-to-day activities autonomously because of a reliance on public amenities to fulfill their needs, such as Laundromats, that were also accompanied by their own set of rules and restrictions.

The maintenance of personal hygiene, clean living spaces, and healthy eating routines allowed participants to indirectly exercise control over their HIV and overall health. Participant GV011110a provided a powerful narrative when she explained that having access to necessary amenities, such as her own kitchen space, not only inspired her to cook more but it also inspired her to make healthy food choices. This, in turn, had positive effects on her physical health and she saw her CD4 counts begin to rise. She explained, “So it’s a huge inspiration – especially to have that kind of power over my own health. It’s nice. So I don’t rely on anyone, and no one has to worry about taking care of me” (GV011110a). In many cases when a person is following a HAART regimen, their HIV is transformed from a progressively fatal disease into a chronic condition (Moloughney, 2004; Montaner et al., 2006; Préau et al., 2005). With the examination of health outcomes among people living with chronic illnesses, like HIV, HRQL has been identified as a key measure of overall health, as well as a measure used to examine the relationship between people’s beliefs and health outcomes (Préau et al., 2005). “Perceived control” was found to be an important concept with these measurements and psychologists concur that people are more likely to engage in certain behaviours if behaviours are associated with high reinforcement value and expectancy (Préau et al., 2005). This concept reinforces participant GV011110a's aspiration of cooking more and making healthier food choices since these behaviours were perceived to lead to her increasing CD4 counts. Furthermore, study findings indicate that perceived control over one's illness and HIV is associated with positive mental health outcomes, such as fewer depressive symptoms and less anxiety about death (Préau et al., 2005).

Controlling the entry of guests was another way that participants "watched their boundaries" in maintaining their physical safety, as well as their emotional wellbeing. Participants that lacked autonomy and control in their living space, either because of their reliance on public amenities or because of the restrictions placed on them by others in their living space, were less likely to be satisfied with their current living situation. Dunn and Hayes (2000) affirm that people's satisfaction with their homes, "and the amount of control they were able to exercise in the social and economic aspects of their domestic relations were associated with self-reported general health and mental health" (p. 584). Furthermore, feelings of privacy and refuge are continuously described as important characteristics of a home (Després, 1991; Smith, 1994). Smith (1994) notes that having control over privacy and the level of socialization in which a person engages are important factors in characterizing a person's home environment. Participants in this study noted the importance of privacy and having control over their levels of social interaction, which helped them create a space where they could feel relaxed and at ease. While some participants felt relaxed when they could close the door on social obligations, others attributed various components of their living space to making them feel relaxed (i.e., a bed, a TV). Setting social (and even physical) boundaries can be especially important for people living with HIV/AIDS, who may seek privacy when managing symptoms and side effects from medications (i.e., fatigue), when engaging in strategies for their own self-care, and when preserving disclosure of their HIV status in fear of being discriminated against or stigmatized for their illness.

Supportive living environments

Experiences across a continuum of housing situations were shown to create environments with varying levels of autonomy and control. Supportive, or assisted, living environments provided one practical opportunity to discuss the varying levels of control and autonomy afforded in these living environments, but also provided the means to discuss how participants' need for autonomy and control could change over time. Supportive living arrangements provide participants with particular structures around preparing and eating meals, as well as other supports to meet health and social needs. For instance, participant GV910121a was first introduced to a supportive living environment when he was battling severe complications from his ARV regimens. For people managing severe health complications, getting out of bed can be a challenging endeavor, never mind preparing a meal and managing treatment regimens. The Dr. Peter Centre offered him the appropriate support to help him manage his immediate complications and to get him back to a point of being able to navigate daily activities independently and freely. But as the previous chapter explained, when participant GV910121a was again feeling well, he expressed challenges with the social environment that ensued at Dr. Peter Center, noting the negative attitudes and behaviours of other residents.

For another participant, a supportive living environment was necessary for her to transition from precarious living situations to healthier, independent living environments. Like the Dr. Peter Centre, Turning Point (an abstinence-based residential environment) had rules and schedules for residents to abide by, and provided participant GV421121a with the necessary structure and support needed when transitioning to more stable forms of accommodation. The appropriate balance between rigidity and support also helped her achieve her own goals around substance use and recovery. However, there was a limited time for which these supports were perceived as positive by participant GV421121a and she noticed the negative implications of housing people in supportive living environments when the enhanced supports offered no longer served residents fittingly. Both participants' narratives demonstrate that while supportive living environments can be positive at the time needed, they can also be perceived as restrictive and create dependency among residents who were ready for more independent living options.

During the PLN session, one member discussed an overwhelming lack of support for people transitioning from unstable living situations to stable housing accommodations, and this was consistent with many of the narratives provided by participants in this study. For instance, several participants mentioned the positive benefits of having additional supports and procedures to assist them with establishing and adhering to routines for cooking and eating regularly, taking medications, managing money, and building the skills necessary to live independently in new housing environments. Accompanying these externally imposed guidelines was the need to rebuild, or in some cases relearn, skills to live independently in stable housing accommodations. For example, participant GV011110a's described the benefits of Covenant House's structured meal times that provided residents with two cooked meals a day, as well as the capacity to prepare at least one meal each day independently. This level of structure was effective in meeting the needs of many residents with varying levels of capacity, while giving them the tools to exercise autonomy to the degree that was appropriate for them. Another necessary skill mentioned during the PLN session was money management. For various reasons, money may not always be used towards rent when people are living in transitional accommodations and instead being used towards recreational activities. Participant GV321101a described that not having a place of her own was the primary reason for not spending her money wisely.

> There's enough money for the casino. Like right now, I'm just spending money. Like right now, I could be broke like right now. Even though I just got my cheque last week…I don't have anywhere for my money to be going, and I'm bored as hell there. […] So…that's- if I had my rent, like that's all I really care about is being- and I never, ever was not able to pay my rent. That's just one thing I've always done. And then, yeah, it's just…and that's another thing, too, I'm worried about, that now that I've gotten comfortable being able to go spend all my money (GV321101a).

Therefore, rebuilding skills around preparing cooked meals and money management can be an important point of intervention for those transitioning to more stable and independent forms of housing.

There is seemingly a temporal component attached to participants' pursuit of spatial independence (having a space of their own), independent living situations, and having some degree of independence in making decisions about one's daily living activities. While supportive living environments can provide a necessary intervention for those transitioning from previously precarious living situations to more stable accommodations, they can also be perceived as restrictive to those wishing to exercise more autonomy and control over their living space and daily routines. Participants' narratives discussed in this section can help to inform potential points of intervention for when and how to support people in regaining the independency that they need in their home environments.

Housing needs changing over time

Sixsmith (1986) proposes that spaces being defined as "home" can change over time, and "a home is home depending on the extent to which it fulfills the persons requirements, their changing objectives and circumstances" (p. 285). This changing of needs was evident in participants' descriptions of the various housing features that were described as essential for creating their home environment. Participants were likely to view features of their home, like kitchen spaces and laundry facilities, as positive when they met their everyday needs around preparing food and washing, respectively. However, participants perceptions of other features of their home were likely to change in the event that basic needs were met and participants were now concerned with other needs. For example, participant GV011110a employed a step-wise approach to filling up her living space, and the slow accumulation of her own unique possessions was her way of transforming her house into a home. However, participants' needs were also shown to change in the event of unexpected life circumstances or when transitioning to and from more unstable living situations. For example, when some participants received their HIV diagnosis, it put them on a path of making more health conscious decisions, such as satisfying basic needs for secure housing, which later benefited them in meeting other immediate needs related to their physical health and HIV care.

Maslow's (1943) Hierarchy of Needs model has been used in numerous of studies examining the effectiveness of housing and housing services, and the model has also been interpreted in studies of mental health and recovery (Henwood, Derejko, Couture & Padgett, 2015), as well as in addictions treatment perspectives (Best, Day, McCarthy, Darlington & Pinchbeck, 2008). Maslow's five-stage model is depicted as a pyramid, divided by varying levels of needs. At the base of the pyramid are the four levels of basic needs (also referred to as deficiency needs) that extend up the pyramid to one level of higher needs (growth or being needs) at the top. Deficiency needs include physiological needs (such as food, water and air), followed by the needs for safety, belonging and love, and esteem as you move up the pyramid. The need for self-actualization sits at the top of the pyramid and is described as the desire "to become everything that one is capable of becoming" (Maslow, 1943). McLeod (2017) reiterates,

> Maslow (1943) initially stated that individuals must satisfy lower level deficit needs before progressing on to meet higher level growth needs. […] When a deficit need has been 'more or less' satisfied it will go away, and our activities become habitually directed towards meeting the next set of needs that we have yet to satisfy. These then become our salient needs.

Life experiences and events may cause individuals to move back and forth between different types of needs in a non-liner way (McLeod, 2016). While the hierarchical nature of Maslow's pyramid of needs has been contested for not wholly considering the complex (and ever changing) needs of individuals (Wahba & Bridwell, 1976), many participants in this study that have described step-wise strategies in attaining their needs. Some described needing to go back to school before getting a job, or needing a place of their own before pursing social relationships or rekindling relationships with family.

In one noteworthy example, participant GV011110a explains how her needs for her housing situation changed though repetitive cycles of being housed and being unstably housed. After years of unstable housing situations like couch surfing, she became more permanently housed in an SRO, where she perceived herself as having what she needed to become stable. During her time in the SRO, participant GV011110a continued going to school to pursue her goal to become a pharmacy technician, along with her goal of securing a bigger living space where she could cook for herself more autonomously. However, when she was met with a challenging circumstance, she had let these goals go. She explained, "…[After] I let go of my goals, that's when I started partying. But I was still working. And so I think the goals would've kept me going if they seem attainable, but at this point they just didn't seem attainable so I just let them go. And…and it was a tough time" (GV011110a). She claimed that having a secure, unfurnished rental suite would have helped her attain her goals at that time. She continued to explain,

> That's the only thing that I lacked, the ambition, because I was living in other people's spaces and I just couldn't see anything of mine around me, and what I did see around me,

> it was just like small little items. It wasn't really enough to call it my own home, so I think what would've helped me is like having a space where I can start filling it with my own belongings (GV011110a).

Therefore, the current situation that an individual is living in (and their most salient needs), their past experiences (and the requisite needs that have already been met), as well as the resources and capacity that an individual holds are all important factors that determine a person's success in attaining their needs. This may be why a continuum of housing situations exists so that individuals can choose living situations pertaining to the needs that they have and wish to have met.

In the New York Services Study (NYSS), Henwood and colleagues (2015) noted a similar step-wise strategy among homeless adult participants living with serious mental illnesses. Participants in the study were enrolled in either a Treatment First (TF) program or a Housing First (HF) program to examine whether there were differences in meeting deficiency needs or identifying being needs. Study findings suggested that Maslow's Hierarchy of Needs provided a useful roadmap "to consider how material deprivation, or a lack of basic needs such as housing, affect one's recovery potential" (Henwood, Derejko, Couture & Padgett, 2015, p. 226). Similar to participant GV011110's experiences with living in a SRO, participants enrolled in the TF programs in the NYSS were more likely to focus on goals of self-actualization, rather than focusing on basic needs being met. For instance, even though GV011110a had private SRO suite, she was unable to fill up her space with her own belongings, and she also lacked the capacity of a kitchen space to prepare her own meals. So while she idealized goals of becoming a pharmacy technician, she lacked the fulfillment of more basic needs, which may have, in part, caused her to give up on her goals altogether. Henwood and colleagues (2015) further assert, "[Participants] who focus on self-actualization as a way to escape their current reality may have a more difficult time planning for incremental but necessary steps towards change" (p 226). On the other hand, participants enrolled in the HF program had their basic needs for food and shelter met more readily, and permanent housing situations were shown to better facilitate step-wise approaches to setting and attaining subsequent goals to improve health and wellbeing. Being needs were also commonly embedded in discussions about deficiency needs, where goals for gaining employment could be associated with goals for improving self-esteem (Henwood, Derejko, Couture & Padgett, 2015).

A discussion of these findings highlight the importance of planning and developing housing programs and housing options that are appropriate for people living with HIV/AIDS to effectively meet the diversity of their needs. The development of individual care plans for mental health and substance use recovery tend to cover questions related to the purpose of care plans, the importance of goal setting, and client involvement (Henwood, Derejko, Couture & Padgett, 2015), and I would assert that the same structure should be applied to when matching people with appropriate housing options. However, discussions about the meaning of home and how service providers and housing supports can help people achieve a sense of ontological security in their living situations may still be needed. For instance, helping people meet their most immediate, basic needs (i.e., a roof over their head) are paramount, but satisfying these needs is not the end goal. The hierarchy of needs model would suggest that service models that focus on getting people housed are not enough, but rather interdisciplinary approaches that comprehensively address the specific and changing needs of clients after they are stably and appropriately housed are necessary (Best, Day, McCarthy, Darlington & Pinchbeck, 2008). Looking at treatment services, Best and colleagues assert, “The aim of treatment should be a ‘hierarchical journey’ with care plan reviews addressing transitions in the level of need to be addressed and creating resulting action plans” (p. 307). One way of ensuring people are having their subsequent needs and goals attained, as well as appropriately transitioning from one living situation to the next, is to develop and implement a continuum model for housing (discussed further in the following section).

