

Research Article

Evaluating Facilitators' Experience Delivering a Stress-Reducing Intervention for Indigenous Women with and without HIV

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Indigenous women encounter increased stressful life experiences such as socioeconomic insecurities as well as inequities in health services and outcomes. These stress inequities, which stem from the historical and ongoing effects of settler colonialism, also worsen health outcomes for those women living with HIV. As a part of a broader research project on the impacts of stress-reducing interventions for indigenous women, this study examines the experiences of the women who facilitated the intervention. This research was conducted to evaluate the impacts of a biweekly stress-reducing intervention conducted in Thunder Bay, Ontario. The facilitators of the intervention participated in a focus group in 2019 where they detailed the reach, effectiveness, adoption, and implementation of the intervention. The results suggest that effective stress-reducing interventions should strive to be accessible and inclusive and that doing so can increase program engagement with the service organization hosting the intervention. Further, the results highlight the strengths and challenges of the intervention, including how it helped foster leadership skills and increased indigenous cultural learning among facilitators. These findings demonstrate the strength of community-led interventions and subsequent opportunities for facilitators to grow as leaders. Further, the study highlights how this style of intervention can also encourage participants to engage in other health and wellbeing programs offered by the community partner hosting the intervention. These findings suggest that interventions aimed at reducing stress among indigenous women facing socioeconomic insecurities, including those living with HIV, are both feasible and beneficial for participants, facilitators, and the nonprofit service organizations delivering them.

1. Introduction

The ongoing effects of settler colonialism and the embedded systemic discrimination therein contribute to inequities in health service and outcomes among indigenous people living in Canada. Indigenous people also encounter increased health-related stressful life experiences such as socioeconomic insecurities related to housing, food, income, employment, and education [1]. These insecurities can translate to a higher incidence of disease, such that one study evaluating mortality among First Nations adults in Canada and nonindigenous showed avoidable causes (e.g., diabetes, substance disorders, and unintentional injuries) contributed to two times higher mortality rates among First Nations persons compared to nonindigenous persons [2]. For indigenous women, these health inequities are often exacerbated by gender-related impacts of intergenerational trauma, where indigenous women experience higher rates of childhood sexual, physical, and emotional abuse including adverse parenting experiences (e.g., neglect, parental substance use, foster care, and the trauma of residential school) [3–6].

These inequities and experiences are also linked to increased rates of HIV and the overrepresentation of indigenous women among those with the disease [2, 7, 8]. For example, 11.3% of all new HIV infections are among indigenous people despite the fact that they make up less than 5% of the national population [9]. Further, a study of those living with HIV in Ontario found that people living with HIV were more likely to be female or trans women, younger, have lower educational attainment, unemployed, homeless or unstably housed, and experienced housing-related discrimination [10]. The overrepresentation of indigenous women among those living with HIV is compounded by their increased likelihood to experience stressful life events. The interplay between HIV and stress can contribute to the progression of mental illness and other chronic diseases [11–16] while stress-reducing interventions have been shown to reduce anxiety, distress, and cortisol levels while improving mood among participants [17–19].

Given the connection between stress, mental health, and HIV progression [10, 20] and the related outcomes among indigenous women, this research seeks to understand how a stress-reducing intervention can be implemented in community settings. As a part of the broader Indigenous Women's Stress Study (IWSS), this research examined the feasibility and utility of a culturally inclusive intervention aimed at reducing stress levels and improving the overall wellbeing of indigenous women in Ontario, including but not limited to those living with HIV. Looking to the experiences of the women who facilitated the intervention over a six-month period, this analysis highlights their perspectives.

While the broader IWSS aimed to describe indigenous women's life stressors and measure changes in stress through salivary biomarkers and questionnaires, this aspect of the project looked to evaluate this culturally inclusive stress-reducing intervention. Following the implementation of the twice-weekly intervention in Thunder Bay, Ontario, our

team conducted a focus group to elicit feedback from the facilitators. The objective was to evaluate the intervention to better understand the experiences of facilitators, how they described the program's strengths and challenges, and the extent to which the intervention was seen as being feasible and useful in a real-world setting as a part of community programming through a nonprofit service organization. To achieve this, the study broadly employed the RE-AIM (reach, effectiveness, adoption, implementation, and maintenance) Implementation and Evaluation framework [21]. This framework is used to evaluate research interventions, particularly prevention and health behaviour change programs and provide internal and external validity perspectives [21].

