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Immigrant Women Living with Hiv/Aids: Their Barriers as Experienced by Service Providers

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**IMMIGRANT WOMEN LIVING WITH HIV/AIDS: THEIR BARRIERS AS
EXPERIENCED BY SERVICE PROVIDERS**

by

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BIS, University of Waterloo, 2007

A Major Research Paper
presented to Ryerson University

In partial fulfillment of the requirements for the degree of

Master of Arts
in the Program of
Immigration and Settlement Studies

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A B S T R A C T

A review of statistics on HIV infection in Canada shows that the rates of HIV infection are on the rise among immigrants. Like other newcomers in Canada, immigrants living with or affected by HIV/AIDS seek services from various agencies serving immigrants. The purpose of this study is to identify and highlight barriers experienced by service providers when dealing with immigrants and particularly immigrant women who are living with HIV/AIDS. Some of the barriers they experienced include stigma, denial, fear, and discrimination, as well as socio-cultural and religious beliefs, economic and structural factors like immigration status, racism, marginalization and language.

Key words:

Immigrant women, service provision, barriers, persons living with HIV/AIDS (PHAs), Canada, stigma.

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Table of Contents

Author's Declaration.....	ii
A B S T R A C T	iii
Acknowledgements	iv
Table of contents	v
INTRODUCTION.....	1
Background	1
Canada's immigration policy and HIV	2
A review of literature on immigrant women and HIV/AIDS	8
Stigma associated with HIV/AIDS	12
Racism	14
Culture and religion	15
Powerlessness	16
Focused services	17
METHODOLOGY	18
Data collection	18
Recruitment	18
Interviews	18
Participants' profile	19
Transcription and Coding	20
FINDINGS	21
Stigma regarding HIV/AIDS	21
Language	23
Immigration status in Canada	24
Cultural practices and religious beliefs	26
Gender and sexual orientation	28
Limited Resources	30
Socio-economic barriers	31
Race and Ethnicity	32
Criminalization of HIV/AIDS	32
Education	32
DISCUSSION	34
Discussion on service provision in the guiding AOP framework	37
CONCLUSIONS AND RECOMMENDATIONS	39
References	41
Appendix A	46
Table 1. Study Sample	47

INTRODUCTION

This study focuses on perspectives of service providers dealing with persons living with HIV/AIDS (PHAs) regarding these barriers experienced by immigrant women. A two-pronged approach was developed – the first was a review of literature to highlight barriers identified in other studies and suggested solutions. These barriers include stigma, denial, fear, and discrimination, as well as socio-cultural, economic and structural factors like immigration status, racism, marginalization and language. Some of the barriers are unique to immigrant women.

The second approach involved a qualitative study involving key informants; workers from agencies providing services to people living with HIV/AIDS in the Greater Toronto area and one second tier city outside Toronto. The purpose of the study was to highlight barriers identified by respondents. A discussion of the findings is then provided, identifying areas in which this study and other literature agree or differ. The conclusion identifies areas that need further research and suggest ways in which service providers can be better accessible to their clients – immigrants and immigrant women living with HIV/AIDS.

BACKGROUND

HIV infection rates for immigrants are on the rise (Tharao and Massaquoi, 2001; Jimenez, 2004). According to Jimenez (2004) the face of Canada's HIV crisis has moved from gay people to immigrants and refugees from regions where the virus is endemic. Yet Canadian government has not developed guidelines to adequately address this rise in rates of infection among immigrants from HIV endemic regions. According to Jimenez (2004) there is an HIV strategy for aboriginal communities, for intravenous drug users (IDU) and gay men. But there

is no information on how to deliver services to people from HIV-endemic regions. There is also a systemic gap in data collection in research which may cause barriers for HIV positive immigrant women who may need to access ethno-specific services (Remis, 2003).

This study is informed by the need to highlight the unique challenges faced by women with HIV when they access services. During a recent visit to Kenya, I observed how HIV/AIDS has devastated the country and its population. I took part in a three month internship program in Kenya working with women who are living with HIV/AIDS in the summer of 2007. I found that women were experiencing cultural barriers such as polygamy, patriarchy which was a cultural phenomenon that prevented them from owning property and from making decisions that would protect them from HIV/AIDS. Women experienced poverty due to limited access to formal education and employment. I found that women face systemic, cultural, economic, and structural barriers that prevent them from seeking and accessing services from healthcare agencies. These barriers may have caused and/or aggravated the AIDS pandemic situation in Kenya. This study is therefore also informed by my interest to assess whether HIV positive immigrants women in Canada are faced with similar barriers of access to services that I observed in Kenya.

Canada's immigration policy and HIV

According to Citizenship and Immigration Canada HIV infection is not of itself considered a significant public health risk in Canada (CIC website, 2006). Since 2002, HIV testing is mandatory for all immigrants applicants fifteen years of age and older and children who have received blood or blood products, or have a known HIV positive mother. Testing is also required for potential adoptee children, or where a risk factor is

identified. If test for HIV status is found positive, the applicants are deemed inadmissible due to the perceived high demand they may place on the Canadian universal health system¹. Canada however allows HIV positive persons to migrate to Canada if they are refugees, asylum seekers and applicants who are either a spouse, a common-law partner, or a conjugal partner of a permanent immigrant or a Canadian citizen sponsor (CIC website, 2006). In such a case, post-test counseling is recommended including how the applicant should inform their partner of their HIV status. The information about HIV status is also released to the public health offices in the immigrants' residence area (CIC website, 2006). Visitors on a six month visa to Canada do not require testing for HIV. As a result, people who enter Canada on a short term visa and make a refugee claim learn of their HIV status upon arrival in Canada. According to Alana (2001) HIV positive status has successfully been used as a ground for claiming refugee status in Canada. This means that immigrants who are HIV positive will continue to be admitted to Canada and ways must be found to provide appropriate and effective services to them.

Exclusionary discourses have existed in the immigration system in Canada. An example is a survey conducted by the federal government in 1994 aimed at inviting Canadians to participate in shaping an immigration policy for Canada. In public meetings across Canada, citizens raised the issue of the protection of the health of Canadians, as well as the medical care program. People felt that immigration applicants to Canada with AIDS, or who have tested positive for HIV should not be allowed into the country (Anonymous, 2005). Wente (2006) exemplifies this exclusionary argument in a newspaper article, arguing that our immigration policy, which admits people who are HIV positive or

¹ Excessive demand on healthcare is defined as any medical expenses greater than \$15,000 of publicly funded healthcare costs over a period of five years (Alana, 2006)

with AIDS, is contributing to the spread of HIV/AIDS and adding significant health and social costs to the social system.

According to Statistics Canada, overall, a majority of the newcomers (78%) rated their health status as either excellent or very good. Another 19% reported themselves to be in good health. Only 3% rated their health as fair or poor (Statistics Canada, 2003). This dispels the myth that immigrants who come to Canada deplete the universal health system.