Constrained choice

Just as different living environments and life experiences create different conditions for expressing (and needs for) control and autonomy over one’s living situation, factors external to the individual and home nexus can influence people’s attainment of these feelings. Dover and Lambert (2016) define the agency of choice as the “relevant and weighted social, environmental and policy variables that are at an individual’s disposal to be able to make informed health-behavior decisions” (p. 4). Through participants’ narratives, it becomes clear that in some cases participants were perhaps unknowingly constrained by external factors that limited their options for appropriate housing options, thus hindering the full expression of autonomy and control. For example, the described economic and physical vulnerabilities often associated with living with HIV/AIDS can be can further compounded by the limited volume of affordable housing options in the GV area. Furthermore, the challenges experienced in trying to afford housing costs, while covering the costs of other health-essential necessities, can put people at a higher risk for other mental and physical health issues.

A majority of participants reported PWD as their primary source of income, which in some cases was supplemented with income from other part-time or casual employment opportunities, including financial compensation for volunteering. Participants seemingly navigated the high cost of housing in GV by applying for housing assistance programs, living with others to share housing costs, reducing their spending on other health-enhancing goods and services, and in some cases, enduring inappropriate and unsatisfying housing conditions. All of these alternative options had some negative connotations for many participants in this study. For instance, several participants chose to use HIV-designated portable subsidies or live in HIV-designated residential buildings to subsidize their housing costs, which had implications for disclosing their status to community members and potential landlords. Several participants also noted that living with other people could be bothersome, especially when the size of the house did not appropriately accommodate for the number of people living under one roof. Some participants also explained having to live in both socially and physically harmful environments (i.e., pests and rodents) because “[it] was either that or be homeless” (GV031110a). Finally, another example of constrained choice comes to light in participants’ narratives discussing the implications of having lower income levels in relation to rising housing costs. Several participants indicated that they had to choose between paying for housing costs and buying groceries, and needed to rank the value of having a roof over their head or food in their stomach. Dover and Lambert (2016) explain:

> …[Decision-making] moments that impact on health status, are made within a more comprehensive context which may include pragmatic influences such as expediency and competing priorities, and more abstract vectors, based on individual value systems, or more complex values hierarchies. Furthermore, these health behavior decision-making

> moments are mutable, whether from an individual perspective such as: disposable income, personal health belief systems, health identity and current health status, or within a broader social context, for example: community or cultural value system and social norms, or state- implemented programs and policies (p. 2).

Thus it is obvious that the financial constraints of living with a chronic illness and the high expenditures associated with housing costs, as well as the cost of health necessities, such as food and medications, can reduce people's options for appropriate and meaningful housing.

Along with the financial restraints and insecurities that leave participants with few options for affordable housing, the specific health requirements of living with HIV/AIDS further constrain participants' choice of where to live by keeping them close to necessary health services and supports. Furthermore, several participants mentioned that their HIV status kept them in their current housing situation even when they were not completely satisfied. When participant GV910121a was asked about prior housing experiences and how his HIV diagnosis led him to his residency at Dr. Peter Centre, he explained,

> Yeah, but I guess you're looking at the question in an entirely different way. I had no choice…I guess- I mean, I suppose I had a choice. But it's just that that was so obviously the best choice, at that point, if you were HIV positive. What're you going to do? Well, I know how to get into the Dr. Peter's Center, okay.

While it appears as though some participants have some choice in where they would like to live, they were often only presented with a limited choice set, or lacked the agency to act upon other choices due to their health and economic limitations.

While Dover and Lambert (2016) studied the individual capacity to make "healthy" choices in the nexus of food consumption and food security, their discussion of constrained choice can relate to how people living with HIV/AIDS navigate decisions about where to live. They explain, "…there will always be choice-constrained conditions, along a continuum representing factors over which the individual has little or no control, to those for which they have greater agency" (Dover & Lambert, 2016, p. 1). Factors constraining choice become evident when participants explain where they live and their particular reasons for choosing their current living accommodation. Such factors include the location of HIV and housing services (congregated in urban centers), access to and availability of public amenities (i.e. washrooms and soup kitchens), transportation means, cost of housing and income, health and medical needs (nearby clinics), prior experiences in other housing situations, and personal preferences. Decisions about where to live are multifaceted and situational, thus individuals should be fully aware of their options for housing as well as the constraints, giving people the capacity to make informed decisions.

Intervention

The "continuum" model (also known as the "staircase" model) is a type of housing intervention that attempts to house individuals in a staged process, moving people through transitional and unstable living situations to more secure housing situations (Mahamoud, Gardner & Roche, 2012). Additionally, there are varying levels of support and independency associated with each stage of housing, depending on the needs of the individual (Mahamoud, Gardner & Roche, 2012). While this framework has been shown to affiliate housing readiness with the resolution of treatment issues, it may also be effective in meeting subsequent, hierarchal needs after shelter needs are met. Although the continuum model may be an effective housing intervention for people living with HIV/AIDS and for other populations at risk of homelessness, there are several important limitations to this model, as well as areas that require further research. The demands and assessments for housing readiness may fail to understand the complex health-related needs of the population living with HIV/AIDS, including the challenges associated with adhering to HIV treatment regimens. Moreover, "this model may fail to appreciate the cyclical nature of such health issues, limiting therapeutic progress to periods of conformity rather than advancements in the day to day management of complex health conditions" (Mahamoud, Gardner & Roche, 2012, p. 13). Finally, another critique of this housing model, and consistent with participants' narratives in this study, is that people may get "stuck" in prolonged periods of transitional living that are not appropriate for participants' needs, given both their life stage and prior experiences (Mahamoud, Gardner & Roche, 2012). Participants found it ineffectual, and in some cases harmful, to stay in living situations that no longer served them or met their most salient needs.

Findings from the Ontario PSHP study indicate that HIV housing services are not always representative of the people they serve – people that comprise a diversity of languages, cultures, living arrangements, and that do not always fit what Greene and colleagues (2012) consider the “Eurocentric mould”. In consideration of these factors, research findings from this thesis work revealed that features of participants’ living spaces could be perceived either as positive or negative depending on the most salient needs of the individual, their prior experiences, and their own individual characteristics. The most commonly expressed factor for finding appropriate and meaningful housing options was for participants to have a degree of choice in the matter. This degree of choice should not be limited to decisions about the option to furnish suites and what to put on the table for dinner, but should include the ecological and situational factors that constrain people’s choices of where to live and how to construct their home environment. Dover and Lambert (2016) suggest,

> [A] change in response or a re-evaluation of the weightedness of the different factors that comprise choice set, whereas constrained choice by design, ostensibly directed toward the choice set, requires a change in choice architecture, “drafting social policies with the aim of increasing opportunities for people to pursue better health” (p. 6).

While responding to the social and economic factors that shape people’s health may seem a sizeable endeavour, this research can help increase the capacity and volition of individuals to make informed choices in their specific context. This can be done by informing individuals of the various factors that hinder their agency in choosing appropriate housing options and by offering tools that enable individuals “to better evaluate and weigh the factors that comprise their choice set” (Dover & Lambert, 2016, p. 7).

Concluding remarks

The Ottawa Charter for Health Promotion claims that in order to enable people to achieve their fullest health potential, we must create opportunities that support the development of “a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices” (World Health Organization, 1986, p. 1). Most importantly, people must be able to exercise full control over these endeavours, as well as the factors that determine their health. Dupuis and Thorns (1998) affirm that the home can provide a place in which people can work at attaining a sense of control and autonomy in a world, or living with an illness, that at times can be perceived as threatening and uncontrollable. Participants felt a greater sense of control and autonomy in their living space when their income was supplemented by a portable housing subsidy that granted them greater freedom in choosing where to reside. A private, independently owned or rented space afforded more autonomy and constancy for participants in their living space and allowed them to participate in day-to-day activities in ways they found suitable. It is also important to consider the experiences and stages that people have to understand how to best meet their needs for independence and participant GV421121a advocates for different levels of support offered in different residential accommodations. Lastly, for people constrained financially, physically, or otherwise, Dover and Lambert (2016) suggest "researchers and policy makers should focus their interventions on existing assets and a 'group-empowerment' agenda" (p.3). Researchers from the Positive Spaces Healthy Places study in Ontario affirm that "[healthy] housing for people with HIV should address financial and social concerns to ensure stability, attend to their physical and emotional safety, be non-stigmatizing, and foster social support and a sense of community" (Chambers et al., 2014, p. 324).

Constancy and Routine

Having constancy and routine in one's living environment was an expressed requirement for good health among many participants, and could be achieved in various ways and in a variety of living situations. Constancy was primarily described in relation to maintaining routines and the safeguard of having a place to return to time and time again. Converging with the theme of autonomy, participants viewed the features in their home positively when they had consistent access and could develop their own routines around them as they wished. Constancy was also attained though private living areas and storage facilities that allowed participant's to store their possessions securely. Having control over routines, access to amenities, and security over possessions allowed participants to maintain consistency in both their material and physical environments.

The maintenance of day-to-day activities and routines

In many cases where participants expressed stability in their living situation, they discussed routine activities and the regularity of a "typical day". Participants described the habitual activities of waking up, showering and getting ready for the day, preparing a meal, grocery shopping, watching TV, reading a book, doing chores, and exercising. Most activities described took place with participants' dwellings and utilized the amenities offered by their personal living space. Participant GV031130a discussed the cascade effect in which stable housing promoted consistently scheduled eating times, which in turn promoted routines around grocery shopping, and so on. Participants in the PLN session also concurred on the importance of "occupying their time", and how establishing routines around cooking and shopping for food helped satisfy this need. Even when living on the streets, participant GV428090 managed her living space by establishing certain routines around washing her sleeping bag [bedding] and other items on cheque day and routinely cleaning the shower facilities at housing agencies with her own cleaning supplies. It was clear from participant GV428090's daily and weekly routines that she attempted to establish and maintain healthy behaviours within her living space, even though the basic amenities needed were not situated within the same vicinity.

Participants also described certain features of their living situations that supported them in maintaining routine healthy practices. One participant explained how scheduled eating and sleeping times at a women's shelter provided her with a desirable degree of structure and constancy that supported her in keeping up with her treatment regimens. Consistent day-to-day routines were further reinforced in supportive housing situations, where participants had scheduled mealtimes (coordinated with treatment regiments), which was helpful to some people depending on their life stage. Participants also discussed how other people in their living environment kept them accountable to maintaining healthy practices and self-care. For instance, one participant lived in the same household as her two daughters, one of whom was also living with HIV. Wanting to be a positive role model and regain conformity in her own life, participant GV321101a inserted herself in the routines of her children, which included helping them to get ready in the mornings, taking them to school, and preparing meals for the family. Taking HIV medications added another dimension to the routine schedules of living with her daughter, who kept her accountable to taking her medications habitually, which eventually brought her viral counts to undetectable levels.

Participants noted the benefit of independently owned living spaces, supportive housing arrangements, and the social influence of others in maintaining routines; however, other participants expressed challenges with these elements at times. For example, one respondent explained that the rigidity of scheduled mealtimes at shelters impinged on his ability to autonomously take his medications at a time that was most appropriate for him. And in the case that participants did not have access to their own washing facilities, long wait times to use these amenities at day centres made it difficult for participants to plan their day ahead of time or to use their time efficiently. Furthermore, the reliance on public amenities created challenging and unpredictable circumstances for many participants that were often expressed by participants as being beyond their control.

Constancy in material and physical elements of one's space

Another positive feature of having constancy in one's physical environment is having a space to return to time and time again for relaxation and rest. Without access to a stable housing situation, participant GV428090 felt that she was always on the go and unable to properly rest because of her constantly changing home environment and the fear of losing her possessions. Similarly participant GV011110a's experience with stolen food in communal kitchens diminished her ability to make use of the kitchen space and to prepare her meals independently. Having consistent and regular access to amenities that help individuals take care of their physical and health needs can be especially important for people living with HIV/AIDS. Consistent sleeping times and eating is important not only for the overall health of individuals, but is especially important for maintaining HIV treatment regimens and keeping CD4 counts high. In this sense, having access to necessary amenities characterized "home" as a physical space in which tasks could be completed and basic needs could met. Furthermore, inconsistent living environments obligated participants to invest immense amounts of energy and time towards having their daily needs met, and toward regaining equilibrium after their items were repeatedly stolen or lost. In these instances, inconsistent living environments did not afford participants the predictability and consistency of having their needs met, and rather put them at a further disadvantage for achieving other hierarchical or future needs.

Intervention

Focusing on the perspective that housing is a resourceful, conditional, and foundational component to better health outcomes, housing and the health-essential amenities that housing can provide, are needed first. Participant GV031130a claimed, "…[Housing] just mellowed me out.

Settled everything in. It’s just like; this is what I’m supposed to be doing…Gave me a good perspective. Giving back to the community, being part of the community.” This quote highlights the necessity of having certain needs met and achieving a certain perspective in order to attain other needs, such as connecting with community. The Housing First (HF) model emerged from criticisms of the continuum model of supportive housing and was aimed at addressing the needs of vulnerable populations with a history of homelessness, or at increased risk of homelessness (Mahamoud, Gardner & Roche, 2012). The HF model proposes that individuals should be given housing first, without conditional behavioural or treatment expectations, and then offered supports to meet their varying needs (Gaetz, Scott, & Gulliver, 2013; Mahamoud, Gardner & Roche, 2012). Central tenets of the HF model are choice and self-determination, meaning that people should be given a degree of choice in determining the location and type of housing they receive (Gaetz, Scott, & Gulliver, 2013). The At Home/Chez Soi Toronto research team conducted a review of the literature and found that HF had a positive impact on housing stability, and reduced the number of unnecessary emergency visits and hospitalizations, improved mental health outcomes, stabilized or reduced addictions symptoms, reduced involvement with police and the criminal justice system, and improved overall quality of life (Goering, Veldhuizen, Watson, Adair, Kopp, Latimer, Nelson, MacNaughton, Streiner & Aubry, 2014).

