

A variety of challenges meet immigrants entering Canada where culture and language are vastly different from the country they originate from. Some barriers to accessing health care include; language barriers, cultural differences, lack of available information on HIV and services, gender, and poverty related issues.

## **DEMOGRAPHICS**

A brief discussion of demographics will allow a deeper understanding of the immigrant population in Calgary and, by extension, the people to which immigrant-related HIV outreach should be targeted.

The 2001 Census of Canada showed that 21% of Calgary residents had immigrated to Canada. In addition, 16% of Calgary's population had immigrated within the five years prior to the census, and thus could be considered "newcomers" at that time. In 2001 the highest percentage of immigrants to Calgary are Asia, South Asia, and Africa. Despite the predominance of Asian-born immigrants, 152 countries were represented among immigrants to Calgary in 2001<sup>9</sup>. Most of the immigrants that moved to Calgary in 2001 were between the ages of 26 to 35<sup>10</sup>.

## **HIV: AN ISSUE FOR IMMIGRATION**

According to Citizenship and Immigration Canada, immigration into Canada for an HIV positive person is determined on a case-by-case basis. A potential immigrant to Canada is given a medical examination - including an HIV test by a designated health care professional in their country of origin. That medical information is then forwarded, along with the remaining information regarding the application, to the Regional Assessment Unit in the region for which the person is destined.

To pass the medical exam the applicant must not have a condition which is a danger to public health or safety or would cause excessive demand on health or social services in Canada<sup>11</sup>. HIV has not been officially or publicly classified as such a condition, so a positive test does not automatically exclude a person from immigration to Canada. Medical factors considered include whether or not hospitalization or medical, social or institutional care are required and whether potential employability or productivity could be affected<sup>11</sup>.

## **HEALTH COVERAGE**

If you are returning to Alberta from outside Canada, you may be eligible for coverage on the date of your arrival. To ensure coverage, you must register within three months of arrival. Newcomers to Canada are required to present a copy of their Canada entry document.

## **PERCEPTION OF RISK**

Risk perception is crucial in order for HIV education to be accepted by specific populations. Unfortunately, immigrant communities - just as non-immigrant communities - often do not acknowledge their levels of risk for HIV. A study of the growing South Asian community in Vancouver shows that risk perception is very low. Seventy five percent of single South Asian men reported initiation of new sexual relationships in the past year, however less than half of the respondents used condoms consistently. Among those who had sex with new partners, 41% reported practising anal intercourse without increased use of condoms. Only 39% of the men and women surveyed reported awareness of AIDS organizations in their community and only 30% believed that AIDS is a problem among the South Asian community. Exacerbating the lack of risk perception are high levels of AIDS denial, cross-cultural dating before marriage, esteem for female virginity, and the belief that young men should be sexually active.

The expectation that women provide contraception is problematic, as that contraception is also expected to be unobtrusive and thus is less likely to involve condom use. AIDS is also perceived as a disease of gay White men, despite the prevalence of high risk behaviour within the South Asian community (Manson-Singer, et al, 1996). It is important that HIV awareness and prevention programs be presented in a manner that is ethno culturally, linguistically, and gender appropriate. HIV awareness and prevention programming would help to provide information more specific to cultural contexts, increasing the likelihood that specific population would recognize their risks.

## **CULTURAL AND LINGUISTIC BARRIERS**

Individuals who immigrate to Canada are often unaware of or have difficulty accessing or understanding the services and information available to them.

Dr. Parminder Sandhu stated that linguistic barriers can lead to difficulties with diagnoses, lack of compliance, lack of disease prevention and health promotion, patient isolation, and extreme difficulties with mental health issues and psychotherapy. Cultural differences included varied perceptions of personal health needs, disease causation, health maintenance, taboo topics, gender roles, and other social patterns. Alongside these barriers were additional administrative and organizational barriers, indicative of the extent to which the first generation Canadian is represented in and/or has participation in the planning, development, and delivery of health care services<sup>4</sup>.

Community outreach through poetry, drawing, handicrafts, card design, posters, condom displays, and appearances on Spanish-language radio talk shows were all shown to increase awareness of HIV prevention and transmission among Latin American immigrants with low levels of English literacy.

Outreach programs aimed at Canadian immigrant populations have been addressing these problems. In Toronto, challenges related to diverse cultures and languages among African immigrants are being addressed by involving immigrants in program planning. Community development and network building are focal, along with addressing racial stigma, the creation of language and culture-specific programming, cultural sensitivity training for service providers, and using elders among the African community to disseminate information<sup>8</sup>.

Africans in Partnership Against AIDS is also involving over 135 African immigrant volunteers in providing workshops, brochures, newsletters, radio programs, condoms, and one-on-one counseling on HIV and AIDS to the estimated 100 000 African immigrants in Toronto. This volunteer outreach has been highly effective, with three fifths of the African community receiving brochures on HIV prevention and transmission over a period of six months<sup>7</sup>. The "Lime Tree" project is also involving African communities in Toronto in linkages with AIDS Service Organizations in member's home countries. These linkages have allowed the "Lime Tree" to become a conduit through which resource sharing, program development, and intercultural communication can take place<sup>2</sup>.

## **DISCUSSING SEXUALITY**

Sexual health continues to be a taboo subject in many spheres of society, including immigrant groups. Ethnicity and cross-cultural issues impact on attitudes towards sexuality and thus, on HIV prevention and transmission. One study of South Asian, Jamaican, and sub-Saharan African communities in London, England aimed to understand the cultural context in which learning about sex occurs. Respondents were asked about their sexual history, current relationships, sexual orientation, sexual practices and their importance, socio-religious and cultural influences on sexual attitudes, sexual health, and attitudes towards and their use of sexual health services. The timing, source, and content of learned information about sex varied among the communities, with the most marked differences being observed among recent immigrants. The importance of informal sources (peers, older adults, media) and the weaknesses of formal sources (parents, school) became obvious through the study, resulting in the conclusion that approaches utilizing peers and culturally appropriate media may be most effective in promoting learning and discussion about sexual health<sup>3</sup>.

## **GENDER ISSUES AMONG IMMIGRANTS**

Differences in gender roles vary more markedly outside than within North America and Europe. Thus, immigrants arriving in Canada will likely encounter gender-related norms dissimilar to those which exist in their country of origin. Women are particularly affected by such gender role differentiation, as they tend to hold less social power than men.

Latina immigrants, for example, are among those women affected by HIV and gender roles. In 1996, nearly 60% of AIDS cases among Latinas in the US were related to unprotected sex with men. Strong cultural gender norms discourage communication about sex and minimize the sexual decision-making abilities of women. Economic disadvantage and language barriers exacerbate the situation, resulting in the higher rates of HIV transmission. HIV risk behaviours have, however, been addressed by a multifaceted empowerment program for Latina immigrants. Women attended up to nine different activities - from formal workshops to informal friendship circles- focussed on

empowerment, particularly in the sexual realm. The program resulted in increased comfort in discussing sex, reduced maintenance of traditional sexual gender norms, and changes in decision-making power. By targeting social factors, this initiative created a healthier environment for the reduction of HIV transmission among this particular immigrant group<sup>5</sup>.

Though cultural differences must be taken into account, awareness of HIV increases when immigrant populations are involved in developing training workshops. HIV 101 workshops developed by and for Asian immigrants in New York were proven effective in increasing HIV knowledge, proper condom use, and intention to practice safer sex<sup>1</sup>.

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