Proponents of HIV positive immigrants and other immigrants with disabilities argue, and rightly so, that HIV is neither a cost nor a public health issue. Not everyone who is HIV positive is sick (Clark et al, 2004). Research has shown that the median time from infection to AIDS diagnosis now exceeds 10 years. The advocates criticize the barriers to immigration that people with disabilities face, questioning whether Canada can consider itself compassionate if the country deliberately screens out the crippled and the sick. Those advocating for immigrants maintain that policies that discriminate against visa applicants on the basis of disease risk stigmatizing entire sections of society. They insist that to base any decisions on the presence or absence of illness is appallingly discriminatory and emphasizes the stigmatizing nature of political debate (Anonymous, 2005)

Ignoring the HIV situation among the immigrant community is a great mistake, since the immigrants are already in Canada. Lessons should be learnt from what happened when the first cases of AIDS were reported. Chirumuuta and Chirumuuta (1987) discussed how in the early 1980s the first cases of high rates of HIV infections were ignored in the United States. Instead of managing and preventing the disease, leaders and the general public concentrated their efforts on blaming the gay population for causing and spreading

the disease. They were looking for ways and means of isolating the gay people. Before long, AIDS became a problem for everybody because it was apparent that anyone could get AIDS if proper protection was not adhered to. Likewise, during the same period of the reports of the first HIV/AIDS infections in Africa, many African nations denied the existence of HIV/AIDS in their countries in an attempt to refute and dispel the racist claims that AIDS was an African disease. The consequence of these denials may have resulted in the pandemic that has claimed over 25 million lives (UNAIDS, 2008). This scenario should not be repeated in Canada through stigmatization and blaming immigrants and failing to provide them with the appropriate services. The need to provide specialized services to immigrants who are HIV positive must be acknowledged and addressed adequately and in a timely manner. Obviously AIDS has no boundaries and if its management is left unchecked, it will become a major problem in Canada.

Theories about where HIV originated and spread among human populations have unjustly stereotyped African people (and, by extension, African Caribbean communities) as being at the epicenter of the pandemic. Attention focused on Africa is double-edged: while it has led to more action to help eradicate HIV in Africa, it has also stigmatized African and African Caribbean people (Ilana, 2006).

According to United Nations AIDS program (UNAIDS) (2008) over 33 million people are living with HIV/AIDS. The Public Health Agency of Canada (2008) estimates that 58,000 people in Canada were living with HIV infection at the end of 2005 - a 16 per cent increase from the 2002 estimate of 50,000. An estimated 27 per cent of these individuals - or 15,800 people - were believed to be unaware of their infection and thus were not seeking treatment and may have been unknowingly infecting others. Between

2,300 and 4,500 people were newly infected with HIV in 2005 and more than one quarter of Canadian living with HIV are actually unaware of their infection (Elliott, 2008).

The World Health Organization (WHO) estimates that only about 10% of persons living with HIV/AIDS in low- and middle-income countries know their HIV status, terming it a global crisis (Canadian HIV/AIDS legal Network, 2006). Newcomers to Canada from these countries who seek asylum within Canada find out their HIV status upon arrival (Alana, 2001). According to the Canada Communicable Disease Report, 7 to 10 per cent of the 56,000 people in Canada living with HIV or AIDS at the end of 2002 were heterosexuals from African and Caribbean countries. Fifty-eight per cent were gay men, and 20 per cent were injection-drug users.

HIV rates among immigrants who arrived in Canada before 2002 are unknown, and data on those who have been infected within Canada is not being systemically collected. Since data on HIV rates for recent immigrants is unavailable, Dr. Remis of the University of Toronto has developed surveillance reports in Ontario based on statistical modeling with a view to estimating the number of infections among immigrants (Jimenez, 2004). Remis' (2003) study estimates that 12% of Ontario's 22,100 HIV/AIDS cases at the end of 2002 were people from Africa and the Caribbean. His team recommended that Health Canada should mention the HIV positive immigrants' statistics in their annual surveillance report as this is a distinct group with its own epidemiology. Without focused attention to this vulnerable and growing group, there could be a medical time bomb waiting to happen for immigrants and for Canadians in general. Remis (2003) has found that up to half of HIV cases among immigrants, transmission occurs after arrival in Canada, challenging the stereotype that immigrants are bringing the virus here.

Overall positive test reports attributed to the HIV from endemic countries increased from 3% in 1998 to a peak of 8.5% in 2004 and more recently to 8.4% in 2006 (HIV/AIDS Epi Update (2007)). The increase could be due to a true increase in new infections among individuals born in HIV-countries, better reporting in this group by provinces, or increased HIV testing in this population. Increased testing is at least partly responsible for the increase as a result of the recent policy of Citizenship and Immigration Canada (CIC) whereby immigrants and refugees are tested for HIV (HIV/AIDS Epi Updates 2007). Studies have signaled a probable lack of awareness among immigrants, and a degree of complacency especially for immigrants who are originally from HIV endemic countries. A newspaper article by Sinnema (2007) quoted a victim of HIV infection, who is originally from a HIV endemic country, claiming that she never expected to get the virus here in Canada. Sinnema has noted that while the rate of death from AIDS has dropped, the rates of new infections have picked up even among other high risk population such as gay men and intravenous drug users (IDU). The rise has partly been attributed to a lack of awareness about HIV/AIDS among younger generations, a false belief that AIDS is now curable, protection fatigue among HIV positive people, and the knowledge that HIV is no longer a death sentence because of the presence of life-prolonging anti-retroviral drugs (ARVs).

Persons from countries where HIV is endemic are over-represented in the HIV/AIDS epidemic in Canada with the infection being diagnosed at a younger age than in other heterosexual exposure subcategories. According to HIV/AIDS Epi Update (2007)

almost 80% of positive HIV test reports assigned to the HIV-endemic² exposure category are from individuals under the age of 40.

According to the HIV/AIDS Epi Update (2007) report, HIV/AIDS has a significant impact on women from countries where HIV is endemic with women representing 54.2% of positive HIV test reports attributed to the HIV-endemic exposure category.

A review of literature on immigrant women and HIV/AIDS

Economic marginalization is the most powerful social barrier to HIV prevention and it offsets the imbalance in gender relations. Statistics Canada (2006) has shown that immigrant women remain in the lowest income group, with highest rate of unemployment and underemployment. Having a good income is the cornerstone of good health. When income is threatened, other determinants of health are destabilized (Ilana, 2006; Tharao, 2001). People living in poverty are less likely to insist on fidelity, demand condom use, or refuse sex with their partner when they doubt their partner's status. Immigrant women may believe they have to be loyal and submissive to their husbands for social and economic sustenance (Shirwadkar, 2004). UNAIDS has estimated that more than four-fifths of all infected women get the virus from a male sex partner. Because of physiological differences, the risk of transmission from a woman to a man through vaginal intercourse is less than from a man to a woman (Canadian Legal Aid Network, 2008).

² “HIV-endemic countries” are generally defined as those that have an adult prevalence (ages 15-49) of HIV that is 1.0% or greater and one of the following:-

- 50% or more of HIV cases attributed to heterosexual transmission;
- A male-female ratio of 2:1 or less among prevalent infections; or
- HIV prevalence greater than or equal to 2% among women receiving prenatal care.