In regard to our country’s southern neighbours, Padgett (2007) comments that even though HF approaches are being used in the United States, a “treatment first” (TF) philosophy still prevails. TF services can be problematic because people in need of housing often must satisfy a series of program requirements before they are eligible for housing of their own. Additionally, without permanence and housing stability, people are less likely to form meaningful attachments to their dwelling when they continually move from one place to another (Padgett, 2007). Dupuis & Thron (1998) claim that “...ontological security in the modern world is fragile and tenuous in nature” (p. 27), and this concern is concurs with persisting challenges associated with housing security and the diversity of housing support programs, which both “pose real challenges as they strive to identify what models are best suited to support individuals and communities, under what circumstances” (Mahamoud, Gardner & Roche, 2012, p. 15). The literature suggests that a HF approach may be an effective means for having the various components of ontological security (i.e., constancy, control, daily routine, and privacy) met more readily (Padgett, 2007). However, Padgett (2007) suggests that a deeper exploration of the meanings and dimensions that make a place a ‘home’ are needed to better inform the methods and means to effectively support ontological security in people’s living environments.

Concluding remarks

Dunn and Hayes (2000) claim, “Housing plays a central role in routinized, everyday life and is fundamentally bound up in one’s sense of control over life circumstances” (p. 563). Furthermore, authors explain that the population health framework helps investigators better understand the importance of routinized experiences, since the increased agency to do so seemingly rests on a social hierarchy that is associated with a continuum of health outcomes (Dunn & Hayes, 2000). This claim becomes significant when we compare the life circumstances of participant GV428090a, who is living in transient, street environments, to other participants with access to secure housing accommodations. Participant GV428090a relied on external sources, such as housing organizations and emergency shelters, to have her needs met and expressed a lack of constancy and control over her living situation. From these examples it can be explicated that the more control and autonomy participants have in accessing health-essential amenities (i.e., a kitchen), the more constancy they have over their physical environment and the more likely participants are to express good health outcomes.

From a population health perspective, the WHO (1986) claims that housing is a resource (and fundamental condition) for health that gives people access to the amenities that allow them to maintain and sustain healthy practices and behaviours. Mallett (2004) suggests that people are “home-makers” and construct their homes through the actions they perform in order to fulfill their individual needs. Furthermore, through Sixsmith’s (1986) description of the physical home, she explains that a space becomes a home on the basis that it fulfills a person’s requirements, objectives, and circumstances over time. Therefore, attaining constancy and consistency from one’s living environment is less dependent on what the shelter or living space looks like and more about what it consists of and the amenities that the space provides.

The theoretical construct of ontological security also discusses the implications of constancy in people’s physical and material environments. As discussed above, participants who had a consistent place to return to and a place that provided the conditions necessary for the maintenance of routines and schedules were more likely to express feelings of constancy in their living situation. Additionally, Padgett's (2007) study of ontological security among people living with serious mental illnesses suggests that the engagement in everyday routines might be a way of normalizing participants' experiences through "socially normal behaviours" and provides a "means of gaining parity with their nonmentally ill peers" (p. 1933). This finding is consistent with the results from this study that show how routines and chores provide a means for participants to "occupy their time" and ensue feelings of accomplishment. Participants also expressed how the accomplishment of household chores and the maintenance of positive routines often led to the idealization of other prospective goals, activities, and societal roles, such as finding part-time employment or returning to school. Again these findings point to a sequential or hierarchal ranking of needs that can only be idealized once more fundamental needs are attained. Furthermore, many of the conceptual categories from the data align with the requirements for obtaining ontological security from respondents' living spaces, but had slightly different connotations for people living with HIV/AIDS, depending on their life stage, their current living situation, and their most salient needs.

Security and Privacy

Summarizing participants' narratives from the previous chapter, housing security was understood and discussed in alternative ways depending on both the housing status and prior housing experiences of participants. For some, the term housing security was used interchangeably with safety as participant's described strategies (i.e., camping with others) and amenities (i.e., a locked front entrance) within their living space that allowed them to feel safe from the external environment and other outside factors. For others, security was discussed in terms of long-term stability and financial security that would allow them to stay in their current living situation for as long as they needed. The financial security to afford both housing costs and living expenses, and the signing of housing contracts and rental leases to ensure were features discussed by participants that helped them attain longevity in their living situations. These described features also provided participants with the necessary foundation to develop and maintain healthy behaviours, which subsequently had positive effects on their health and wellbeing.

Discussions pertaining to participants' feelings of security and safety in their living environments seemed to involve quite a bit of debate on the topic of substance use, both in terms of one's individual use and other's use of substances in confined living spaces. Some participants noted having to use substances in order to feel safe while staying indoors (at least at first), while others felt unsafe in low-barrier housing services that permitted the use of substances among other residents. Safety concerns related to substance use typically involved the perceived physical threat of altercations among people who were using substances, as well as contact with drug-related paraphilia. Some participants also felt that their recovery from substance use may be threatened when living with others who engaged in substance use and when substances were in close vicinity of their living space. Secure housing environments also meant keeping participants safe from harmful exposures that threatened their physical health (i.e., exposure to extreme temperatures), as well as keeping possessions safe from loss or theft.

Participants also noted the importance of controlling the entry of guests, which allowed them to control their level of engagement and socialization, as well as their sense of safety. In some cases, restrictions imposed by landlords and building management around having visitors were said to impede on participants' feelings of autonomy and control. However, in other instances, residential buildings that lacked mechanisms for controlling the entry of outside guests (i.e., a FOB system or having a visitor sign-in protocol) threatened the safety of residents. Després (1991) asserts, "The psychological need for privacy is among the most powerful theoretical concepts that have been used to explain the meaning of the home as a refuge" (p. 100). In addition to controlling the entry of visitors (and the level of noise and surveillance), other privacy needs include, freedom of action, and feelings of solitude within the home. However, a tremendous amount of protection over one's privacy can also lead to feelings of isolation (Després, 1991), and this aligns well with poignant narratives from participants who have isolated themselves to protect their social, emotional and physical wellbeing. Herek (1999) claims that stigma and fear of disclosure can further isolate people living with HIV/AIDS from social interaction and support in times when it is needed most.

Participants’ concerns about housing security sometimes extended beyond concerns for their own security and involved concerns about the security of both family members and intimate partners. Participants who were mothers often discussed the relative safety of their living situation for their children or dependents, and several participants cited the riskiness of substance use in areas neighbouring their place of residence. Parental concerns about the availability and use of illicit substances by other residents in nearby residential buildings were echoed in other studies examining housing security for parents living with HIV/AIDS (Greene et al., 2010). Greene and colleagues found that the presence of crime and substance use was more likely to go hand in hand with precarious living situations among many single caregivers living with HIV/AIDS because they were more likely to experience issues related to financial and housing insecurity. Similar to the parents in this study, parents affected by HIV/AIDS were further challenged in addressing their own needs (health, housing, and financial) while tending to the collective needs of family members (Greene, Chambers, Masinde & O’Brien-Teengs, 2012). Although home was commonly defined as the social locus, housing supports for those living with HIV/AIDS were often “unable to accommodate the definition of family” (Greene, Chambers, Masinde & O’Brien-Teengs, 2012, p. 123) and comprehensively address the social needs of residents.

Participants’ definitions of housing security were seemingly related to their most salient needs at the time of the interview, which points to some temporal or hierarchal element in the process of satisfying needs. Since participants were in various stages of life and had lived in various housing situations, what was required from their current living situation in order to feel secure was likely different as well. And these requirements for security were likely associated with how participants defined the term “housing security”. Maslow (1943) makes point of this by explaining that when humans have satisfied their safety needs (being free from adverse exposures, crimes, and assault), they no longer have safety needs as active motivators. Maslow (1943) claims, “Just as a sated man no longer feels hungry, a safe man no longer feels endangered” (p. 379). However, when these immediate safety needs are met, other safety needs are conceptualized and sought after, including employment opportunities that offer greater long-term security through tenure and protection, the desire for a savings account, and for insurance of various kinds (i.e., old age pension) (Maslow, 1943). Therefore, when a person’s need for immediate safety in their living space are met (i.e., a space allowing them to keep their HIV status private or a place with a lock on the door), they may seek to fulfill more long-term security needs that allow them to create a space of refuge and a place they can call home. The above-mentioned situations demonstrate that security needs differ from person to person, and they can also change over time; therefore, it is important that these needs are assessed and addressed on an individual and ongoing basis.

Intervention

In addition to contracts and lease agreements for market rental accommodations (discussed in the results section), housing subsidies may provide another means for assuring longer-term housing arrangements. Dickson-Gomez and colleagues (2009) found that people who received subsidies often had prior experiences with unstable housing situations, cycled in and out of homelessness, and experienced the challenges associated with securing permanent housing (i.e., long wait lists). Having an awareness of the often-onerous process associated with obtaining housing subsidies motivated people with subsidies to keep them (Dickson-Gomez et al., 2009). People were also more likely to engage in strategies, such as limiting their substance use and controlling the availability of substances around their apartment, in order to maintain their housing (Dickson-Gomez et al., 2009). Furthermore, participants in the study reported feeling happier with a housing subsidy, which naturally led to a reduction in their desire to use substances. Dickson-Gomez and colleagues (2009) conclude that housing subsidies and supportive housing programs were associated with not only the control of substance use, but also with the reduction of HIV risk. Finally, the long-term security of housing subsidies also intersects with the concept of autonomy in that it offers people greater volition in choosing what home looks and feels like. While the convenience, affordability, and availability of HIV-specific housing and housing subsidies have been beneficial for many people living with HIV/AIDS, Greene and colleagues (2012) document a number of issues associated with population-specific housing options that need to be given consideration, including required disclosure of HIV status, safety concerns, social isolation, and HIV-related stigma and discrimination.

Concluding remarks

Giddens (1991) concurs with Maslow's (1943) theory of human motivation in that needs for safety and security emerge during the early years of a person's life and even supersede their physical needs, such as hunger and thirst. This theory aligns well with participants' narratives about not wanting to own any belongings while in transitional living situations because the risk of losing their possessions was so high and needs for stable housing were more urgent. Additionally, some participants discussed instances in which they skipped hot meals at housing agencies in fear of their unattended possessions being stolen, as well as to avoid altercations with other residents. Therefore, the needs for both security and safety were a highlighted priority, especially among participants living in transient or unstable conditions.

Kearns and colleagues (2000) summarized Somerville (1997) by claiming, "The privatisation of the home, with privacy as a foundation for intimacy and personal fulfilment, has occurred at a time when life is more publicised…and a retreat from the gaze and demands of the modern world is desirable" (p. 389). Participants in this study also discussed the benefits of having a home, a refuge, to retreat to when needing a break from social engagements or needing to attend to their health needs. This was seemingly important for people living with HIV/AIDS who often had to manage the complications of new treatment regimens that left them feeling physically drained. Furthermore, the privatisation of home meant being free from surveillance (i.e., staff supervision and security cameras), which proved important for participants wanting to feel autonomous and independent in their home environment. Whether participants needed their immediate safety needs met or anticipated longer-term stability and permanence in their current living situation, providing participants with the appropriate measures to satisfy their unique security needs was imperative for participants to exercise autonomy and cultivate their identity (Giddens, 1991; Kearns, Hiscock, Ellaway & Macintyre, 2000).

Construction and Strengthening of Identity

Participants in this study commonly discussed the importance of washroom and laundry facilities within their living environment. These facilities included access to a toilet; a shower to keep participants clean and fresh so they could present themselves well at work; laundry machines to keep clothes clean and to keep participants from "feeling dirty" (GV428090a); and a mirror to ensure they were looking presentable because like participant GV910121a said, "once you [get] diagnosed, the last thing you want to do is look like it." Having a living space with access to these amenities not only allowed participants to maintain daily hygiene practices, but it provided them with the capacity to "feel themselves" and present themselves in a way that was most reflective of them. However, not all participants had consistent access and the autonomy to use of these amenities. For instance, the participants that lacked laundry facilities within their primary residence had to rely on coin washing machines in residential buildings or Laundromats. Perhaps the most noteworthy example comes from participant GV428090a and her experiences with having to navigate various barriers at housing agency buildings, such as long wait times, to have her washing needs met. She explained, "[Being] clean has just been my hardest hurdle." With the dialogue around necessary amenities for washing within participant's living spaces, poignant discussions about the importance of one's external appearances, HIV disclosure and feeling like one's self emerged.

In a study examining the physical changes caused by lipodystrophy [a disorder in which the body is unable to produce fat] among people living with HIV/AIDS, Alexias, Savvakis, and Stratopoulou (2016) found that the representation of the body was exceptionally important in the formation of people's social identity. Researchers found that the physical changes caused by lipodystrophy instigated generalized negative body images among participants and many felt dysphoric with their physical appearance (Alexias, Savvakis & Stratopoulou, 2016). The negative implications associated with the disorder lead to a diminished quality of life and "certain ambivalence towards visibility of the signs of the disease" (Alexias, Savvakis & Stratopoulou. p. 585). The ambivalence towards the visibility of certain features associated with HIV/AIDS is in line with participant GV910121a's statement claiming, "the last thing you want to do is look like *it*", meaning HIV/AIDS. Already facing potential changes in their physical appearance, people living with HIV/AIDS can be further challenged to maintain a positive self-identity and self-esteem when they are unable to access washing facilities to maintain hygiene routines. Participant GV428090a described the importance of never leaving the house without a shower; however, without consistent access to such amenities, her reflection of self was, "This is so not *me.*" Therefore, a change in body image and the consequent dissatisfaction can be partly due to the presence of HIV and loss of control over the body (Alexias, Savvakis & Stratopoulou, 2016), but it can also be attributed to a loss of control and autonomy over one's physical living space.