2. Methods

2.1. Study Design. The Indigenous Women's Stress Study was a single-arm intervention trial that was delivered bi-weekly to indigenous women living in Thunder Bay, Canada, over six months. Participants of the intervention were led through the program by a group of facilitators who are themselves the focus of this portion of the analysis. These facilitations led the intervention, which was comprised of three components. The first component was a 15-minute relaxation technique known as autogenic training which consisted of repeating a set of visualization statements focused on the sensation of feeling calm, warm, or heavy. Following this, participants engaged in the second component, which was an educational and strength-based activity. Examples of the 13 activities included reclaiming ancestral foods, emotional self-regulation and attachment, healthy sexuality and ceremonies, traditional dancing, drumming, the effects of stress, stress management, learning Cree syllabics, and naloxone training. The educational and strength-based activities were developed alongside community partners, and many were rooted in cultural identity. This particular aspect of the intervention is to account for the positive role that cultural continuity can play in health outcomes for indigenous people [22]. Facilitators of the intervention included Indigenous Cultural and Healing Practitioners, Knowledge Carriers including Elders and Helpers, Clinical Psychologist (a guest speaker), and Research Assistants with dual roles as Outreach Workers. The final component of each biweekly session was a 20–45-minute guided imagery relaxation exercise which was designed and guided by elders or indigenous healing practitioners. The exercise included stimulating or recreating perception of sights, sounds, tastes, smell, movement, and/or touch to conjure pleasant images of past or new experiences with the occasional use of cultural tools (e.g., drum or rain stick) to induce relaxation.

2.2. Recruitment. Focus group participants were recruited through two community partners, nonprofit service organizations in Thunder Bay. The indigenous community partner's office is located within the nonindigenous organization. Eligible participants for this aspect of the study

were facilitators from one of the four periods when the intervention was delivered between May 2017 and May 2019. Eligibility to act as facilitators included local community members who have worked within the organization, which itself worked directly with indigenous women living with HIV. Facilitators of the intervention included staff from the community partners hosting the intervention: a community developer and an elder as well as the lead research assistant. Two former intervention participants were also recruited; one as a facilitator and helper to the elder to foster mentorship and ownership over the intervention, and the other as a research assistant who subsequently began working as an Outreach Worker for the community partners. The research assistants provided feedback on the design of the intervention and administered the intervention, inviting local guests to facilitate some sessions and collect data from study participants. The facilitators' roles included designing and running the cultural activities, leading the guided imagery and relaxation sessions, and ensuring group cohesion. As the intervention itself was in indigenous culture for indigenous women, all facilitators were indigenous women themselves, one of which was living with HIV. This community-led component is critical to the intervention and has been highlighted in related literature on community programming [22–24]. All of these facilitators were invited to participate in the focus group portion of the study, with five facilitators agreeing to take part.

2.3. Measures. As mentioned above, measuring evaluators' experience highlights the organization-level changes as made clear through the RE-AIM Framework [21]. Typically, "Reach" and "Effectiveness" evaluate dimensions at the individual level, such as who the participants are in the intervention (i.e., reach) and whether the intervention reduced their stress levels (i.e., effectiveness). These measures are intended to be collected from participants recruited into the intervention itself. For this facilitator-focused aspect of the study, however, reach is examined at the organizational level and is characterized as the (re)engagement of participants at the study site (the nonprofit service organization) beyond the intervention and perceived effectiveness of the intervention to reduce stress among the facilitators' participants. The "Adoption" (e.g., interest of the intervention by external groups) and "Implementation" (e.g., changes from research to real-world settings such as delivery, use of resources, and costs) components are measured at the organizational level. "Maintenance" refers to more long-term implications, so this aspect of evaluation is not captured in the design of the focus group questionnaire or in the data analysis.

2.4. Data Collection. Data collection occurred through a 1-hour focus group in June 2019 with all five facilitators who led the intervention throughout the 2017–2019 study. The focus group guide was grounded in the RE-AIM framework. "Reach" questions focused on understanding who participated in the intervention, and how facilitators observed retention and drop-off rates. The "Effectiveness" aspect

included questions relating to facilitators' views on changes in stress for their participants and changes in leadership capacity for facilitators and participants alike. The "Adoption" component was covered by questions that asked about how the intervention was used by the nonprofit organization and whether the facilitators saw any further adoption of some of the activities among their colleagues. This mirrored the "Implementation" questions that focused on the actual intervention of activities, how they were facilitated, costs and consistency in delivering the intervention, and any challenges associated with specific aspects of the intervention. As noted above, "Maintenance" refers to more longterm implications, so this aspect of evaluation is not captured in the design of the questionnaire or in the data analysis.