According to Hyman (2003), the majority of infants born to HIV-infected mothers in Canada are born to immigrant women from HIV-endemic countries. This suggests that immigrant women learn of their HIV status when they attend pre-natal screening or after an onset of a chronic condition. This might be attributed to many immigration specific barriers, such as language barriers faced by immigrant women which impede their ability to communicate, resulting in underemployment. In other times, the kind of employment that they access does not provide benefits such as a drug plan. As a result, they may seek treatment only when they are ill. This has the impact that they only seek treatment when ill. Because of poverty, immigrants may have less access to a balanced diet which may compromise their health. As Clark and others (2004) observed, people with regular sexually transmitted infections (STIs) have higher chances of contracting HIV. STIs are personal and sensitive conditions and immigrant women who rely on their children, spouses or friends to translate for them while visiting a doctor may choose not to disclose those conditions.

Debjani et al (2006) carried out a survey in Montreal among health care practitioners and immigrant women to determine how to encourage immigrant women to be tested for HIV under the Volunteer Testing and Counseling (VCT) program. The results showed that both practitioners and patients identified women's lack of knowledge about HIV transmission and prevention as a primary need. The patients identified inadequate awareness of the benefits and harm of HIV screening and treatment services. In addition, women were unaware of the various VCT options. Both practitioners and patients also highlighted the issue of stigma and negative outcomes associated with testing that created barriers and/or contributed to delays in women receiving testing. Debjani et al, (1996)

found women preferred anonymous testing, and recommended that information and decision support regarding HIV testing be provided via non-targeted strategies, and integrated within general health services or public education.

According to Tharao and Massaquoi (2001), African immigrant women in Canada represent a significant element of the HIV epidemic however researchers and policy makers have largely ignored them. The absence of African women in the HIV arena in terms of accessing prevention, treatment, support, and care initiatives is especially evident. Tharao and Massaquoi (2001) state that African immigrant women are usually present in staggering numbers as presented in epidemiological updates or in reference to prenatal HIV transmission and prevention. Like all other women, African women's vulnerability to HIV infection is biologically similar but it is also unique and deeply rooted in socio-cultural and structural factors that intersect with gender, race, class, and political and economic conditions (Tharao and Massaquoi, 2001)

Although women can apply to come to Canada independently, immigration is generally seen as a male phenomenon with women coming to Canada as dependants of men. Some of the reasons for this phenomenon are that men in general tend to have more education, more economic resources and more power to make major decisions such as immigration than women, making them more likely to qualify as principle applicants in immigration (Coté et al 2004).

Data on immigration to Canada show that over 59% of family class immigrants are women (Statistics Canada, 2006). As dependants in the family class immigration category, women's education or skills are devalued. From an anti-oppression practice perspective, this can be seen as systemic discrimination inherent in immigration policies which require

a spouse (in most cases a husband) to bring their partner to Canada as a sponsored spouse. The women are dependent on their husbands and may not access social assistance such as social welfare and social housing because their husbands are expected in the sponsorship agreement to meet their basic needs, including settlement and integration needs. Women's labour at home is treated as unskilled, informal and it is unpaid. This creates a gender imbalance. The immigrant woman is economically disadvantaged and discriminated against through limiting her access to services due to her sponsored status (Thobani, 2000; Belleau, 2003). An immigrant woman who is sponsored and unemployed lacks economic opportunities and autonomy which increases dependency on her spouse. Women in such situations are often deprived of rights and may face sexual control over their body (Larkin, 2000; Tharao and Massaquoi, 2001).

According to Tharao and Massaquoi, (2001), cultural practices such as female genital mutilation (FGM) and vaginal cleansing increase risk of HIV infection. Additionally, limited educational opportunities for immigrant women - which is sometimes a cultural phenomenon - lead to misinformation about the epidemic in Canada, a country to which they had migrated in search of a better life for themselves and their families. An understanding and documentation of these barriers is imperative to improve access to services and ensure the involvement of women in prevention, treatment, support, and care programs.

A number of authors who have discussed the challenges that service providing institution may present to their clients thus hindering access to them. Systemic exclusion is indeed seen in the healthcare environment in which African women seek assistance. Tharao and others assert that the healthcare environment imposes substantial barriers that

hinder access to health services (Tharao and Massaquoi 2001; Randall and Varnillia, 1993; Larkin, 2000; Hyman, 2003; Debjani et al, 2006). These barriers are compounded by the fact that many of the immigrant communities' needs do not conform to North American systems of healthcare delivery that are based primarily on a bio-medical, monocultural model (Hyman, 2003; Larkin, 2000; Debjani et al, 2006; Tharao and Massaquoi 2001; Randall and Varnillia, 1993). Because of these barriers, immigrant communities tend to utilize health care services less and receive critical diagnosis and treatment significantly later than other populations largely due to the cultural, linguistic, racial, gender, and class barriers embedded within the system (Tharao and Massaquoi, 2000; Tharao and Massaquoi, 2001).

A number of studies have discussed challenges that people living with HIV face especially while accessing services. Among the barriers that have been discussed is stigma (Tharao, 2004; Ilana, 2006, Lawson et al 2006, Jimenez, 2004) racism, and culture (Fowler, 1998; Jimenez, 2004; Lyman, 2001).

Stigma associated with HIV/AIDS

Stigma is a term applied widely to any condition, attribute, trait, or behaviour that marks an individual or community as culturally unacceptable or inferior. According to Goffman (1963) stigma is linked to notions of shame and disgrace. HIV-related stigma, often has a negative impact on health; affects social support networks, employment and working conditions, personal health practices, and coping skills (Tharao, 2004; Ilana, 2006). A person may be afraid to take an HIV test in case someone finds out and judges them as engaging in "immoral" behaviour. Other people may keep their HIV status secret,

to help them avoid discrimination in the workplace.

HIV-related stigma has implications not only on HIV-positive people, but also for their families and communities. In Canada, the fear of stigmatization for the whole community, has been identified as a deterrent for HIV testing (Tharao et al, 2005 as quoted by Ilana, 2006). Lawson and others (2006) confirm that organizational practices and policies may support stigma and discrimination, even if unintentionally.

Stigma affects attitudes about sexuality in the country of origin and culture (i.e. sexual practices, notions of morality and promiscuity, orientation, poverty) (Jaboya, 2007). In Canada, racialization affects African and African Caribbean people through social and economic exclusion, discrimination and the extent that service providers or their affiliated agencies fail to provide a level of care appropriate for Africa and African Caribbean people. All of this is compounded by stigmatization specifically related to HIV and racist discourse that promote the notion that Canada is importing HIV from sub-Saharan Africa (Wente, 2006).

Fearing stigmatization, immigrants from Africa who test positive are concerned about maintaining their anonymity that they do not want to go in person to the nearest HIV clinic. In Medicine Hat, for example, patients seek treatment at a clinic in Calgary, 185 Kilometers away (Jimenez, 2004). They worry that they may lose their jobs or will be deported. They also fear that by disclosing their HIV status, they could be isolated, further shrinking an already limited support system (Jimenez, 2004). Many newer immigrants are also affected by lack of official Canadian language skills and associated challenges like lack of professional jobs. HIV positive status could result in additional challenges to gaining professional jobs and alienation from connections within their ethnic communities

(ASAP, 2001).

Studies by Debjani and others (2006) show that HIV positive people will not see a specialist counselor within an agency if everyone knows that the counselor is a HIV/AIDS expert. The same studies show that immigrant women prefer to participate in training and workshops that work with a larger group, rather than with a small or a specific group. Since immigrant women rely heavily on their social community networks, their fear of stigmatization and exclusion is justified.