In addition to the meaningfulness that participants attached to amenities within their living space that allowed them to “put their best foot forward”, the physical structure of these spaces and the contents confined within provided a means of self-expression for participants, and for some, these physical features also served as markers of success. The physical structure of participants’ living spaces provided a blank canvas for which participants could express themselves through the use of furniture, decoration, and meaningful objects to reflect their tastes, interests, and character (Després, 1991). For some participants, having a space to fill meant having a fresh start, as well as a secure storage for which they could accumulate their belongings. The slow accumulation of belongings seemingly mirrored a growth and progression towards stability, and a filled out space gauged their success. Repeating Sixsmith’s (1986) description of the “personal home”, a person’s living space is an extension of the person who occupies the space. Therefore, by filling a space with meaningful possessions and materials that reflect occupants, people create spaces where they can be themselves, and preserve feelings of happiness, security, and belonging (Sixsmith, 1986). A point of differentiation in the data revealed that some participants found the process of filling up a space on their own and with their own accumulated possessions was a meaningful endeavour, while others saw an empty room as a sign of defeat. That being said, giving people a level of choice and agency in how their internal home environment is created can be a significant determinant for feeling at home, and allow people to feel confident that their most salient needs are being met.

Along with the internal appearance and contents within participants’ living spaces, several authors describe the role of the external appearance and physical structure of a household in conveying certain attributes, such as the social status and socioeconomic position, of the person that lives there (Després, 1991; Galobardes, Shaw, Lawlor, Lynch & Smith, 2006). For participants in stable housing living situations, where they could consistently find food in their fridge and had their space decorated in an appealing way, the outward presentation of their home conveyed the message that they were doing well to others. Several participants noted not being able to invite family members to their living spaces, in fear that the appearance of their space would portray them negatively, and create unnecessary burden and worry among family members. In a couple of instances, participants noted their community’s reference to certain buildings as “HIV houses” and “crack shacks”, which had implications for the people wanting or needing to live in these buildings. Participant GV011110a further explained that the burden of not having a stable place to live was intensified by not having work. Other participants expressed similar feelings of shame, as well as feeling humiliated and discriminated against when seeking housing arrangements and/or employment opportunities. The CAC concluded that there were certain social expectations associated with housing status and employment status. For several participants whose housing status comprised living in subsidized rental units and their employment status defined by their Disability status, this could create feelings of shame, guilt, and inadequacy in meeting social expectations. Després' (1991) review of the literature also revealed that social status was an important element in the social construction of home. She explained how the exterior characteristics and the location of a person's living space could convey information about the individual. Furthermore, her review of the literature concluded that homeownership was most desirable because it gave occupants a mark of respectability and the notion of "having made it" (Després, 1991)

Dunn and Hayes's (2000) review of the literature also revealed that people's housing status and conditions were "crucial in the production and reproduction of social identity and social status" (p. 564). They noted that when residents were proud of their dwelling and felt that it was a good reflection of their selves, they were more likely to report better health outcomes and health satisfaction. These findings echo findings from two distinct neighbourhoods in Vancouver in a study that compared a neighbourhood with a relatively low standardized mortality ratio (SMR) with another neighbourhood with a relatively high SMR. Furthermore, Rourke and colleagues (2012) found that people living with HIV in low-quality accommodations and neighbourhoods were likely to influence people's perceptions of their own self-worth. With the discussion of the external appearance of people's residential buildings being an outward symbol of people's status, it is important to consider the implications of certain subsidized and supportive housing arrangements (that more accurately portray the continuum of housing beyond homeownership and rental accommodations, as seen in the literature).

The impact of stigma

In a study examining people's access to HIV care and other support services among two populations living with HIV/AIDS (MSM and people who inject drugs), Collins and colleagues (2016) found that stigma was not only attributed to certain behaviours and populations, but it was also associated with particular spaces and geographical settings. These authors found that when stigma was associated with a space, referred to as “territorial stigma”, it could have an impact on how individuals negotiated their identity, as well as the identity of certain places. This study has important implications for the study of home because these researchers found “[the] resulting ‘blemish of place’ denigrates neighbourhood occupants who often embody stigmatizing discourses, disrupting their sense of identity and social interactions, while also constraining their access to other neighbourhoods” (Collins et al., 2016, p. 169). Thus, people are less likely to feel at home and more likely to engage in inappropriate, and even harmful methods of identity construction (i.e., isolation), when they perceive their living space as “blemished” (Collins et al., 2016). Furthermore, territorial stigma can also lead to undue stress and negative coping mechanisms, as well as undermine people’s access to necessary supports and services in spatially stigmatized neighbourhoods (Collins et al., 2016).

Housing subsidies have not only helped participants become gainfully housed, but they have given participants more choice in determining the location of their residence, what their space looks like, and the diversity of their neighbourhood. Housing subsidies can therefore be seen as supporting the development of meaningful housing opportunities and promoting higher satisfaction with the spaces in which people are living. Subsidy programs offered in HIV-designated buildings, however, can have implications for the population living with HIV/AIDS. For instance, although the external appearance of said buildings might be inconspicuous and offer residents discretion around the disclosure of their HIV status, friends and community members may still question residents on the process of acquiring such accommodations. Participant GV421121a expressed challenges in responding to other people’s inquiries about her housing status, and often found herself having to choose between being dishonest about her housing situation or having to reveal her HIV status. While the indecision to disclose may be the result of various intersecting factors, Herek (1999) claims that nondisclosure might, in part, be a result of internalizing societal stigma of HIV/AIDS.

People’s ambivalence around decisions to disclose their HIV status may be further complicated by legal requirements for disclosure and by society’s perception of HIV/AIDS. People living with HIV/AIDS have a legal obligation to disclose their HIV status when engaging in activities that pose a higher risk of transmission (i.e., sexual intercourse), yet this obligation may complicate people's understanding of when and whom to disclose their status to, including in social circumstances with friends or family, or in contract agreements with landlords (PHAC, 2015a). Furthermore, when people living with HIV/AIDS are pressured to disclose their HIV status in circumstances in which they are not obliged to do so, it can lead to experiences with stigma and discrimination, stress, rejection and abandonment (PHAC, 2015a). A review of the literature conducted by Mill and Canadian Aboriginal AIDS Network (CAAN) (2007) revealed the process in which HIV became a stigmatized illness and included a lack of knowledge about the disorder, negative perceptions that have been attributed to HIV/AIDS over time (i.e., HIV being the result of individuals violating the moral order of society), and the association of HIV with groups already marginalized in society. HIV-related stigma, defined as "prejudice, discounting, discrediting, and discriminating directed at people who have or are perceived to have HIV" (Herek 1999), and other forms of identity discrimination have been identified as prevalent barriers to accessing and maintaining stable housing (Chambers et al., 2014). Greene and colleagues (2010) also found that certain housing experiences further challenged individuals in dealing with their positive status. Thus, access to stable housing often superseded people's acceptance of their HIV status, as well as the prioritization of their HIV care and overall health (Greene et al., 2010).

Intervention

Peer navigators can provide a crucial point of intervention for people navigating new living circumstances and newly diagnosed HIV statuses (BC Ministry of Health, 2012). In this study, the presence of peers in HIV-designated housing buildings helped participants feel more at home in their living environment, helping some come to terms with and strengthen their identity. Participant GV421121a noted the pleasant feeling of returning home each day to people that share common experiences, and also feeling less judged for the activities or behaviours that she chose to engage in. Furthermore, several participants noted the strength of the "HIV community" in providing both a respectful and supportive space to benefit the social, emotional, and physical health of people living with HIV/AIDS. Together, the home setting and the relationships constructed within provide an "atmosphere of social understanding where one's actions, opinions, and moods are accepted" (Després, 1991, p. 98). Furthermore, people with shared lived experiences in the home environment may be better equipped to understand and support people living with HIV/AIDS, and help to further validate their actions, opinions, and feelings about the world, as well as themselves. Not only do peer navigators encourage the development of strong social networks, but other research has shown that peer navigators were key agents in increased service retention among people living with HIV/AIDS (BC Ministry of Health, 2012), which may also have positive implications for keeping people stably housed.

Concluding remarks

The theory of ontological security states that stable social and material environments provide a means for which people can reconstruct or repair their self-identity (Després, 1991) and Sixsmith (1986) communicates the importance of relationships built and sustained in the home setting. Furthermore, access to various household amenities and household conditions are housing indicators commonly used in research to determine a person's wealth and socioeconomic circumstance (Galobardes, Shaw, Lawlor, Lynch & Smith, 2006), and can therefore be taken up and used by society to depict a person's social identity. Participants were clear in defining home as a place where they could have their social needs met, and a place where their thoughts and feelings were validated and supported. In some cases a place became a home over time and through the gradual accumulation of meaningful belongings that resonated with participants' sense of self, and through the social relationships that were developed. For others, home was less physically defined and more about the people participants lived with. Regardless of how the feeling of home came to be, participants that expressed satisfaction with their current living environment described how their home was closely related to their self identify, and how it served as a symbol of how they understood themselves (Smith, 1994).

Bringing Theory Together

In the literature review, I discussed two key frameworks used to examine the relationship between housing and health: the socio-ecological model and the population health (social determinants of heath) framework. Here I will discuss how my own research findings relate and add to the findings from studies that used these models, and where other theoretical frameworks might serve to benefit further inquiry of the housing-health relationship.

The Socio-ecological Model

Health behaviour choices and the amount of agency given to people to choose where they wish to reside, do not rest alone on the considerations of one's own health and wellbeing; rather, these choices encompass social, environmental, and policy elements (Baral, Logie, Grosso, Wirtz & Beyrer, 2013; Dover & Lambert, 2016). The socio-ecological model helps researchers to better conceptualize the behavioral factors of people living with HIV/AIDS, while examining the community and societal-level variables that also influence the health and wellbeing of these individuals (Fink, 2013; Dover & Lambert, 2016). This model was useful for understanding the complex behaviours, choices, and negotiations employed by participants in the construction of their home environment, and what factors facilitated or impeded their feeling at home. For instance, findings from this study revealed that the economic and health vulnerabilities associated with living with HIV/AIDS can impact participants' agency in choosing affordable housing options that contain the amenities they require and reside in the geographical areas they wish. Having reduced agency in housing choice also had implications for the social dynamics of participants' living spaces (i.e., living with roommates and in socially toxic environments), the health and safety of individuals (i.e., precarious housing having harmful exposures and high housing costs leaving less money for health-necessary amenities), and for the disclosure of one's HIV status (i.e., when living in HIV-designated housing or when asked by a potential landlord). Finally, the socio-ecological model proposes that health outcomes are determined by the relative "fit" between a person and their environment, which relates to one's perceived meaning of home, as well as the conditions and elements that are requisite for creating a home environment.

As stated before, the socio-ecological model has been critiqued for lacking a theoretical orientation to develop hypotheses linking the meaning of home to individual health (Grzywacz & Fuqua, 2000), which can create challenges when translating research findings into useable outcomes. Furthermore, "the dialogic nature of such an eco-logical model suggests that individuals are both actors and agents in the construction of their health status" (p. 2), yet this perspective of health is not often considered in the development of individual- and community-based health interventions (Dover & Lambert, 2016). So while the socio-ecological model may be useful in considering the environmental conditions that influence people's agency in housing choice and health outcomes, it may be necessary to use other theoretical models to enhance our understanding of the meaning of home, and how to leverage this knowledge to create more meaningful and appropriate housing options for people living with HIV/AIDS.

The Population Health Framework

The population health framework considers the broader determinants of health, such as access to housing, and how these determinants can influence the health of people living with HIV/AIDS, as well as people's risk of acquiring HIV/AIDS. Moloughney (2004) explains that people's living environments contain both physical and psychological dimensions of health, in addition to relational and social elements contained within surrounding neighbourhoods. This raises important considerations for this study since participants often derived meaning from the physical elements and amenities within their home environment that allowed them to meet their most salient needs. Furthermore, even though participants had access to a house (a four-walled structure), they didn't necessarily feel at home, thus illustrating the social, psychological, and environmental conditions also necessary for the construction of home.

While the socio-ecological model may be effective in considering the individual and behavioural factors that influence people's access to housing, the population health framework is criticised for not fully considering these factors and focusing more on macro-level influences (Coburn, Denny, Mykhalovskiy, McDonough, Robertson & Love, 2003). Focusing on macro-level factors can create challenges for researchers because they may not be able to fully conceptualize and identify the oppressive effects that the social determinants of health can have on people living with HIV/AIDS, which can further impede access to appropriate housing. Both the population health framework and socio-ecological model tend to focus on the material and spatial dimensions of housing, respectively, which tends to focus more on the social and economic conditions for people's health and wellbeing. Ontological security has been effectual for considering the more micro-level influences of housing, helping researchers to better explore the meaningful dimensions of home. Thus, ontological security may provide a necessary theoretical framework to fill in the missing pieces (adding to the more macro-level theories of housing) and provide more of a conceptually refined understanding of relationships between housing, home, and health. In addition to the integration of ontological security into population health and socio-ecological frameworks, further attention should be given to micro-level approaches that explore the myriad of factors that shape individual experiences of living with HIV/AIDS, and influence on their health and wellbeing.