2.5. Data Analysis. All data gathered during the focus groups were audio recorded and transcribed verbatim. Consistent with recommendations by Onwuegbuzie et al. [25] for analyzing focus group data, we employed Strauss and Glazer's [26] constant comparison and followed their three stages of analysis. In the first stage, open coding was employed and referred to "the part of analysis that pertains specifically to the naming or categorizing of phenomena through close examination of data" ([26], p. 62). In this first step, we grouped smaller units of our data that expressed similar properties and assigned a code (e.g., friendship, accessibility, and stigma reduction). In the second stage of coding-axial coding-we grouped the codes "back together in new ways by making connections between a category and its subcategories" ([26], p. 97); italics in original). In the final stage-selective coding-a theme was developed to highlight the content of each group. Selective coding is the process of "selecting the core category, relating it to other categories, validating those relationships, and filling in categories that need further refinement and development" ([26], p. 116). This three-stage process also included a team-based analysis where individual codes were collected from coauthors to assess for consistency in categorizations. To further ensure the trustworthiness of the findings, as the paper was finalized, we sought out focus group participants who were also coauthors to assess the validity of the analysis. This helped to account for the nature of data collected in a group setting, where focus group participants may echo one another or not be as forthcoming with negative responses. The analysis was also done keeping in mind repeat comments or when focus group participants had either shared or discrepant views.

3. Results

Guided by the semistructured focus group guide, the coding and thematic analysis examined subthemes across the three main groupings: (1) reach, (2) effectiveness, and (3) implementation and adoption of the intervention. In keeping with the RE-AIM framework, the results highlight the extent to which the facilitators felt that the intervention encouraged growth at the nonprofit service organization and re-engagement with participants. Further, the analysis shed light on how the intervention was implemented, the degree

to which it could be adapted to real-world community settings, and how indigenous culture was embedded in programming. Finally, the coding demonstrated the impacts of the intervention on the nonprofit service organization and the skill development of the facilitators. A summary of the results with select quotes is displayed in Table 1.

3.1. Demographics. These facilitators included local women, including a community developer, two research assistants, an elder, and a helper. The demographic characteristics of the facilitators varied by age and socioeconomic status, but all five of the facilitators were previously engaged with the nonprofit community organization and four were hired as staff. One woman is living with HIV, all the women were caregivers of children aged <18 years. The in-person focus group was led by a student research assistant, who was not involved in the design and delivery of the intervention or participant-related research activities in Thunder Bay.

3.2. Reach. This aspect of the results' highlights the reach of the intervention in terms of how the nonprofit service organization developed further ways to incorporate indigenous culture and re-engagement with participants.

3.2.1. Organizational Community Building. For the community partner that hosted the biweekly intervention in Thunder Bay, the sessions drove engagement and built trust within the community. The community organization had also been actively looking to implement changes in response to the health-related calls to action in the Truth and Reconciliation Commission's Final Report (2015). The organization also saw participants returning for the site's other program offerings and services, including health clinic appointments. The intervention has also informed the content of other programming and research activities at the organization. For example, the facilitators described including intervention content in the programs they are responsible for delivering.

"Well, we've had people that were involved in this study who were maybe not members [of the nonprofit service organization] at the time, but they have since become members, or who come to our monthly women's clinic where I maybe didn't see them much before."

"I've also seen another facilitator here, [name], use auto-genic training or mindfulness for groups, I've seen the crafts come out, I've seen a lot of different things."

Furthermore, the intervention reaffirmed facilitators' commitment to incorporating indigenous ways of knowing and doing into their daily practices, noting that education and sharing knowledge can come in many forms.

"Doing a craft is just as educationally valuable as, like, having a presentation on a particular topic, and sometimes more valuable because of the informal learning that comes

out of that. So, I think it expanded our... the scope of what's possible in the work that we do. And what's valuable."

Overall, facilitators echoed each other in confirming that the reach of the intervention resulted in participants joining other programs or accessing other services at the nonprofit, something that has been noted as a priority in other organizations offering indigenous cultural programming [27].

3.2.2. Connections. The facilitators also drew attention to the friendships and connections built during the intervention, noting many intervention participants looked forward to seeing other participants both inside and outside of the regular sessions. Facilitators even noted how participants would arrive early and discuss spending time with other participants outside of the intervention.