Racism

According to Bannerji (2000), non-whiteness is a basis for oppression and immigrants are blamed for their HIV status. Racism is defined by Allahar (1998) as the:

Practice of including and excluding individuals and groups from participating fully in the social economy on the basis of imputed racial similarities or differences, and their denial of access to certain services and resources on the same bases (p. 337).

Racism has a lot to do with power of the dominant racial groups (Yee, 2008). Racist discourse in which immigrants are blamed for their status discourages HIV positive immigrants from seeking services due to stigmatization. Assigning blame and pointing fingers is detrimental when serving immigrants who are living with HIV/AIDS in Canada. Wente (2006) has asserted that Canada is importing HIV/AIDS from sub-Saharan Africa. Although she defines this statement as "*the greatest 'unsayable' of all*" (p. 2), she nevertheless says it. As a headline capturing statement, this then becomes the general public knowledge that is disseminated by mainstream and community media that play a huge role in shaping public opinion and in influencing attitudes and beliefs among the

public (Lawson et al 2006). With the awareness of such statements by Wente and others that are racist, discriminatory and stereotypical, immigrants from countries that are considered endemic shy away from seeking help from mainstream agencies that are staffed by mainly members of the white dominant race group.

Culture and religion

Culture is an important aspect of people's lives and should be considered in policy formulation and interventions. Fowler (1998) has argued that since immigrant women often maintain strong beliefs in their traditions and religions, approaches used for health promotion and reproductive health for this group should be culturally sensitive. These sentiments were echoed by Jimenez (2004) who noted that practitioners and service providers working with immigrants say cultural taboos; fear of discrimination and deportation; and the shame associated with HIV may make people from regions where the disease is endemic reluctant to seek medical attention or be tested.

Lack of culturally sensitive and appropriate approach to healthcare support, prevention and education is an aspect that prevents immigrant women from seeking and accessing services (Hyman, 2003). Cultural norms and religious beliefs may deter immigrant women from seeking services. Some women may believe that FGM is an important aspect of their culture and mandatory practice, and continue to practice it (Litorp et al, 2008; Ndiwane, 2008).

Like culture, religion plays an important role in the lives of many African and African Caribbean people. Some religious adherents overtly or covertly believe that they cannot acquire and/or transmit HIV infection simply because they are "saved",

"believers", protected by deity/divine power, "born again", or have converted/recommitted to a religion or spiritual path (Ilana, 2006). Tharao and Massaquoi (2001) mention a case where an immigrant woman was not keen on taking life prolonging drugs as she believed that it was Allah's decision that she dies of AIDS, and she should not go against Allah's plans for her life, or death. Even if this one woman's this is a religious belief that can be hard to change.

Powerlessness

Lack of involvement of immigrants in HIV policy work is a systemic barrier. When women do not see their own ethnic background represented in management, training and advocacy work, they may feel neglected and unrepresented. Barough (1992) has shown that HIV positive people feel comfortable working with people who are like them. Representation may mean their views are expressed and addressed in policy development.

Ethno specific services help immigrants fit in. I did my placement at an ethno-cultural AIDS organization and my experience is that people are more open about their HIV status in this agency because they feel supported and understood. I sensed that they felt empowered as a group and they are able to advocate through mobilization.

More women need to recognize they have rights, including rights over their bodies as well as their sexual and reproductive health. Women who do not feel empowered are not in a position to negotiate safer sex. It is ironic that sex trade workers who routinely insist that their clients use condoms often have more protection than housewives who do not feel they have the right to ask their husbands for safer sex (ASAP, 2001).

Focused services

The federal government has an HIV strategy for aboriginal communities, for IV drug users and gay men. But there is no information on how to deliver services to people from HIV-endemic regions and no guidelines have been developed (Jimenez, 2004). Testing and treatment for HIV is a human rights issue within Canada (Canadian HIV/AIDS Legal Network), which means patients must consent to the test and must be adequately supported pre- and post-testing. Therefore, testing for immigrant women who are already experiencing other barriers should be accompanied by appropriate support. Researchers such as Remis and community such as African and Caribbean Health (ACHHO) groups say they have pressed the federal government for years to collect epidemiological data on this group, and to tailor prevention and treatment programs to their needs (Fowler, 1998; Jimenez, 2004).

The issue of tailored programs for distinct groups is however paradoxical. Macintosh (2005) in her research found that focused services for immigrants sometimes create segregation. For example, in the Palliser health region, in Brooks, Alberta service providers worry that HIV will spread without effective prevention programs. Yet they also fear that the safer-sex campaign they plan in the region may cause a backlash by linking HIV with immigrants in the public mind. Brooks is a town besieged by racial tensions after the eruption of a racially-charged riot in a meat processing plant in 2005 (Simich and Este, 2007).

This literature review was sourced mainly from selected Canadian social science journals and publications, a few Kenyan publications, government reports and reports by non-governmental organizations working with HIV/AIDS. The next section provides detailed information about the themes that emerged from the data, and quotations to illustrate these themes, as well as recommendations that merged from the interviews.

METHODOLOGY

A qualitative study was conducted during the month of July in Toronto and one second tier city. Data were analyzed and a report was prepared to assess experiences of service providers working with immigrants who are living with or affected by HIV/AIDS.

Data collection

This study is based on face-to-face interviews with key informants. Interviews were conducted with individuals working in agencies that directly serve immigrants who are living with HIV/AIDS. Prior to commencing the study, the research protocol was reviewed and received approval from the Ryerson University Research Ethics Board.

Six respondents were contacted and interviewed for the study. Three interviews were carried out at the office of the service providers, two were carried out at Ryerson University and one was carried out at the participant's home. Interviews were recorded with the consent of respondents. These recordings were transcribed in full.

Recruitment

E-mails were sent directly to the directors of the agencies who suggested to the researcher names of prospective participants. Service providers working directly with immigrants living with HIV/AIDS were invited to participate in the study. Five emails were sent to individual service providers. Out of these, four agreed to participate in the study but two of them could not participate due to time constraint as they were preparing to attend the International AIDS Conference which took place in Mexico beginning July 31, 2008.

Six participants were interviewed. They consisted of two women working in AIDS

organizations, one female participant working as an AIDS Prevention Coordinator in an ethno cultural AIDS Services Organization (ASO) in Toronto while the other worked as a Support Coordinator in a mainstream regional ASO located in a two tier city. The other four participants were male. Three of them work in ethno cultural ASOs agencies in Toronto; two are Immigration, Settlement and Adaptation Program (ISAP) Coordinators while one is a Support Coordinator. The fourth male respondent is an Advocacy Coordinator working in a mainstream ASO in Toronto.

Interviews

Interviews took place between July 16th and July 25th 2008. Two interviews with female participants lasted three hours each, one interview with a male respondent lasted ninety minutes, while the other three with male respondents lasted 45-60 minutes. All respondents answered a total of 11 questions dealing with the services provided. A list of these questions is attached as Appendix A.

In addition to the information elicited as informants responded to the 11 questions, discussions continued after the interviewees were asked if they had anything more to add. This was a source of important information. Generally people opened up more after the scheduled formal interview and spoke significantly more freely.