Ontological Security

Restating Dupuis and Thorns' (1998) conditions for ontological security, a home can be defined as the extent to which the home environment meets the conditions for security and privacy; constancy in the social and material environment; allows for a sense of control and autonomy; and provides a secure base around which identities are constructed and strengthened. Although Kearns and colleagues (2000) define ontological security as an "abstract concept", the conditions for ontological security seem to resonate with findings from this study and describe the conditions necessary for participants' sense of home. Furthermore, by exploring how the conditions for home can be explicated for people living with HIV/AIDS across a continuum of housing experiences, we can give meaning and tangibility to these finding by informing the development more meaningful and appropriate living circumstances.

In the past, ontological security has been critiqued for applying its tenets to extreme housing situations, such as homelessness and homeownership, rather than to a continuum of housing situations that more readily reflects housing experiences in urban settings. As the PLPH study sampled participants from four discrete housing categories (transitional, subsidized, supportive, and rental/ownership), and included participants with transitional experiences in various housing statuses, it allowed me to examine housing along a continuum. Through the inquiry of the meaning of home across the housing continuum, the conditions for ontological security were found to be fluid and not requisite for all participants. For instance, the condition for security and privacy differed among participants depending on their most salient needs, which also defined their understandings of "housing security". The psychological and socio-psychological interpretations of home "suggest that home is a process that can only be experienced along time and that peoples' particular life events influence their experience of home" (Després, 1991, p. 101). Furthermore, Després' (1991) review of the literature affirms that people's housing histories (including the memories made and routines established within living spaces) are associated with people's motivations, ideas, and images of home.

Findings from this research serve to expand the theory of ontological security by drawing more attention to the temporal components of ontological security, and the in processes in which people's needs for and responsiveness to the various components of ontological security change over time. Therefore, other theoretical frameworks, such as Maslow's Hierarchy of Needs, could also be used to better understand the real-life implications of the components of ontological security, and how they may be negotiated among individuals who move along a continuum of housing experiences. While the theory of ontological security considers the impact of constancy in one's social environment, the conceptual framework may not comprehensively address the health implications of the diverse social environments in which people are living. The need for constancy can be of particular importance to people living with HIV/AIDS, since participants were shown to seek constancy in their social environments to feel uplifted and supported; to provide accountability for maintaining health-essential behaviours and activities; to ensure that their aloneness is followed by feelings of refuge, repose, and tranquility; and to strengthen and realign their own identities. Thus, the implications of ontological security can be complex, but can be attended to through participatory and community-based methods used to explore a diversity of lived experiences, a variety of housing situations, and the number of ways in which people living with HIV/AIDS construct meanings of home.

Conclusions About the Meaning of Home

Although interviews conducted with participants during the data collection process did not directly question participants about their individual definitions of home, we were able to construct their meaning through discussions about the various necessities in people's living environments and through their narratives of what feelings and securities were elicited by such features and possessions. Throughout the interview process it was evident that participants didn't always make explicit connections between the elements of their living space and their health and wellbeing, at least in the initial stages of the interview. However, through repeated questioning and engagement in the mapping exercise, participants seemingly became more aware of the value and meaningfulness of the elements in their home.

For many, home was a place where they could exert a desirable degree of control over their living space and could autonomously make use of the amenities that enabled them to have their various needs met. Participants were able to manage their spaces, even when constrained by the economic and physical limitations associated with living with a chronic illness, to attend to their physical and emotional needs. The needs for autonomy and control were also shown to change over time; therefore, it is important to ensure that people's living environments reflect their evolving needs.

Participants' narratives made it clear that engagement in healthy practices and daily routines required more than the knowledge and desire to do so. Rather it required having control over and access to social and economic conditions, which reinforced their ability and motivation to engage in health actions. For example, having consistent access to food, a kitchen, and proper storage wasn't enough to keep participant GV321101a engaged in her HIV treatment regimens, but it was the positive influence of her relationship with her daughter that helped hold her accountable to these practices. Therefore, the material, spatial, social, and meaningful dimensions collectively make housing a resource for health (WHO, 1986), and help support people in developing and maintaining healthy practices and behaviours.

Having constancy and routine in one's living environment were expressed requirements for good health among many participants, and could be achieved in various ways and among a variety of living situations. Housing was shown to play a central role in routinized, everyday life and was fundamentally bound to people's sense of control over life circumstances. With consistent access to household amenities, participants were more likely to engage in routine practices, including their adherence to HIV treatment regimens. This translated into feeling more in control over their HIV care, as well as their health and health outcomes. Having a foundation to establish routine practices was also important for participants to "occupy their time", which lead to subsequent feelings of accomplishment and satisfaction. Finally, constancy and consistency in one's living environment was shown to be less dependent on what the shelter or living space looked like, and more about what the space consisted of and what amenities the space provided.

Security and privacy were other commonly noted elements in defining a home. Security was necessary for participants to ensure that their immediate safety needs (for themselves, their families, and their possessions) were met, but to also ensure that they had reassurance for the long-term projections of their tenancy status. Privacy needs were important for participants to live freely in their space, but also to control their level of social engagements and maintain healthy boundaries. This meant that participants had the power to gauge their own social connectedness, which was shown to reduce isolation and anti-social behaviour. Finally, security and privacy had important implications for the disclosure of participants' HIV statuses, and participants became more comfortable with their decisions to disclose once conditions for privacy were met.

The home was also seen as the hub for social communion and where relationships were developed. The types of relationships established in the home setting were quite unique in nature (i.e., relationships between parents and children; romantic partners; peers), but made participants feel at home on the basis that these relationships were perceived as positive and beneficial. Participants' relationships with others validated their belongingness to certain home environments, and their feelings of rootedness were very much tied to the acceptance and social connection with others. Findings from this study support the final conclusions made by researchers' from the Positive Spaces Healthy Places study, claiming that healthy housing for people living with HIV/AIDS should ensure stability in their social environments, "attend to their physical and emotional safety, be non-stigmatizing, and foster social support and a sense of community" (Chambers et al., 2014, p. 324).

Previous research described throughout this paper clearly indicated the utility of a person's home in conveying a social meaning about the person that occupies the space (Després, 1991; Dunn & Hayes, 2000). Home was described as a space that was unique to the individual living there, who made a space their own through the gradual accumulation of material possessions that resonated with and communicated participants' self-identity. People's material environment and circumstances, the social meanings that people attached to their material environments, and how people felt about themselves relative to the things they had access to and control over, were key determinants of their health and wellbeing (Dunn & Hayes, 2000). The home was not solely a symbol of social status in itself, but it was also a place that gave participants access to necessary facilities and tools (i.e., washing facilities) that enabled them to preserve a positive self-identity and self-esteem.

The meaning of home appears to be quite situational and individually determined. While living situations and access to different household amenities differed among participants, individuals still sought meaning from their living environments, and this had positive implications for their health and wellbeing. The needs for autonomy and control; constancy and routine; security and privacy; supportive relationships and social communion; and a foundation to establish and strengthen one's identity radiated through participant's narratives. While the elements within participants' living spaces that satisfied these abovementioned needs differed from person to person, the positive effects that they had were similar. There was also a temporal component associated with meeting these needs, which meant that some needs had to be met before others, and that the timing at which needs had to be met was dependent on participant's current and prior experiences. Stable living environments were determined to be fundamental to participants' journey for self-improvement, giving them the resources to invest in their health and wellbeing, to repair and strengthen their relationships with others, to cultivate goals of returning to work or school, and by creating positive spaces were they could create, reflect, and be themselves (Chambers et al., 2014).

People living with HIV/AIDS had a specific relationship to the various elements of home, partly due to the various unique needs associated with living with a chronic illness. All this being said, the meaning of home is very much individually defined and important for improved satisfaction with one's living environment and health outcomes. Therefore, mechanisms should be in place to ensure that individuals living with HIV/AIDS have access to health-necessary features and to ensure that individuals can derive meaningfulness and benefit from the physical, mental, and emotional health outcomes of calling a place a home.

CHAPTER VI: FINAL CONCLUSIONS

This chapter concludes this thesis by examining one final intervention and a community giveback project that aligns with other previously mentioned interventions, and proposes tangible implications for creating meaningful housing options for people living with HIV/AIDS. I will also include a discussion of the study design, study limitations, as well as my own personal reflection on the research findings and process of engaging in community-based research.

Intervention

Throughout the discussion of study findings, I have pointed to numerous types and points of interventions when pertinent to the discussion of several conceptual categories that collectively construct people's meaning of home. I previously described the successes of using peer navigators to support people living with HIV/AIDS, and the effectiveness of navigators in creating meaningful opportunities for people to engage in services and programs. Furthermore, the efforts of housing support workers did not go unrecognized by study participants, and many participants commented on the success of accessing (more) appropriate housing options through the support of frontline service providers. I also described the benefits of Housing First and Housing Continuum Models in addressing people's preliminary needs for housing, and in delivering housing services appropriate to people's needs.

In considering the abovementioned interventions and lived experiences of the people that participated in this study, choice was found to be one of the most fundamental elements in the construction of home. The CAC collectively agreed that an important step in improving existing housing services and supports would be to increase people's degree of choice and agency. A person's degree of choice should not be limited to decisions about how to furnish suites and what to put on the table for dinner, but should include considerations of the ecological and situational factors that constrain people's choices of where to live and how to construct their home environment. Dover and Lambert (2016) suggest,

> [A] change in response or a re-evaluation of the weightedness of the different factors that comprise choice set, whereas constrained choice by design, ostensibly directed toward the

> choice set, requires a change in choice architecture, “drafting social policies with the aim of increasing opportunities for people to pursue better health” (p. 6).

While responding to the social and economic factors that shape people’s health may seem a sizeable endeavour, this research can help increase the capacity and volition of individuals to make informed choices in their specific contexts. This can be done by informing individuals of the various factors that hinder their agency when choosing appropriate housing options and by offering tools that enable individuals “to better evaluate and weigh the factors that comprise their choice set” (Dover & Lambert, 2016, p. 7).

A self-administered, individually completed questionnaire could be developed and used to supplement housing assessment checklists that are often completed by housing workers. While the role of housing support workers includes assisting people in “communicating with landlords, reviewing lease agreements, securing convertible leases, responding to landlord concerns, developing budgeting skills and helping…access additional financial supports” (Canadian Observatory on Homelessness, 2014), questionnaires can provide additional information necessary to help people make decisions for appropriate housing options. Findings from this study can help inform the development of a questionnaire that would address the more meaningful dimensions of people’s criteria for housing, focusing on the features that would help people feel more at home in various living situations, as well as the features that would enable them to have their health and social needs met. Too often participants expressed “if I had been smart and had more time, I don’t think I would’ve moved into where I am” (GV03110a), which highlighted a critical gap in housing services and supports. In several instances, participants commented that they would have benefited from more information about a space and would have benefited from more time to consider how the various features and amenities offered within the space may contribute to their health and wellbeing.

While housing workers help to motivate and advocate on behalf of participants in finding housing, they may be constrained by time, resources, and knowledge about the specific needs of the individual, especially the needs of individuals living with chronic illnesses. Furthermore, individuals may not wholly consider the influence that potential housing situations can have until after they have moved in. Therefore, a questionnaire on the meaningful dimensions (or to supplement an existing choosing checklist) would take some of the burden off of housing workers while helping people reflect on potential housing opportunities before they commit.

Mahamoud, Gardner, and Roche (2012) claim that the great potential of frontline innovation has not been fully conceptualized and taken up. This is largely due to the fact that there has been “little systematic evaluation of community-driven service provision” and fewer avenues for sharing and building upon best practices (Mahamoud, Gardner & Roche, 2012, p. 19). Mahamoud and colleagues (2012) suggest identifying promising innovations, evaluating their implications beyond the context in which they were assessed, sharing effective practices widely and scaling up successful initiatives as appropriate. Through these processes “a permanent cycle and culture of frontline innovation on housing and other social determinants of health” can be developed (Mahamoud, Gardner & Roche, 2012, p. 19). Therefore, new methodologies might be needed for a deeper exploration of both the meaningful dimensions of home, and how people conceptualize what it means to feel “at home”, to apply these dimensions of housing to practice. This research used the combined strengths of participatory approaches, as well as pictorial methods for mapping participants’ spaces, to help bring about the emic perspective and to facilitate the unraveling of participants’ experiences with housing and HIV. Other participatory approaches, as well as longitudinal studies of interventions targeting individuals across a continuum of housing situations (Mahamoud, Gardner & Roche, 2012), could produce valuable discoveries about the effectiveness of interventions and the unanticipated ways in which housing and health intersect for people living with HIV/AIDS.

Findings from this study will inform the development of a community giveback project to ensure that the community can directly benefit from the research process and outcomes. The advisory committee will continue to assist me in the development of this project so that their personal and professional contacts might leverage better usability of research outcomes (Flicker & Nixon, 2015). Furthermore, the final tool created may not only be of use during the process of seeking appropriate housing for people living with HIV/AIDS, but may also be advantageous to other individuals living with chronic illnesses and people that face social marginalization.