"We [a facilitator who was a former participant] looked forward to coming to the meetings every other Thursday and coming early just so I can connect with them and see them all."

3.2.3. Stigma Reduction. Analysis of the focus group transcript also reveals the extent to which the intervention helped to reduce HIV-related stigma among both participants and facilitators. For the facilitator living with HIV, they discussed that leading the intervention and "seeing others (with HIV) living well" was a positive takeaway. All facilitators also observed reduced changes in perceived levels of stigma among their participants without HIV and shifts in comfort among those participants living with HIV. These results highlight the benefits of the group dynamic and the connection and trust built amongst community members throughout the course of the intervention.

"Like it was, it actually eliminated the stigma for the [HIV] positive women, actually, and probably the women who are not living with HIV."

"And I think it's given some of the women, some of the [HIV] positive women, like a lot more confidence to talk about it [HIV], to be open and to be that role model for other people."

3.3. Effectiveness. This section of results demonstrates how the programming impacted the nonprofit service organization and facilitator development.

3.3.1. Facilitator Development. Facilitators described increased leadership capacity and improved facilitation skills as key impacts on the service organization. They experienced improved confidence in their leadership and technical skills, increased ability to navigate difficult conversations, and skills development as a member of both the research and nonprofit teams.

TABLE 1: Summary of results by theme and subtheme with select quotes.

Reach	Organizational Community Building	<p>“I’ve also seen another facilitator here, (name), use autogenic training or mindfulness for groups, I’ve seen the crafts come out, I’ve seen a lot of different things.”</p> <p>“We looked forward to coming to the meetings every other Thursday and coming early just so I can connect with them and see them all.”</p> <p>“Like it was, it actually eliminated the stigma for the (HIV) positive women, actually, and probably the women who aren’t living with HIV.”</p>
Effectiveness	Facilitator development	<p>“I didn’t think (cries) that I could be in that role (of facilitator). So, it was empowering to know that I can do this, and people trust me.”</p>
	Participant development	<p>“But there’s always a leader (participant) in the group that would show somebody else how to have techniques or (laughing) make fun of me (a facilitator) for not having some.”</p>
	Knowledge carrier development	<p>“I would get some of the participants, when we were doing the smudging, to get them to do the smudging on their own.”</p>
Adoption + implementation	Accessibility	<p>“Sometimes activities maybe weren’t a good fit, or the skill level was, the expectation was a little too high, so we would modify to make things a little bit easier.”</p>
	Connecting to indigenous culture	<p>“I enjoyed doing the outings, getting connected with the land and nature and, for me it makes me feel good when other people are enjoying themselves.”</p>
	Challenges for the nonprofit	<p>“Um, to be really forthcoming I struggled with the honorarium . . . it was not enough money, and it was also too much. And it’s just, it’s just how it goes with research.”</p>

“I didn’t think [cries] that I could be in that role [of facilitator]. So, it was empowering to know that I can do this, and people trust me.”

3.3.2. Participant Development. Facilitators (those who led the intervention and participated in the focus group) also observed how the intervention participants (indigenous women including those living with HIV undergoing the intervention) displayed improved leadership and communication skills, increased confidence, and newfound social ease. The facilitators highlighted how intervention activities also allowed for participants to function as leaders (i.e., cultural roles as helpers and typical research roles such as research assistants and facilitators) throughout different activities, further fostering a sense of empowerment among the women.

“But there’s always a leader [participant] in the group that would show somebody else how to have techniques or [laughing] make fun of me [a facilitator] for not having some.”

3.3.3. Knowledge Carrier Development. An elder, acting as one of the facilitators, also discussed the degree to which the intervention helped with the development of their own leadership skills. Beyond leading activities and ceremonies, they also highlighted their growth as “mentors” and opportunities to pull the intervention participants out of their comfort zone or help to encourage them as leaders in their own right.

“I would get some of the participants, when we were doing the smudging, to get them to do the smudging on their own.”

3.4. Implementation and Adoption. This final aspect of the results speaks to how the intervention was implemented, the degree to which it could be adopted in a real-world community setting, and how indigenous culture was embedded in programming.

3.4.1. Accessibility. The facilitators highlighted the accessibility of the intervention and how relatively low barriers made for increased participation. Within this subtheme, facilitators and an elder highlighted a focus on “meeting people where they are” and providing meals and covering any costs associated with activities. This included ensuring that the intervention was adaptable, including considerations to physical limitations and skill levels, and looking to participants for direction on activities and any changes needed as challenges arose.