Participants' profile

Three participants described their ethnicity as African. One was East Asian, one Canadian and one participant self-identified as a mixed race. Their immigration status in Canada varied. Four participants were Canadian citizens; one was a Permanent Resident while

one was a Convention Refugee. With respect to their role in the community, two participants identified themselves as activists and two as PHAs. Participants were also in different age categories. They ranged from 25 to 45 years (see Table 1).

The first question sought to establish the services provided by the agencies, in general, and the responsibilities of the individual participants. All interviewees worked in AIDS Services Agencies and their job titles are shown in Table 1. From the interviews it was clear that the regional mainstream agency provided many more services than the ethno-cultural agencies. This mainstream agency has a community kitchen where they cook and package food and take to clients. They receive donations from a pharmaceutical company consisting of four cases of medicine each month. They also organize vitamin drives that provide free vitamins to the clients. Other services that they provide include a massage therapy and organize a coffee night with donations by *Starbucks*. Because of this donation, they save on their budget for coffee. The mainstream agency serves all the people in that region living with or affected by HIV/AIDS. The main stream agency reported that 53% of its clientele comprise of immigrants from one specific region.

All ethno-cultural agencies provide services that mostly target a certain ethnic groups living with or affected by HIV/AIDS in the Greater Toronto area. They do not however turn away anybody seeking services from them.

Transcription and coding

Interviews were transcribed in full and coded manually for content and themes. In analysis, specific attention was paid to the way the participants described their frustrations due to the barriers that they experienced. The next section details information about core themes

that emerged from the data and quotations that illustrate the themes.

FINDINGS

This study sought to establish barriers experienced by service providers while serving immigrant women living with HIV/AIDS. However, respondents described experiences faced when they provided services to both male and female clients. A majority of respondents described more barriers when accessing male clients than accessing female clients. This observation, where barriers faced applied mostly to male clients than female is discussed in detail under the theme of gender.

A number of themes emerged from the interviews. Stigma and language was repeatedly highlighted as major barriers experienced by service providers. Other barriers that stood out in the study are religion and culture, gender and sexuality, and immigrations status. These five barriers, as well as other themes identified in the study, are discussed in detail here.

Stigma regarding HIV/AIDS

All the participants felt stigma was the most important barrier that affected their client's access to their services or interactions with service providers. Most of the participants told stories of how stigma affects their clients and limits them from accessing services. One respondent said:

...stigma is a huge barrier that stops people from accessing services. I remember one time going to meet with a client downstairs and the client said I cannot come to your office and I don't want to be seen at all. We had to go somewhere to do an intake.

One respondent was able to categorize clients from different countries and their general reaction towards stigma. Stigma was seen to be more prominent among PHAs living

in a small city and accessing services from a regional agency. She said that people from some communities are really stigmatized. She gave an example of a client who was continuously harassed by a person from his community.

There's this guy who lives near the bus terminal and there's this woman who I guess is not a PHA but I don't know and when she sees him she yells "AIDS AIDS" and she spits at him especially if he has a woman with him. She yells at him to shame him and also to warn the woman, like, why are you with him and he has AIDS. It's something that we have gone to the police about because obviously it is not something that is appropriate. And the man just cries. You know he is so-- upset to be treated this way. It's awful. It's almost something that you read in the bible or something. It's like he is a leaper. It's so old fashion and you would think this doesn't happen in this day and age but it does. It wouldn't happen if those words were said in English because nobody would tolerate that. So because again we look at the issue of the language, nobody knows. Her employer doesn't know what she is saying otherwise she would be fired. It would be a human rights violation. But it is hidden. It is out there in a busy public place but it is hidden. But because the language is not a main stream it goes unnoticed. He has a great affordable clean apartment and he is ready to move to anywhere he doesn't care whether it's dirty, small, expensive, just to get away from her. 'Cause he feels trapped by her. He now catches the bus elsewhere because he won't go near her any more.

A respondent working in a mainstream regional agency said that some communities experience and fear stigma more than others. This stigma comes from the belief that being HIV positive means death. She talks of her experience while serving newly diagnosed clients:

I sometimes try to introduce the newcomers to some of my long term survivors and I tell them that they have been positive for 25 years and they go "what? Really are you lying to me?" Because I have this one guy who said to me "how long do I have?" I didn't know what he meant and I asked 'for what? For lunch?' He thought I was joking with him but I really didn't know what he was talking about and he was asking how long he had to live. Obviously I didn't know that. I said I can't really answer that question but your health is good, you have your home, you are taking medication, you have food and you have a doctor. I said you are going to live a long time. And he was pushing me one year? Two years? Five years?

She gave an example of how in a certain immigrant community people will not want anyone in the community know about their status. They don't want to be seen walking to the

agency and will not want people in their community to translate for them. The stigma in this community is so bad that the agency has to use different vehicles while transporting clients to an AIDS clinic. They use different vehicles and the appointments which must take place on a certain day of the week must be spread out so that the clients do not meet at the clinic. One respondent specifically identified challenges faced by clients of certain origin as follows:

[An ethnic group] think HIV is a punishment from God for some sin that they committed. Clients will be afraid to seek or access services because by doing so they would be judged.

Stigma is a barrier for service providers because if people fear stigma then they will not come forward and get help. Few men participate in support programs. One respondent said that HIV is seen as "gay man" disease and therefore straight men who are PHAs are unwilling to come forward lest they are mistaken for being gay.

Language

All participants saw language as another big barrier they face while serving immigrant PHAs. One respondent stated that with the complexity of African languages they are unlikely to find a translator for each and every language and dialect. Another respondent working as a settlement coordinator said that even with translators there were still communication problems. He put it as follows:

A client might have problems with communication and because of that they have problems in explaining themselves and being understood. ...another party is doing the interpretation that he is saying something else. ...from the body language you can tell that what he is saying is not really getting across and you can see the client getting really frustrated and trying as much as possible to say it in English. You get frustrated when you [know] didn't really get through to the client.

Relying on external interpreters is problematic because it can become a gender and

cultural issue as a respondent explained:

I have to speak through the husband and quite often because the man speaks English and the woman doesn't or it's simply not appropriate for me to address the woman. And I can see she wants to say something even in broken English... but the interpretation doesn't seem to be right...

Gender and cultural barriers will be discussed below. A respondent working in a regional agency had a similar experience with language as a barrier. Some times a couple would come to the agency for support but then it is usually the male partner who speaks on behalf of both. A respondent put it this way:

Even when I try to address the woman directly, it is the partner who answers.

Immigration status in Canada

It is important to note that numerous barriers related to settlement exist for immigrants irrespective of their HIV status. As Wayland (2006) discussed, immigrants and refugees face legal and policy barriers including restricted access to the determination process and social services when they arrive. It is therefore overwhelming for newcomers who are HIV positive juggling the many issues that they have to deal with because of their immigration status. All respondents described the overwhelming needs of their clients that make it hard for them to show up for their appointments. One service provider working as a settlement coordinator highlighted the following issues that their clients have to address within a limited time during their first stay in Canada:

“We say why didn't you come earlier because we could have serviced you before you deteriorated like this”

They say, 'well I had to fulfill ABCD and before I could do that it was not possible for me to come' "But it's about your health?"