Limitations of Study Design

There are a few noteworthy limitations of my study design. First, because this is a secondary analysis of the first phase of data collection in the PLPH study, the data collected by the PLPH study limits the scope of my research and the research questions that I have set out to examine. I was not involved in the development of the original interview guide, and therefore, did not have the ability to include questions that sought to further explore respondents' meaningful attachments to their living space. Secondly, this study is limited in that it only explores the living situation of study participants at the time that data were collected. Many participants have a history and experiences with many different living situations and this may influence their current understanding and reflections of their current living situation, and how they thought it influenced both their health and HIV status. Thirdly, this study was undertaken within a specific HIV service environment (most notably in the metropolitan areas of Vancouver) and findings, therefore, should be considered within this context. The HIV service environment (characterized by world-renowned HIV specialists and treatment approaches) and progressive harm reduction philosophies that prevail in BC are unlike any other physical, political, and social environment in provinces across the country, which makes the GV area quite a unique setting for study. Thus, the relevance, applicability, and transferability of research findings need to be assessed with regard to similarities and differences with respect to the specific context of other settings. Finally, given the relatively small sample size I analyzed, I was not able to assess differences in the meaning of home across genders or cultures. In the literature, there (also) has been a noticeable absence of discussion concerning the cross-cultural perspectives on home, place and space. This may be due to the fact that "only rarely have any differences been considered in the empirical research dealing with the meaning of home" (Smith, 1994, p. 34). Therefore, additional research is needed to understand the gendered dynamics between housing and home (and home and health), particularly with respect to what elements in the home environment are considered as meaningful and what impacts the process of constructing meaning have on men compared to women. Similarly, additional research into the specific experiences of Indigenous peoples in a continuum of housing situations is needed to identify culturally specific dimensions of home.

Despite these limitations, study findings elucidate the critical role of examining the meaningful dimensions of housing to better understand the relationship between housing and health, and to inform the development of meaningful housing options for people living with HIV/AIDS. This study also demonstrates that conditions for feeling “at home” extend across a continuum of housing, and are dependent on individuals’ stage of life and prior experiences to determine what their most salient needs are from their living space. Thus it is important for housing supports and services to take an person-centered, individualistic approach when determining the housing needs of a population or in creating housing supports, especially for populations with complex physical and social needs.

Reflections

Since this is my first time conducting qualitative research and first time working within a larger study using a CBR approach, the methods and frameworks used evolved as this research progressed. Padgett (2012) noted that qualitative research rarely follows a predictable course, and many authors would agree that the process of engaging in community-based research could be quite variable. That being said, it was important for me to keep track of the progress and changes made to the research plan. I was diligent in documenting my personal reactions, biases, and concerns, as well as any important logistical or theoretical changes during the research process. Memo writing was especially effective in the writing of the Results and Discussion chapters. Writing these chapters challenged me to think and rethink how to present my data in a way that made sense, both logically and analytically. I often questioned both myself as a researcher and the research findings as new revelations in the data took me to sometimes challenging depths and shaky terrain. Strauss and Corbin (1990) claim that "theoretical sensitivity" requires a researcher to identity what is important in the data, give it context and meaning, and conceptualize the observations. Not only did this challenge me as a novice researcher, but I was further challenged to lessen the conscious application of my own theoretical preconceptions, preferences, and worldview to developing themes and conceptual categories on a continuous basis. So throughout this process and I had to continually hone the focus of the research questions and manage the length of this manuscript. Eventually, I put trust in Charmaz’s (2006) words: “Learning to trust in the writing process, if not in ourselves, is like learning to trust in the grounded theory analytic process: our writing, like our analyses, is emergent” (p. 155).

The write-up of these chapters also challenged me in developing conceptual categories that would categorize the major themes in the data that would then be compared with existing literature and conceptual frameworks examining the relationship between housing and health. My method for both analyzing and presenting the data changed over time (and with each discussion with the CAC), so memo writing was an important tool for keeping track of these changes and to justify why changes had been made. Finally, memo writing was important for me in reflecting on CBR processes, and ensuring that my own research process incorporated as many avenues as possible to engage members of the CAC.

Using a critical perspective in research not only applies to the various stages of the research process, but it applies to the researcher as well. Throughout the process of conducting this research and writing my thesis, I often reflected upon my own positionality within the research, my relationships with the various persons involved in the project, as well as the experiences that I have faced personally that led me to have an interest in this research topic. These relationships, and my understanding and reflections of what home means to me are still evolving, but I attempted to remain transparent about these evolutions throughout the chapters of this thesis.

A note on CBR

As stated previously, I endeavored to incorporate participatory approaches where possible in the research process in order to promote engagement among all members of the CAC in a meaningful way that would produce meaningful results. Through my educational experiences at the University of Victoria and my practicum placement at PAN, my values and impressions of the importance of community involvement and engagement grew. The “nothing about us without us” philosophy always held true to me, and I know realize that these values can only truly be actualized through the process of a true CBR study, like PLPH. I could not imagine researching, analyzing, and making conclusions on a research topic without including the voices of the people so profoundly close to and affected by the issue at hand. And since I was able to engage the CAC in various phases of the participatory thematic analysis, and recommended thematic ideas and conceptual theories to such a knowledgeable and experienced group, I felt more confident in the findings and recommendations I put forth.

Given the sensitive nature of the research topic, it became clear that the interview process itself became a kind of intervention. Through this process, participants were able to reflect upon their housing and life experiences, making reference to the elements that influenced their physical, emotional, mental, and physical health and wellbeing. Although interview questions didn't explicitly ask participants what the meaning of home was or whether they felt that their current living situation was "home" to them, the interview questions were designed to be a self-reflective. It became clear that the interview encouraged participants to discover (or rediscover) how their housing situation connected with their health and wellbeing. Many of us have a place we call home, or at least a place or a thing of comfort and sanctuary, but we may not always recognize the connections between our internal selves and external environments on a day-to-day basis. Therefore, the process of reflection, inquiry, and the ability to make these connections can become quite an empowering process for all of those involved.

The intention to incorporate elements of a CBR approach was not without its challenges. Firstly, as a novice researcher, I was exploring new territory as I began to research the ways in which participatory approaches had been applied in previous studies. I was met with many challenges as I endeavored to make my own research process remain my "independent work" for degree requirement purposes, but also as participatory as possible on a small budget, a tight schedule, and among many stakeholders dispersed across the province. This meant having to engage members in meaningful discussions over the phone and Internet, which typically is not optimal for engagement and collaborative processes. Secondly, the process of analysis can involve reading long transcripts of original data, reviewing and discussing key findings, and determining methods for dissemination. This process can be quite intimidating for committee members that already have other ongoing projects and roles; therefore, I was often placed in an equivocal position of having to keep members of the CAC accountable to the analysis process (including myself) without burdening them with a sizeable workload. Finally, I recognized fairly early on the differences in power between members of the CAC and myself. While true CBR projects require a dispersion of power among all people involved in the research process, I had obligations and criteria to meet to fulfill degree requirements; therefore, I practiced greater agency in choosing which key findings to focus on and how conceptual categories were constructed. Regardless of the efforts, participatory processes and collaborative inquiry contribute to positive, relevant, and actionable change that improves the health and wellbeing of affected communities. And through the building of strategic alliances, both in research and at the frontlines, we make an effort to regain and strengthen solidarity, while ameliorating the pervasiveness of societal stigma and discrimination.

REFERENCES

Alexias, G., Savvakis, M., & Stratopoulou, I. (2016). Embodiment and biographical disruption in people living with HIV/AIDS (PLWHA). *AIDS Care, 28*(5), 585-590. 10.1080/09540121.2015.1119782

Aidala, A. A., Lee, G., Abramson, D. M., Messeri, P., & Siegler, A. (2007). Housing need, housing assistance, and connection to HIV medical care. *AIDS And Behavior, 11*(6), 101-15.

Aidala, A. A., Cross, J. E., Stall, R., Harre, D., & Sumartojo, E. (2005). Housing status and HIV risk behaviors: Implications for prevention and policy. *AIDS and Behavior, 9*(3), 251-265. doi:10.1007/s10461-005-9000-7

Aidala, A. A., Vardy, Y., & Yomogida, M. (2013). *Housing is Health Care Food is Medicine*. [Presentation for North American Housing and HIV/AIDS Research Summit]. Retrieved from http://www.hivhousingsummit.org/2013/2013-09-25-Aidala-Angela.pdf

Aidala, A. A., Wilson, M. G., Shubert, V., Gogolishvili, D., Globerman, J., Rueda, S., . . . Rourke, S. B. (2016). Housing status, medical care, and health outcomes among people living with HIV/AIDS: A systematic review. *American Journal of Public Health, 106*(1), e1-e23. doi:10.2105/AJPH.2015.302905

Ask Wellness Society (n.d). *Housing & Outreach*. Retrieved from http://www.askwellness.ca/housing-outreach/

Baral, S., Logie, C. H., Grosso, A., Wirtz, A. L., & Beyrer, C. (2013). Modified social ecological model: A tool to guide the assessment of the risks and risk contexts of HIV epidemics. *BMC Public Health, 13*(1), 482-482. doi:10.1186/1471-2458-13-482

BC Centre for Disease Control. (2015). *HIV in British Columbia: Annual Surveillance Report 2014*. Retrieved from http://www.bccdc.ca/util/about/annreport/default.htm

BC Housing. (2015a). *Subsidized Housing.* Retrieved from http://www.bchousing.org/Initiatives/Providing/Subsidized

BC Housing. (2015b). *Supportive housing for seniors and people with disabilities*. Retrieved from http://www.bchousing.org/Options/Supportive_Housing/SSH

Best, D., Day, E., McCarthy, T., Darlington, I., & Pinchbeck, K. (2008). The hierarchy of needs and care planning in addiction services: What Maslow can tell us about addressing competing priorities? *Addiction Research & Theory, 16*(4), 305-307. doi:10.1080/16066350701875185

Bourhis, J. (2017). Narrative Literature Review. Encyclopedia of Communication Research Methods. 2017. In Allen, M., *The SAGE Encyclopedia of Communication Research Methods*. (p. 1076-1077). Thousand Oaks, CA: SAGE Publications Ltd.

Boyatzis, R. E. (1998). *Transforming Qualitative Information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Brathen, R. & Bosnak, B. (2017, June 16). *Living with Asthma: Using Meditation to Heal and Learning How to Breathe @ From the Heart: Conversations with Yoga Girl*. Retrieved from http://rachelbrathen.com/podcast-2/

British Columbia Ministry of Health. (2012). *From Hope to Health: Towards an AIDS-free Generation*. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2012/from-hope-to-health-aids-free.pdf

Bryant, T. (2003). *The Current State of Housing in Canada as a Social Determinant of Health*. Montreal: Institute for Research on Public Policy.

Campbell, D. T. (1988). Evolutionary epistemology. In Radnitzky, G., & Bartley, W.W. (ed.), *Evolutionary epistemology, rationality, and the sociology of knowledge* (p. 47-90). LaSalle, IL: Open Court.

Canadian AIDS Society. (2008). *"Bring Me Home": The Canadian AIDS Society's Position on Housing and HIV/AIDS*. Retrieved from http://www.cdnaids.ca/files.nsf/pages/microsoftword-backgrounddocument-housingandhiv-aids/$file/Microsoft%20Word%20-%20Background%20Document%20-%20Housing%20and%20HIV-AIDS.pdf

Canadian Housing and Mortgage Corporation. (2014). *Housing in Canada Online*. Retrieved from http://cmhc.beyond2020.com/HiCODefinitions_EN.html#_Affordable_dwellings_1

Canadian Housing and Mortgage Corporation. (2012). *Rental Market Report Canada Highlights*. Retrieved from www.cmhc-schl.gc.ca/odpub/esub/64487/64487_2012_B01.pdf

Canadian Observatory on Homlessness. (2014). *Housing Support Workers*. Retrieved from http://homelesshub.ca/resource/housing-support-workers

Canadian Public Health Association. (2005). *Leading together: Canada takes action on HIV/AIDS, 2005-2010*. Ottawa: Canadian Public Health Association.

Canadian Rental Housing Index. (2016) *Community Profile, British Columbia.* Retrieved from http://rentalhousingindex.ca/

Carey, G., Crammond, B., & De Leeuw, E. (2015). Towards Health Equity: A framework for the application of proportionate universalism. *International Journal for Equity in Health, 14*, 81. doi:10.1186/s12939-015-0207-6

CATIE. (n.d). *HIV Basics*. Retrieved from http://www.catie.ca/en/basics/hiv-and-aids#what

Centre for Equality Rights in Accommodation. (2008). *Human Rights in Housing in Canada: An Advocate's Guide*. Retrieved from http://www.equalityrights.org/cera/docs/National%20Guide%20English%20Final.pdf

Centre for Housing Policy and Enterprise Community Partners (2007). *The Positive Impact of Affordable Housing on Health: A Research Summary*. Washington, DC: Centre for Housing Policy and Enterprise. Retrieved from www.nhc.org/media/documents/HousingandHealth1.pdf

Chambers, L. A., Greene, S., Watson, J., Rourke, S. B., Tucker, R., Koornstra, J., … The Positive Spaces Healthy Places Team. (2014). Not just "A roof over your head": The meaning of healthy housing for people living with HIV. *Housing, Theory and Society, 31*(3), 310-333. doi:10.1080/14036096.2014.897643

Charmaz, K. (2006). *Constructing Grounded Theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publication.

City of Vancouver. (2011). *Vancouver's Housing and Homelessness Strategy 2012-2021: A home for everyone*. Retrieved from http://vancouver.ca/files/cov/Housing-and-Homeless-Strategy-2012-2021pdf.pdf

Coburn, D., Denny, K., Mykhalovskiy, E., McDonough, P., Robertson, A., & Love, R. (2003). Population health in Canada: A brief critique. *American Journal of Public Health, 93*(3), 392-396. doi:10.2105/AJPH.93.3.392

Collins, A. B., Parashar, S., Closson, K., Turje, R. B., Strike, C., & McNeil, R. (2016). Navigating identity, territorial stigma, and HIV care services in Vancouver, Canada: A qualitative study. *Health & Place, 40*, 169-177. doi:10.1016/j.healthplace.2016.06.005

Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Los Angeles, CA: Sage Publications, Inc.