“I think if we ever did [change activities] it was just to go with the flow or to meet people’s schedules.”

“Sometimes activities maybe were not a good fit, or the skill level was, the expectation was a little too high, so we would modify to makes things a little bit easier.”

“Well, like, something like dream catchers, some of them couldn’t do dream catchers ... (motions to joints on hands).”

3.4.2. Connecting to Indigenous Culture. As the stress-reducing intervention was inclusive of indigenous culture, the facilitators highlighted changes in indigenous cultural knowledge or where intervention participants were able to connect with each other through culture. More specifically, facilitators spoke of the importance of connecting to the land, and ensuring activities could continue to be implemented at home or through knowledge translation.

“I enjoyed doing the outings, getting connected with the land and nature and, for me it makes me feel good when other people are enjoying themselves.”

3.4.3. Implementation Challenges. Facilitators were asked to highlight any difficulties or tensions that surfaced while implementing the six-month intervention. The group noted that the payment provided to intervention participants in the form of an honorarium and the research study setting made for stricter participation rules than typical nonprofit program settings.

“Um, to be really forthcoming I struggled with the honorarium. . . It was not enough money, and it was also too much. And it’s just, it’s just how it goes with research.”

The challenges the facilitators faced were typically the result of the research setting. For example, some facilitators noted that the honorarium (e.g., payment to participants) could make group cohesion more difficult because of different levels of engagement. Additionally, some of the external activity leaders like fitness instructors were sometimes uncomfortable working with individuals living with HIV and made this clear to facilitators.

4. Discussion

The analysis speaks not only to the strengths and challenges that facilitators highlighted but to the concept of community-led health programming more broadly. These results are in keeping with other studies that have relied on facilitator perspectives and the usefulness of gathering observations from individuals that represent both the community and the intervention lens [28, 29]. This aspect of the evaluation contributes to the broader community-led health and HIV literature. For example, while this study did not use the same framework as Brown et al., [23], it can be examined alongside the “What Works and Why” (W3) framework that Brown et al., establish for peer-led program success, namely:

an ability to demonstrate the credibility of their peer and community insights; adaptability to changing context and priorities; and the maintenance of influence in both community and policy systems (p. 8 [23]).

Looking to the successes of the intervention and how future iterations might adapt it, the facilitators noted how the feasibility of the intervention largely depended on the accessibility of the programming. The adaptability of the program is in keeping with literature that recommends “meeting people [participants] where they are,” to the extent that programming can be made as barrier-free as possible [30]. Specifically, the implementation should be accessible and culturally safe, both of which were strengths highlighted by the focus group participants. These results also highlight how knowledge might be shared between participating service organizations such that adoption challenges are made easier. Further, the community-led element, which was frequently noted as a strength by focus group participants, may also lend itself to increased adoption by other service organizations and partner communities.

The results also speak to the impacts of the intervention in terms of how the programming affected facilitators, participants, and knowledge carriers. Focus group participants noted how each role, be it leading or participating in the intervention, led to increased leadership capacity and knowledge of Indigenous culture. The connection between facilitating culturally inclusive interventions or connecting with others through shared culture and positive self-identity and wellbeing has been documented in other work [31–33] and speaks to the strengths of the intervention more broadly. The focus group results also point to the reach of the intervention, both in terms of how the study drove re-engagement at the nonprofit service organization and how it helped to reduce stigma more broadly at the organization and within the community of participants. Again, this supports earlier studies that highlight the strength of community-led programs and what is needed for them to successfully engage with the community in a sustainable way, including where flexibility in programming and building off existing partnerships is critical [23, 28, 29, 33].

Several recommendations stem from this evaluation. First, certain modifications were made to accommodate individuals accessing the intervention with different skill levels and abilities. Organizations can consider an assessment of abilities upon intake of clients to understand their needs to better plan and develop programming to be inclusive at the onset of implementation. Compared to rigid programming that does not adapt to the needs of participants, future interventions should consider flexibility in programming, including adaptable activities and creating opportunities for participants to provide direct feedback to facilitators throughout the course of the intervention program.