...they are told what you need to do is call CIC ...call the immigration and refugee board ...submit your personal information file within 20 days ...file your medical report within 28 days, ...get a legal aid certificate to the lawyer.cannot get your SIN before you get your work permit; ...wait for your medical results to get to CIC

before they can process your work permit....

If you are suspected or if you have TB it is not possible for them to process a work permit for you so you need to take your TB medication for 9 months. Public health is going to tell you that you have been cleared of TB. Your doctor will then get a letter from public health and then he will tell CIC...

I'm trying to show you a picture of how it takes so long and how much red tape there is for a client who is new to Canada and that is a real barrier for us to reach and serve that client.

The objective of immigrants when they first arrive in Canada is to start work and settle down. However, when they receive a HIV positive diagnosis their lives are negatively impacted. One respondent explained how some of her clients related their experiences:

They are upset, disappointed, and devastated. They assume that it's a death sentence, people told me "I just wanted to kill myself" or "I was happy to come to Canada I thought this was my dream come true and then I found out and everything was so bad I just wanted to die".

People who come to Canada as sponsored refugees are sometimes able to access government assistance during the first year and in rare cases two years when they first arrive. After that they are expected to be economically stable. Unfortunately, people who are diagnosed with HIV require extended assistance beyond the sponsorship commitment. As a result they lack the financial and social abilities to integrate. The other categories of people who are seriously affected when they are diagnosed as HIV positive are people without required immigration status. Because of their status (lack of government required immigration status), they are afraid to approach an agency for assistance regarding their medical situation in case their presence in the country is reported to immigration authorities. In such circumstances, service providers have to convince non-status PHAs that they will not turn them in. Although people without status do not fall in the category of groups from government funded services, they are nevertheless offered some help.

Refugee claimants found it very stressful to wait to be determined by the Immigration and Refugee Board (IRB) whether or not they can stay in Canada. This can increase their

stress and anxiety. One provider also noted that immigrants who are sponsored to come to Canada by their relatives through the family class do not automatically qualify for the province funded health program. The Ontario Health Insurance Program (OHIP) takes effect three months after the family arrives in Canada. During this period sponsors indicate that they will cater for their health needs which is not always the case because of prohibitive costs associated with healthcare. When people are sponsored they are not eligible for other health care plans like the Ontario Disability Support Program (ODSP), or Ontario Works (OW). Some ASOs do however offer some assistance. One respondent noted:

Families sponsored are not eligible for OW or ODSP and they have to get insurance and pay a deductible. We have to pay so much deductible for our clients. ... [For doctors] even though they won't be paid they have the ethics to believe that it is better to serve the person than not serve them. In cases of drugs I have to apply for compassionate use from pharmaceutical companies. I don't get it right away. It is a problem for people with no status. It is a problem when their medication is about to run out.

Cultural practices and religious beliefs

In terms of culture one respondent said that some of their clients were not familiar with the culture of seeking help from agencies. She noted that in some immigrant communities, they do not like to talk about their problems to people that they consider "strangers". This barrier was more common among men who are expected to support others, or at least be self supporting.

It was also noted that among some cultures or because of their belief system like a faith healing, clients failed to follow their medication affecting their health.

Religion was especially identified as a major barrier by all respondents. One respondent stated religious beliefs stopped some clients from participating in certain activities such as listening to music to entertain and relax. A respondent said that her agency was seen as a "gay agency" and they worked hard to dispel the myth by displaying neutral photos and

images in their agency offices. When they approached churches for support in education and outreach work, they had to explain that they were a mainstream agency serving everybody. As mentioned above, gender and sexuality (which will be discussed below) are become intertwined with religiosity and culture. On religious beliefs, one service provider put it as follows:

One is a [religion] and sexual orientation is a big deal. So the first thing they ask you is are you gay, or are you straight, or are you married or you are single. At times you really feel vulnerable and you wonder “I’m I going to be effective while serving this client”. They will have bias in what you are to them. It becomes a barrier already.

Respondents talked about stigma experienced within the community especially in ethnic churches. One respondent felt that education is going to be the way to help address this issue especially among community groupings where clients expect to have support. She stated her experience as follows:

I just want it to be part of the public dialogue. But in that specifically I think we need to do some work with the churches. Because especially with the ethno-cultural population a lot of people do seek support from their churches and a lot of the most frequent places that they report to me that they are stigmatized for the disease is the church. Not necessarily formally through something that the minister is saying, but through the congregation. Whispers oh that person has AIDS or talking about how somebody back home was diagnosed. And the pain and stigma that continues to be allowed to be perpetuated at church. For me I feel that that should be the one place that we are going to be accepted and that we are not going to continue be pointed. I have found people saying that their best friend at church has now started gossiping about someone who they think is positive. And just the devastation of people feeling like that. I’m not sure they realize that they are there...

Another respondent expressed frustrations while working with ethnic churches.

The religious ones are the worst. They don’t want to hear about it. They deny. They preach abstinence. I’m a Christian and believe in abstinence. But abstinence is not for everybody. People are preached to about abstinence but they do it behind the back- you know, it’s hypocritical. It’s a barrier. The church leaders are a barrier because they do

not open doors. Now I'm told in [certain region] church leaders reactive in fighting HIV/AIDS. But here they don't want to hear about it.

Another service provider stated her experience as follows:

I feel that we've got to do something as Christians. This has got to be one place that we can start to combat the stigma. I've been trying for a long time with churches to be education partners but they don't contact us back so I'm at the point where I would like ... I would never really out anyone in their congregation but I would like them to know that there are people in their congregation who are living with HIV/AIDS. And I wonder shouldn't you be concerned that this is happening in your congregation where you preach love and acceptance. That these people are being shunned? It's not right.

Gender and sexual orientation

Respondents reported varied experiences with respect to gender. One female respondent said that male clients were likely not to benefit from her services because of their attitude towards women. She argued that the men might think that as a woman she had nothing substantial to say to them. She regretted that there are not enough resources for male clients to be serviced by men and female clients to be served by women. On the other hand, a male participant experienced challenges while serving women, He said that immigrant women from a certain region did not look him in the eye and he could see that they were feeling intimidated when he looked them in the eye. He said that depending on experiences of the clients they would prefer to be seen by a certain sex. He gave the following example:

I have a client who came from a war torn country. They saw their husband get killed by a rebel and they were sexually abused in front of their husband before he was killed. I did an interview with this client under very difficult circumstances and when I referred her to my colleague who does support counseling I realized that she had concerns. When I realized this, I felt so bad that I did an intake with her and I had to.

All the service providers indicated that they had few problems reaching immigrant women for services. Women were actively seeking services and participating in various

activities such as support groups. Two respondents reported that women were responsive to services including protection issues. The respondent said that when the women were not accompanied by a male spouse they were more responsive but their responses were hindered by the presence of men. Two service providers reported serving couples where the woman was HIV positive and accessing services yet their male partners did not have an HIV diagnosis. This meant that the couple was not involved in protection from re-infection. One female client has had a child and is in the process of a second pregnancy since her diagnosis.