Cunningham, W. E., Andersen, R. M., Katz, M. H., Stein, M. D., Turner, B. J., Crystal, S., … Shapiro, M. F. (1999). The impact of competing subsistence needs and barriers on access to medical care for persons with human immunodeficiency virus receiving care in the United States. *Medical Care, 37*(12), 1270-1281. doi:10.1097/00005650-199912000-00010

Derose, K. P., Domínguez, B. X., Plimpton, J. H., & Kanouse, D. E. (2010). Project new hope: A faith-based effort to provide housing for persons with HIV/AIDS. *Journal of HIV/AIDS & Social Services, 9*(1), 90-105.

Després, C. (1991). The meaning of home: Literature review and directions for future research and theoretical development. *Journal of Architectural and Planning Research, 8*(2), 96-115.

Dickson-Gomez, J., Hilario, H., Convey, M., Corbett, A. M., Weeks, M., & Martinez, M. (2009). The relationship between housing status and HIV risk among active drug users: A qualitative analysis. *Substance Use & Misuse, 44*(2), 139-162. doi:10.1080/10826080802344823

Dieticians of Canada BC Region. (2012). *Cost of Eating in British Columbia 2011*. Retrieved from http://www.dietitians.ca/Downloads/Public/CostofEatingBC2011_FINAL.aspx

Dover, R. V. H., & Lambert, E. V. (2016). "Choice set" for health behavior in choice-constrained settings to frame research and inform policy: Examples of food consumption, obesity and food security. *International Journal for Equity in Health, 15*, 48. doi:10.1186/s12939-016-0336-6

Dowling, R. (1998). Gender, class and home ownership: Placing the connections. *Housing Studies, 13*(4), 471–486.

Druyts, E. F., Rachlis, B. S., Lima, V. D., Harvard, S. S., Zhang, W., Brandson, E. K., … Hogg, R. S. (2009). Mortality is influenced by locality in a major HIV/AIDS epidemic. *HIV Medicine, 10*(5), 274-281. doi:10.1111/j.1468-1293.2008.00684.x

Dunn, J. R., Canada Mortgage and Housing Corporation, & National Housing Research Committee (Canada). (2002). *The population health approach to housing: A framework for research*. Ottawa, ON: Canada Mortgage and Housing Corporation.

Dunn, J. R., & Hayes, M. V. (2000). Social inequality, population health, and housing: A study of two Vancouver neighborhoods. *Social Science & Medicine, 51*(4), 563-587. doi:10.1016/S0277-9536(99)00496-7

Dupuis, A., & Thorns, D. C. (1998). Home, home ownership and the search for ontological security. *The Sociological Review, 46*(1), 24-47. doi:10.1111/1467-954X.00088

Evans, R. G., & Stoddart, G. L. (1990). Producing health, consuming health care. *Social Science & Medicine, 31*, 1347–1363.

Fink, Arlene. (2013). *Evidence-Based Public Health Practice*. Thousand Oaks, CA: Sage Publications.

Flicker, S., & Nixon, S. A. (2015). The DEPICT model for participatory qualitative health promotion research analysis piloted in Canada, Zambia and South Africa. *Health Promotion International, 30*(3), 616-624. doi:10.1093/heapro/dat093

Fulcher, C., & Kaukinen, C. (2005). Mapping and visualizing the location HIV service providers: An exploratory spatial analysis of Toronto neighbourhoods. *AIDS Care, 17*(3), 386-96.

Gaetz, S. (2010). The struggle to end homelessness in Canada: How we created the crisis, and how we can end it. *The Open Health Services and Policy Journal, 3*, 21-26.

Gaetz, S., Dej, E., Richter, T., & Redman, M. (2016). *The State of Homelessness in Canada 2016*. Retrieved from http://homelesshub.ca/sites/default/files/SOHC16_final_20Oct2016.pdf

Galobardes, B., Shaw, M., Lawlor, D. A., Lynch, J. W., & Smith, G. D. (2006). Indicators of socioeconomic position (part 1). *Journal of Epidemiology and Community Health, 60*(1), 7-12. doi:10.1136/jech.2004.023531

Giddens, A. (1991) *Modernity and Self Identity: Self and Society in the Late Modern Age*. Cambridge: Polity Press.

Glaser, B. G., & Strauss, A. L. (2008). *The Discovery of Grounded Theory: Strategies for qualitative research*. New Brunswick: Aldine Transaction.

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.

Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., MacNaughton, E., Streiner, D. & Aubry, T. (2014). *National At Home/Chez Soi Final Report*. Calgary, AB: Mental Health Commission of Canada. Retrieved from https://www.mentalhealthcommission.ca/English/document/24376/national-homechez-soi-final-report

Greene, S., Chambers, L. A., Masinde, K., & O'Brien-Teengs, D. (2012). A House is Not a Home: The Housing Experiences of African and Caribbean Mothers Living with HIV. *Housing Studies, 28*(1), 116–134. doi:10.1080/02673037.2013.729269.

Greene, S., Tucker, R., Rourke, S. B., Monette, L., Koornstra, J., Sobota, M., . . . Watson, J. (2010). "Under My Umbrella": The housing experiences of HIV positive parents who live with and care for their children in Ontario. *Archives of Women's Mental Health, 13*(3), 223-232. doi:10.1007/s00737-009-0090-5

Grzywacz, J. G., & Fuqua, J. (2000). The social ecology of health: Leverage points and linkages. *Behavioral Medicine, 26*(3), 101-115. doi:10.1080/08964280009595758

Hacker, K. (2013). *Community-Based Participatory Research*. Thousand Oaks, CA: Sage Publication.

Hankivsky, O., Cormier, R., & de Merich, D. (2009). *Intersectionality: Moving women's health research and policy forward.* Vancouver, BC: Women's Health Research Network, Simon Fraser University. Retrieved from http://bccewh.bc.ca/publications-resources/documents/IntersectionaliyMovingwomenshealthresearchandpolicyforward.pdf

Henwood, B. F., Derejko, K., Couture, J., & Padgett, D. K. (2015). Maslow and mental health recovery: A comparative study of homeless programs for adults with serious mental illness. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(2), 220-228. doi:10.1007/s10488-014-0542-8

Herek, G. M. (1999). AIDS and Stigma. *American Behavioral Scientist, 42*(7), 1106-1116. doi:10.1177/0002764299042007004

Holtgrave, D. R., Briddell, K., Little, E., Bendixen, A. V., Hooper, M., Kidder, D. P., Wolitsky, R. J., Harre, D., Royal, S., & Aidala, A. (2007). Cost and Threshold Analysis of Housing as an HIV Prevention Intervention. *AIDS and Behavior, 11*, S162-S166.

Hwang, S. W., Aubry, T., Palepu, A., Farrell, S., Nisenbaum, R., Hubley, A. M., . . . Chambers, C. (2011). The health and housing in transition study: A longitudinal study of the health of homeless and vulnerably housed adults in three Canadian cities. *International Journal of Public Health, 56*(6), 609-623. doi:10.1007/s00038-011-0283-3

Inclusion Working Group & Canadian Observatory on Homelessness. (2015). *Homelessness is Only One Piece of My Puzzle: Implications for Policy and Practice*. Toronto, ON: The Homeless Hub Press.

Interagency Coalition on AIDS and Development & Rooftops Canada. (2010). *HIV, AIDS, and Housing Issues*. Retrieved from http://www.icad-cisd.com/pdf/Housing_Fact_Sheet_Final_EN.pdf

Israel, B. A., Coombe, C. M., Cheezum, R. R., Schulz, A. J., McGranaghan, R. J., Lichtenstein, R., & Burris, A. (2010). Community-based participatory research: A capacity-building approach for policy advocacy aimed at eliminating health disparities. *American Journal of Public Health, 100*(11), 2094-2102. doi:10.2105/AJPH.2009.170506

Israel, B. A., Schulz, A. J., Parker, E. A., Becker, A. B., Allen, A. J., & Guzman, A. R. (2003). Critical Issues in Developing and Following Community Based Participatory Research Principles. In Minker, M., & Wallerstein, N. (1st ed.), *Community-based participatory research for health: From process to outcomes* (p. 53-76). San Francisco, CA: Jossey-Bass.

Joint United Nations Programme on HIV/AIDS (UNAIDS). (2014). *90-90-90: An ambitious treatment target to help end the AIDS epidemic*. Retrieved from http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

Jones, E. (2013). *Positive Living, Positive Homes: Navigating HIV and Housing Policies and Programs in British Columbia*. (Unpublished research proposal). University of Victoria.

Karjalainen, P.T. (1993). House, home and the place of dwelling. *Scandinavian Housing & Planning Research, 10*, 65–74.

Kearns, A., Hiscock, R., Ellaway, A., & Macintyre, S. (2000). 'Beyond Four Walls': The Psycho-social benefits of home: Evidence from west central Scotland. *Housing Studies, 15*(3), 387.

Kindon, S. L., Pain, R., & Kesby, M. (2007a). Introduction: Connecting people, participation, and place (Chapter 1). In *Participatory Action Research Approaches and Methods.* London: Routledge.

Kindon, S. L., Pain, R., & Kesby, M. (2007b). Participatory Action Research: Origins, approaches and methods (Chapter 2). In *Participatory Action Research Approaches and Methods*. London: Routledge.

Krieger, J., & Higgins, D. (2002). Housing and health: Time again for public health action. *American Journal of Public Health, 92*(5), 758-768.

Laing, R. D. (1965). *The divided self: An existential study in sanity and madness*. London: Pelican Press.

Laing, R. D. (1969). *Self and Others* (2nd ed.). London: Tavistock Publications.

Last, J. (2002). Health. In Breslow, L. (ed.), *Encyclopedia of Public Health* (p. 519-526). New York: Macmillan.

Leaver, C., Bargh, G., Dunn, J., & Hwang, S. (2007). The Effects of Housing Status on Health-Related Outcomes in People living with HIV: A Systematic Review of the Literature. *AIDS and Behavior, 11*, S85–S100. doi 10.1007/s10461-007-9246-3

Lee, M. (2016). *Housing budget? Not so much.* Retrieved from www.policynote.ca/housing-budget-not-so-much

Lima, V. D., Druyts, E., Montaner, J. S. G., & Hogg, R. S. (2010). Regional and temporal trends in migration among people living with HIV/AIDS in British Columbia, 1993-2005. *Canadian Journal of Public Health / Revue Canadienne De Sante'e Publique, 101*(1), 44-49.

Loutfy, M., Tyndall, M., Baril, J., Montaner, J. S., Kaul, R., & Hankins, C. (2014). Canadian consensus statement on HIV and its transmission in the context of criminal law. *The Canadian Journal of Infectious Diseases & Medical Microbiology, 25*(3), 135.

Macintyre, S., Ellaway, A., & Cummins, S. (2002). Place effects on health: How can we conceptualise, operationalise and measure them? *Social Science & Medicine, 55*(1), 125-139. doi:10.1016/S0277-9536(01)00214-3

Macintyre, S., Ellaway, A., Hiscock, R., Kearns, A., Der, G., & McKay, L. (2003). What features of the home and the area might help to explain observed relationships between housing tenure and health? *Health & Place, 9*, 207–218.

Mahamoud, A., Gardner, B., & Roche, B. (2012). *Housing and health: Examining the links.* Toronto, ON: Wellesley Institute.

Mallett, S. (2004). Understanding home: A critical review of the literature. *The Sociological Review, 52*(1), 62-89. doi:10.1111/j.1467-954X.2004.00442.x

Marmot, M. (2005). The social environment and health. *Clinical Medicine, Journal of the Royal College of Physicians, 5*(3), 244-248. doi:10.7861/clinmedicine.5-3-244

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review, 50*(4), 370-96.

Masquillier, C., Wouters, E., Mortelmans, D., van Wyk, B., Hausler, H., & Van Damme, W. (2016). HIV/AIDS Competent Households: Interaction between a Health-Enabling Environment and Community-Based Treatment Adherence Support for People Living with HIV/AIDS in South Africa. *PLoS ONE 11*(3), e0151379. doi:10.1371/journal.pone.0151379

McLaren Housing Society. (n.d.). *What We Do*. Retrieved from http://mclarenhousing.com/what-we-do/

McLeod, S. A. (2017). *Maslow's Hierarchy of Needs.* Retrieved from www.simplypsychology.org/maslow.html

McMahon, J., Wanke, C., Terrin, N., Skinner, S., & Knox, T. (2011). Poverty, Hunger, Education, and Residential Status Impact Survival in HIV. *AIDS and Behavior, 15*(7), 1503-1511.

Mikkonen, J., & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts*. Toronto, ON: York University School of Health Policy and Management.

Mill, J., & Canadian Aboriginal AIDS Network. (2007). *The influence of stigma on access to health services by persons with HIV illness: Final report*. Ottawa, ON: Canadian Aboriginal AIDS Network. Retrieved from http://www.caan.ca/wp-content/uploads/2012/05/The-Influence-of-Stigma-on-Access-to-Health-Services-by-Persons-with-HIV-Illness.pdf

Milloy, M. J, Marshall, B. D. L., Montaner, J., & Wood, E. (2012). Housing status and the health of people living with HIV/AIDS. *Current HIV/AIDS Reports, 9*(4), 364-374. doi:10.1007/s11904-012-0137-5

Moloughney, B., Canadian Population Health Initiative, & Canada Mortgage and Housing Corporation. (2004). *Housing and population health: The state of current research knowledge*. Ottawa, ON: Canadian Institute for Health Information

Montaner, J. S., Hogg, R., Wood, E., Kerr, T., Tyndall, M., Levy, A. R., & Harrigan, P. R. (2006). The case for expanding access to highly active antiretroviral therapy to curb the growth of the HIV epidemic. *The Lancet, 368*(9534), 531-536. doi:10.1016/S0140-6736(06)69162-9

Niagara Region. (1997). *Report on Homelessness in Niagara*. Fronthill, ON: Niagara District Health Council.