Second, it was observed that in Thunder Bay, study participants could take on leadership roles. Organizations may want to consider including career and training opportunities within programming and research studies for their clients and study participants, respectively. In our study, a facilitator described being recruited into a research study, later taking on

leadership roles in the same study, and then working as a research assistant for an intervention in which she had not been recruited as a study participant. Eventually, the person was hired in a permanent position as an outreach worker by the organization. Opportunities such as these may contribute to the early phases of building generational wealth, setting participants on a potential job or career path, or at the very least building a community to support life and career goals.

Finally, future interventions should consider the challenges for facilitators, not just in administering intervention but any impacts on them as members of the community, especially in cases where they may be subject to further marginalization or stigma related to HIV [34, 35]. Given the ongoing stigma attached to HIV, organizations offering these types of interventions to those living with HIV should be cognizant of working with outside contractors, such as fitness instructors or guides of any kind. As noted in our results, an outside contractor made insensitive comments to the group’s facilitators upon learning that some of those in the group were living with HIV. Maintaining group safety and comfort should be of the utmost importance, so organizations should consider working with experienced contractors or those with established connections to the nonprofit service organization and broader community. Alongside the earlier recommendations, this suggestion can help to ensure that interventions are implemented with care for both participants and facilitators.

4.1. Limitations. This study has several limitations. First, the focus group only included facilitators who led the Thunder Bay intervention. As facilitators, the research assistants delivered the intervention four times at the same site leading to greater opportunity for adjustments at each delivery and increased engagement of facilitators. The intervention was also implemented at three sites in Toronto, though a focus group was not conducted. Perspectives from the Toronto-based facilitators may have yielded different results. However, conducting a focus group specifically for Thunder Bay facilitators was intended to avoid pan-indigenous findings or overgeneralizing the results. In addition, the facilitators, specifically the research assistants, were those that recruited study participants, collected data, prepared each session as well as invited, and greeted guest speakers. Their perspective in the evaluation is critical. In Toronto, there was a high turnover of research assistants as there were more opportunities to move on to permanent positions over the course of the intervention. In fact, this also applied to some participants who were, on occasion, hired at certain study sites and thus could no longer participate in the research study as requested by the sites. This contrasted with Thunder Bay where study participants could be hired or volunteer in the study and where facilitators held positions external to the study. The Principal Investigator was consistently present for all study activities in Toronto, and to establish continuity additional research assistants were not hired. Thus, an evaluation was not conducted in Toronto from the perspectives of facilitators. Lastly, with only five Thunder Bay facilitators participating in the focus group, we worked with a relatively small sample size.

Another limitation of this study is that one RE-AIM measure is not described. Maintenance of the intervention at several time points beyond the study period was not collected since components of the intervention itself were integrated into regular programming following the completion of the 6-month intervention. It is also worth noting that while we are not presenting the individual-level measures which would provide a more comprehensive evaluation of the intervention; this has been reported separately in the participants-focused portion of the study, which was recently published as [36].

5. Conclusion

By bringing together the facilitators, including those who had previously acted as participants earlier in the intervention series, this study highlights the strengths of a stress-reducing intervention for indigenous women in Ontario. These findings may be of use to clinicians, nonprofit groups, community organizers, and others looking to support indigenous women. These findings suggest how the facilitators navigated the intervention successfully and ways in which future interventions or programs could be designed to expand on the strengths of the Thunder Bay intervention. The application of these results could help to improve the feasibility and usefulness of future interventions for indigenous women experiencing chronic stress, including for those living HIV.

Data Availability

The focus group data used to support the findings of this study are available from the corresponding author upon reasonable request. The research goals and questions must align with the community's health priorities for whom the original research is intended to benefit.

Additional Points

What is known about this topic. (i) Indigenous women face higher instances of stressful life experiences such as socio-economic insecurities. (ii) For those women living with HIV, stress can negatively impact their health and HIV progression. (iii) Interventions grounded in ethnic and cultural identity have been shown to reduce stress and improve health outcomes among women living with HIV. What this paper adds. (i) Our findings demonstrate that interventions aimed at reducing stress among indigenous women facing socioeconomic insecurity, including those living with HIV, are feasible in real-world settings. (ii) Focus group analysis shows that facilitators who deliver the intervention grow as leaders, and participants of the intervention are likely to engage in other health and wellbeing programs offered by the community partner hosting the intervention.

Ethical Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and

with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Women's College Hospital Research Ethics Board and the University of Toronto Research Ethics Board. The protocol was also reviewed by the research ethics board of coinvestigators on the project which included Lakehead University, Dalhousie University, McMaster University, and at the University Health Network. Informed consent was obtained from all individual participants included in the study.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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