A respondent stated that her agency was currently involved in developing a project on how to cater to men and she is involved in doing needs assessment for this group. One respondent reported that her agency had started to serve transgender women who are a group that is vulnerable and was neglected. His agency is now trans-positive. Respondents also identified that that women PHAs are involved in AIDS work more than men. He put it this way:

Women PHAs are very much involved than men. Most PHAs women that I know of are very much involved. For women because they have been very vulnerable and it is a population that is involved in research and involved in service implementation. I remember when I came to Canada some people who came with me and others who came after me they were really getting good jobs because there's always jobs for PHA women. Women are really involved at the top and they are having their issues addressed. If you go to [agency] there's a lady working with HIV and she is very open about it. She is running a wonderful program. There's another woman doing [agency] who is also an immigrant. There's another woman with [agency]. There are lots of them who are HIV positive and they are doing a good job. But there's very little for straight men. There are lots that should be done. Getting the men mobilized.

A respondent who is heterosexual and a PHA himself said:

If you are a man and straight, you do not have a deal and you do not have a job to do. It is there for gay people. For me, I am straight and positive but it is really difficult for me to do this work. They think it is only gay men who are infected and should be the ones doing the work. If I do it then maybe I am gay and they will have nothing to do with me.

Limited Resources

Literature shows that the overall funding for HIV/AIDS standing at \$84.4 million for five years. The first sign of action to accommodate HIV positive population from endemic countries by Health Canada was a grant in 2006 of \$200,000 to the African Caribbean Council on HIV in Ontario to develop prevention guidelines, training and a research agenda. The total amount has been reduced with cutoffs and remaining funds being redirected to the Bill and Melinda Gates Foundation for research (Health Canada website, 2008; Elliott, 2008). All respondents indicated that there is need to increased resources to meet the needs of their clients. The mainstream organization in this study seemed to be the more adequately funded need additional staff to work with the immigrant community that they serve. This agency would benefit from funding by Citizenship and Immigration Canada for an ISAP program. The respondent working in this mainstream agency expressed her experience as follows:

I've had no formal immigration training. I m not well versed in immigration issues. Even when I call immigration they can't really educate me they just want to get me off the phone. When people come here and they say they are a protected person and someone has sponsored them and also the church has sponsored them. So I ask them who are you? Is it a protected refugee? And there is this other strange category? And they tell me that "Uncle John sponsored me?" And I ask "who is Uncle John" and they say "he works at that church". And I go "what church?" And no one knows which church. I just fee so unprepared and I fee like it's chance and creativity and a lot of hard work that helps me serve this person but its not through education or training. I feel unequipped. I know that if I had a little training about this or if I could take a little seminar...

More needs to be done to serve those who are already infected and affected by HIV/AIDS. It is ironic to note that through the efforts of two major world leaders in AIDS activism, a former United Nation's special envoy on AIDS in Africa the legendary Stephen Lewis, and musician Bono, both Canadians, have brought awareness among Canadians about the terrible toll HIV/AIDS is taking in Africa and the Caribbean. However, few Canadians

realize how the pandemic is affecting people who have come to Canada from those parts of the world, and how it can affect them too.

Socio-economic barriers

Another barrier that was highlighted in this study is socio-economic barriers. In this case, service providers felt that immigrants PHAs did not have financial capacity to meet their needs. Despite their low economic abilities, newcomers did not inform families left behind at their home countries of their HIV status and since it was expected of them to send money they sent their ODSP money home as remittances. According to the Statistics, 41% of new immigrants send remittances of up to \$2,100 within the first six months of arrival in Canada (Statistics Canada, 2008). Because of such financial constraints, some clients did not take their medication or did not adhere to nutrition guidelines as advised. Aware of these challenges, service providers had to be more flexible, especially for self-care clients. One service provider said that if her clients did not afford to come to her she went to them. One respondent found that newcomers living in shelters have difficulties. He described them as food poor.

They are hungry they need food. They take two hours to get to where you are. You are talking to someone who is hungry. They are staying in a shelter, and some of them have lost appetite or the food there is not culturally what they are used to. Because the client is hungry it becomes very difficult to give services to someone who is hungry and not feeling well.

Service providers felt that if their clients are hungry or have other overwhelming needs, then coming to an ASO to access services is not priority for them. For a service provider involved in protection work she felt that her clients may fail to disclose their HIV status when they are looking to address their financial needs. She put it as follows:

I have a client who came to Canada as a migrant worker and was working... She has been here more than five years and that client now has got AIDS and her visa expired. They wanted [her] to go back because she is from somewhere in [country]. She

doesn't like welfare... is not on welfare and does not even qualify for welfare. Do you think as a service provider I can go to her and give her information about HIV prevention? Do you think she needs this information from us? What she needs is housing, how she's going to pay rent. She is skilled. What she needs is a chance. You will find that if she hooks up with someone who would give her a lot of money then she would have no excuse to protect others.

Race and Ethnicity

During the discussion on race and ethnicity, one service provider did not believe race was a barrier at all. However, two respondents working with ethno-cultural agencies race described race as a barrier. The two respondents noted that their clients sought to know where the service provider was originally from. One respondent explained his experience as follows:

There are issues about where did you originally come from. So I say I originally came from [region]; and then you see somebody looking down. For a fact you know whatever you talk to them about they will feel you don't understand where I am coming from. I am coming from [region]. They are looking down. For me it means they are feeling; OK you can say whatever you want but you don't know me you don't know where I am coming from. You will never understand my issues.

These diverging opinions regarding the role that ethnicity played in service access point to the complexity of ethnicity in communities. An agency serving East Asians and the other serving African and Caribbean communities do not necessarily serve the same community. Africa is made up of over fifty countries, the Caribbean islands comprise of several countries similar to the East Asia region.

Criminalization of HIV/AIDS

Criminalization of AIDS was mentioned by 5 out of 6 respondents. One respondent said this topic was on the agenda for the International AIDS conference which was scheduled to take place beginning July 31st 2008. One respondent observed that the fear of criminalizing of AIDS may cause more people to stay away from services as they do not wish to disclose their status. This, they said, may result in higher rates of infection. One participant expressed

concern that women are now facing criminal charges for exposing their newborns to the AIDS virus through breastfeeding. This is because within some cultures breastfeeding is expected and when a woman does not breastfeed she would have to give a reason to her friends and family or they would suspect her reason for not breastfeeding as being HIV positive which might mean disclosing her HIV status. One respondent spoke about the difficulty of maintaining the boundaries as follows:

We have to be continually knowledgeable of every law of regulation that impact people living with HIV. As you may know or may not know there is a new piece that affects PHAs and that is criminalization of HIV. Issues of disclosing ones HIV status directly impacts the work that we do. Basically PHAs can be charged under the criminal law with infecting another person. For women this has serious implication because they can be charged with infecting their children and there are implications... Speaking to my colleagues who are engaged in prevention, there's only so much that you can do through safe sex practices, safer injection practices. We are not moral agents we don't police sexual behaviours. Our only obligation is to inform the clients on how to best protect themselves. This is for both PHAs and non PHAs. People who are HIV positive have a responsibility as well. ...For newcomers it has another layer to it. To inform them of the legality; it's another challenge. They might see you as a person who is policing their behaviour. If they know that people who are positive can be charged so why would they come to me if they view me as someone who would charge them? It becomes one person's word against another. How do you prove something like that? It's a complex issue...