Pacific AIDS Network. (2016) *Community Based Research*. Retrieved from http://pacificaidsnetwork.org/resources/cbr/

Préau, M., Vincent, E., Spire, B., Reliquet, V., Fournier, I., Michelet, C., . . . APROCO study group. (2005). Health-related quality of life and health locus of control beliefs among HIV-infected treated patients. *Journal of Psychosomatic Research, 59*(6), 407-413. 10.1016/j.jpsychores.2005.06.005

O'Brien, C. (2011). *Fast Facts: The expiration of operating agreements in social housing.* Retrieved from https://www.policyalternatives.ca/publications/commentary/fast-facts-expiration-of-operating-agreements-social-housing

Ontario Human Rights Commission. (n.d). I*n the Zone: Housing, Human Rights and Municipal Planning.* Retrieved from http://www.ohrc.on.ca/en/zone-housing-human-rights-and-municipal-planning

Pacific AIDS Network. (2007). *Pacific AIDS Network Forum and Annual General Meeting*. Proceedings: Forum and Annual General Meeting.

Padgett, D. K. (2012). *Qualitative and Mixed Methods in Public Health*. Thousand Oaks, CA: Sage Publication.

Padgett, D. K. (2007). There's no place like (a) home: Ontological security among persons with serious mental illness in the United States. *Social Science & Medicine, 64*(9), 1925-1936. doi:10.1016/j.socscimed.2007.02.011

Parashar, S. (2014). *"The Way I See it": Towards a community-informed understanding of the relationship between housing and health among people living with HIV in Vancouver, BC.* Retrieved from Summit, the Institutional Research Repository at SFU.

Patterson, M., Somers, J., Mcintosh, K., Sheill, A., & Frankish, J. (2008). *Housing and Support for Adults with Severe Addictions and/or Mental illness in British Columbia.* Vancouver, BC: Centre For applied Research in Mental Health and Addiction and Simon Fraser University.

Public Health Agency of Canada (2015a). *Population-Specific HIV/AIDS Status Report: People Living with HIV/AIDS*. Retrieved from http://www.phac-aspc.gc.ca/aids-sida/publication/ps-pd/people-personnes/chapter-chapitre-4-eng.php#a4-2

Public Health Agency of Canada (2015b). *Summary: Estimates of HIV Incidence, Prevalence and Proportion Undiagnosed in Canada, 2014.* Surveillance and Epidemiology Division, Professional Guidelines and Public Health Practice Division, Centre for Communicable Diseases and Infection Control. Retrieved from http://www.catie.ca/sites/default/files/2014-HIV-Estimates-in-Canada-EN.pdf

QSR International. (n.d). *NVivo*. Retrieved from http://www.qsrinternational.com/nvivo/support-overview/downloads

Raphael, D. (2004). *Social determinants of health: Canadian perspectives.* Toronto, ON: Canadian Scholars' Press.

Raphael, D. (2000). The question of evidence in health promotion. *Health Promotion International, 15*, 355–367.

Reason, P., & Bradbury, H. (2008;2007;2012;). *The sage handbook of action research: Participative inquiry and practice* (2nd ed.). Thousand Oaks, California; London, SAGE Publications.

Rhodes, T. (1997). Risk theory in epidemic times: Sex, drugs and the social organisation of 'risk behaviour'. *Sociology of Health and Illness, 19*(2), 208-227. doi:10.1111/1467-9566.ep10934410

Robertson, L. (2007). Taming space: Drug use, HIV, and homemaking in Downtown Eastside Vancouver. *Gender, Place & Culture, 14*(5), 527-549. doi:10.1080/09663690701562198

Rohe, W. M., & Han, H. (2012). Housing and Health: Time for renewed collaboration. *North Carolina Medical Journal, 73*(5), 374.

Rourke, S. B., Bekele, T., Tucker, R., Greene, S., Sobota, M., Koornstra, J., & Positive Spaces Healthy Places Team. (2012). Housing characteristics and their influence on health-related quality of life in persons living with HIV in Ontario, Canada: Results from the positive spaces, healthy places study. *AIDS and Behavior, 16*(8), 2361-2373. doi:10.1007/s10461-012-0284-0

Ryan, G. W., & Bernard, H. R. (2000). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed., pp. 769-802). Thousand Oaks, CA: Sage.

Rykwert, J. (1991). House and home. *Social Research, 58*(1), 51-62.

Scott, A., Ellen, J., Clum, G., & Leonard, L. (2007). HIV and housing assistance in four U.S. cities: Variations in local experience. *AIDS and Behavior, 11*(S2), 140-148. doi:10.1007/s10461-007-9247-2

Shaw, M. (2004). Housing and public health. *Annual Review of Public Health, 25*(1), 397-418. doi:10.1146/annurev.publhealth.25.101802.123036

Shubert, G. (2010). *Evidence into Action: Housing is HIV Prevention and Care*. [Presentation for North American Housing and HIV/AIDS Research Summit]. Retrieved from http://www.hivhousingsummit.org/Program/0915ShubertJune3.pdf

Shubert, V., & Bernstine, N. (2007). Moving from fact to policy: Housing is HIV prevention and health care. *AIDS and Behavior, 11*(S2), 172-181. doi:10.1007/s10461-007-9305-9

Singer, M., & Clair, S. (2003). Syndemics and public health: Reconceptualizing disease in bio-social context. *Medical Anthropology Quarterly, 17*(4), 423-441. doi:10.1525/maq.2003.17.4.423

Sixsmith, J. (1986). The meaning of home: An exploratory study of environmental experience. *Journal of Environmental Psychology, 6*, 281-298.

Smith, S. G. (1994). The essential qualities of a home. *Journal of Environmental Psychology, 14*(1), 31-46. 10.1016/S0272-4944(05)80196-3

Social Housing BC. (2014). *Social Housing Now!* Retrieved from http://www.socialhousingbc.com

Somerville, P. (1997). The Social Construction of Home. *Journal of Architectural and Planning Research, 14*(3), 226–245.

Stajduhar, K. I., & Lindsey, E. (1999). Home away from home: Essential elements in developing housing options for people living with HIV/AIDS. *AIDS Patient Care and STDs, 13*(8), 481-491. doi:10.1089/108729199318219

Statistics Canada. (2017). *Housing Highlight Tables*. Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/housing-logement/Table.cfm?Lang=E&T=12&Geo=59

Statistics Canada. (2017). *National Household Survey*. Retrieved from http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/fogs-\spg/Pages/FOG.cfm?lang=E&level=2&GeoCode=59

Stead, M., MacAskill, S., MacKintosh, A. M., Reece, J., & Eadie, D. (2001). "It's as if you're locked in": Qualitative explanations for area effects on smoking in disadvantaged communities. *Health & Place, 7*(4), 333.

Strauss, A., & Corbin, J. (1990). *Basics of Qualitative Research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

The National AIDS Housing Coalition (2005). *Housing is the Foundation of HIV Prevention and Treatment: Results of the National Housing and HIV/AIDS Research Summit*. Retrieved from http://www.nationalaidshousing.org/PDF/Housing%20&%20HIV-AIDS%20Policy%20Paper.pdf

The Ontario HIV Treatment Network. (2016). *Positive Spaces Healthy Places*. Retrieved from http://www.ohtn.on.ca/socialdrivers/positive-spaces-healthy-places/

Thomson, M. (2016). *Vancouver Homeless Count 2016*. Retrieved from http://vancouver.ca/files/cov/homeless-count-2016-report.pdf

Ticknor, J., Belle-Isle, L., Gibson Library Connections, I., & Canadian AIDS Society. (2010). *HIV and housing: Toward a national housing strategy: A discussion paper.* Ottawa, ON: Canadian AIDS Society.

Tucker, R. (2009). Housing. In Canadian AIDS Treatment Information Exchange (4th Eds.), *Managing Your Health* (Chapter 22). Retrieved from http://www.catie.ca/en/practical-guides/managing-your-health/22

Vancity. (2015). *Help wanted: salaries, affordability and the exodus of labour from Metro Vancouver*. Retrieved from https://www.vancity.com/SharedContent/documents/News/Help_Wanted_May_2015.pdf

Wahba, M. A., & Bridwell, L. G. (1976). Maslow reconsidered: A review of research on the need hierarchy theory. *Organizational Behavior and Human Performance, 15*(2), 212-240.

Wardhaugh, J. (1999). The Unaccommodated Woman: Home, Homelessness and Identity. *Sociological Review, 47*(1), 91–109.

Williamson, K. (2004). *AIDS, Gender and the Refugee Protection Framework: Working Paper series*. Oxford, UK: International Development Centre, University of Oxford.

Wings Housing Society. (n.d.). *About the Society*. Retrieved from http://www.wingshousing.bc.ca/about.htm

Wolitski, R. J., Kidder, D. P., & Fenton, K. A. (2007). HIV, homelessness, and public health: Critical issues and a call for increased action. *AIDS and Behavior, 11*(S2), 167-171. doi:10.1007/s10461-007-9277-9

World Health Organization. (2010). *Developing guidance for health protection in the built environment - mitigation and adaptation responses*. Retrieved from http://www.who.int/hia/house_report.pdf?ua=1

World Health Organization. (1948). *Preamble to the Constitution of the World Health Organization as Adopted by the International Health Conference*. New York: Official Records of the World Health Organization.

World Health Organization. (1986). *The Ottawa Charter for Health Promotion*. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html

Wright, E. R., & Carnes, N. (2016). *Understanding the HIV/AIDS epidemic in the United States: The role of syndemics in the production of health disparities*. Switzerland: Springer. doi:10.1007/978-3-319-34004-3

APPENDICES

Appendix A

Housing characteristics of the sample.

Order	Participant Number	Current Living Situation	Satisfaction with Current Living Situation	Neighbourhood/ Postal Code	Experience Living in Shelter/ Street/ SRO
1)	GV011110a	Bachelor unit in subsidized rental unit in BC housing building	Yes (“not moving”)	V6A	Yes
2)	GV020101a	1 bdrm market rental	Yes	V6E	No
3)	GV031110a	1 bdrm rarket rental	Wants apt with boyfriend	V3W	Yes
4)	GV031130a	1 bdrm market rental with McLaren portable subsidy	Yes (“not moving”)	V2X	Yes
5)	GV321101a	Staying in family’s rental accommodation	Wants to move out of mom’s place	V7C	Yes
6)	GV412110a	Bachelor unit in McLaren Supportive Housing	Wants to move from a bachelor to 1 bedroom	V6Z	Yes
7)	GV421101a	1 bdrm unit in McLaren Housing Building	Yes	V6B	No
8)	GV421121a	3 bdrm rental unit in Wings Building	Wants 4 bdrm rental unit (w/ portable subsidy)	V5E	Yes
9)	GV428090a	Street	Wants rental unit with McLaren/HIV specific housing	V3T	Yes
10)	GV910121a	Bachelor unit in Dr. Peter’s Enhanced Supportive Living building	Yes	V6E	No

Appendix B

Housing and HIV service organizations referenced in Figures 1 and 2.

Geographical Point on Map	Name of Organization	Address of Organization
1	BC Housing	4555 Kingsway #101, Burnaby, BC V5H 4V8
2	McLaren Housing Society	200-649 Helmcken St., Vancouver, BC V6B 5R1
3	The Heart of Richmond	200-6411 Buswell St., Richmond, BC V6Y 2G5
4	Dr. Peter Centre	1110 Comox St, Vancouver, BC V6E 1K5
5	Positive Living Society of British Columbia	1101 Seymour St, Vancouver, BC V6B 0R1
6	St. Paul's Hospital	1081 Burrard St, Vancouver, BC V6Z 1Y6
7	BC Native Housing Corporation	281 Holdom Ave, Burnaby, BC V5B 3T9
8	The Vancouver Friends For Life Society	1459 Barclay St, Vancouver, BC V6G 1J6
9	Wings Housing Society	1041 Comox St, Vancouver, BC V6E 1K1
10	YouthCO	205-568 Seymour St, Vancouver, BC V6B 3K4
11	Positive Women's Network Society	1033 Davie St, Vancouver, BC V6E 1M7
12	Covenant House Vancouver	326 W Pender St, Vancouver, BC V6B 1T1
13	AIDS Vancouver	1107 Seymour St, Vancouver, BC V6B 5S8
14	Lookout Emergency Aid Society	346 Alexander Street, Vancouver, BC V6A 1C3
15	Surrey North Community Home	10697 135A St, Surrey, BC V3T 4E3
16	BC Women's Hospital, Oak Tree Clinic	4500 Oak St, Vancouver, BC V6H
17	Three Bridges Clinic	1292 Hornby St, Vancouver, BC V6Z 1W4
18	A Loving Spoonful	1449 Powell St, Vancouver, BC V5L 1G8
19	Vancouver Native Health Society	455 Hastings St E, Vancouver, BC V6A 1P5
20	Surrey Memorial	13750 96 Ave, Surrey, BC V3V 1Z2

21	Gathering Place Community Centre	609 Helmcken St, Vancouver, BC V6B 5R1
22	Union Gospel Mission	601 E Hastings St, Vancouver, BC V6A 1J7
23	The Front Room/Positive Haven, Lookout Society	10667 135a St, Surrey, BC V3T 4E3
24	Surrey Urban Mission Society	10776 King George Hwy, Surrey, BC V3T