Education

Most respondents spoke at length on the theme of education and awareness. A respondent stated that education for all will help curb stigma. He put it as follows:

It is the immigrants, refugees, and PHAs who should be engaged in creating alternative policy that facilitates changes. In partnership and collaboration with NGOs, pharmaceutical companies... They all have a vested interest... All government levels; we all have a responsibility. It should be part of policy to work with the stigma.

They identified the need for HIV education for both PHAs and non-PHAs. Two respondents were involved in getting communities to talk about HIV in churches and other community groupings. They, however, expressed their frustrations as they encountered

barriers. One respondent reported that ethnic church leaders were either unwilling to discuss the issue of HIV in their community or in denial. She put her experience as follows:

I asked one of the [church] leaders to allow me to talk to parents about how to dialogue with their children about sexuality. But the pastor asked me “how much are you gonna pay?” Because they think everything is money. It’s another barrier. They think you are having lots of money. [They] don’t want to support each other because they think you are taking money and using them. How can I transform these people to understand it’s not about money it’s about information? And our population is dying again. This is my frustration.

DISCUSSION

This study was conducted to understand the barriers that service providers experience when they work with immigrant women living with HIV/AIDS. An analysis of data was carried out to establish whether the barriers experienced by service providers were reflected in or differed with barriers highlighted and discussed in various studies.

This study found that barriers experienced by service providers were similar and dissimilar compared to the barriers experienced by immigrant women who are PHAs while seeking and accessing services from ASOs. Similar barriers include stigma, language, cultural practices and religious beliefs, immigration status, gender and sexual orientation, racism, education/knowledge and awareness, socio-economic barriers, resources, fear, trust (Alana 2001; Jimenez, 2004; Lawson, 2006; Remis, 1999; Tharao & Massaquoi 2001; Tharao et al 2000). Criminalization of HIV and boundary issues related to HIV status and or ethnicity of service providers were barriers that we different from those identified by women in other studies. A barrier not found in the literature but which came out among all respondents was the gender imbalance in relation to access to services for heterosexual males both PHAs and non-PHAs. This group was underrepresented with most agencies reporting service between 70-75 percent female PHAs. Different from the literature is the fact that respondents expressed a degree of satisfaction in access to services and participation of female PHAs. However they

were concerned that heterosexual men were not only missing but they might present a barrier to their female partners' participation in HIV programs. This barrier was connected to limited language ability which required the men to translate for the women. Cultural roles for women, where they are expected not to speak but let their husbands represent them as a barrier that has feature prominently in literature (Okoth, 2000; Morris and Sinnott (2003). Service providers stated that for there to be success in reducing the rate of infection among immigrants, men have to be involved in HIV work given the socio-cultural factors that give a male partner the role of head of family among many immigrant communities.

Language barriers were similar to those identified by Lawson et al (2006). Concerns about interpretation and the complexity of dialects among immigrants were clearly described by respondents. Some immigrant PHAs did not want people from their communities interpreting for them while some interpretation provided by friends or relatives was evidently inaccurate to the service providers.

Ethnocentrism was evident especially in ethno-cultural agencies where clients doubted the ability of service providers to meet their needs if they were not from “their culture”. Africans or Asians are not a homogeneous group. There are hundreds of different cultures and tribes. Within an AOP framework, it is expected that cultural competency will be achieved when immigrants are served by an ethno-cultural agency. Yet, according to the participants in this study, people of similar ethnicity were suspicious of each other. Another example is discrimination among PHAs and non PHAs. Service providers said they experienced mistrust from clients who suspected non PHA workers’ motives for doing HIV work if they were not HIV positive.

No problems were identified regarding cultural practices such as female genital mutilation and vaginal cleansing. Since four out of six participants in this study were immigrant males this may have minimized their ability or willingness to mention this issue.

Most of the barriers identified in serving immigrant women in this study are similar to barriers that have been reported in literature. The same barriers have been experienced by

women in their countries of origin (Jaboya, 2007; Lawson et al, 2006). Unless these barriers are addressed, the prevalence of HIV/AIDS will continue to rise in Canada and other immigrant receiving countries.

Other gaps that have been identified in the literature (Jimenez, 2004; Larkin, 2000; Lawson, 2006) are funding for specific programs tailored to immigrants living with HIV/AIDS and those from endemic regions. This barrier was identified in this study as lack of culturally competent staff in the mainstream agency and limited funding in the ethno-cultural agencies.

Lawson (2006), Ilana (2006) and Tharao (2004) have found that HIV-related stigma, discrimination, and denial often have a negative impact on health including social support networks, employment and working conditions, personal health practices, and coping skills for immigrant PHAs.

My study confirms Tharao et al (2001) findings that immigrants' moral values are judged by their HIV status. This not only discourages from taking an HIV test but also from accessing services after they receive an HIV positive diagnosis. HIV-related stigma has implications not only on HIV-positive people, but also for their families and communities. Similar to findings in this study, Debjani et al (2006) showed that HIV positive people will not see a specialist counselor within an agency if everyone knows that the counselor is a HIV/AIDS expert. Debjani also studies show that immigrant women prefer to participate in training and workshops that work with a larger group, not just a focus group. Since immigrant women rely heavily on their social community networks, their fear of stigmatization and exclusion are justified. In Canada, the fear of stigmatization for the whole community, as opposed to personal stigma, has been identified as a deterrent for HIV testing for immigrants whose lifestyle is communal-based. The racist discourse exemplified by Wente (2006) that Canada is importing HIV from sub-Saharan Africa does little to help removed the stigma. As Lawson et al (2006) have noted, organizational practices and policies may support stigma and discrimination, even if unintentionally, especially when clients have to access services from

AIDS services organization.

This study has confirmed Jimenez's (2004) report that immigrants from Africa who test positive for the virus are so concerned about maintaining their anonymity that they do not want to go in person to the nearest HIV clinic but would rather travel miles where they are unlikely to meet people that they know. In my study this avoidance was shown in the case where service providers have to provide different volunteer drivers to transport clients to an AIDS clinic at different times of the day and ensure that the clients do not meet at the clinic reception area.

Respondents identified religion as a barrier based on stigma experienced by clients within ethnic church communities and in terms of lack of support from religious organizations servicing immigrants. This finding is different from the studies in the literature review by Tharao and Massaquoi (2001) that have shown that religious beliefs of immigrants prevented them from accessing services.

Because this was a qualitative research design with a small, nonrandomized sample drawn from service providers in Toronto and one regional agency in a second tier city, these results cannot be generalized. However, the characteristics of the current sample seem to be representative of the service providers' experiences since there are few AIDS Service Organizations in Toronto and the regional ASO represents a population of over 700,000 people. There may be other factors that make this sample group different; for example Toronto and one regional agency in a second tier city are predominantly immigrant receiving regions.

Discussion on service provision from an AOP framework

These studies have identified a number of organizations that offer services to newcomers. They offer good services for newcomers including immigrant women living with HIV/AIDS. However, based on the study, barriers exist that warrant a discussion on how organizations that are supposed to support newcomers create barriers or have structures that discriminate against the intended beneficiaries of the services.

In anti-oppression practice which aims to provide more appropriate services by responding to people's needs regardless of their social status, there is a general assumption that access to health care services in Canada is a human right and therefore it is guaranteed and automatic for everyone. This is not always the case because, and as Yee (2008) observed, "...individuals require different type and levels of support to achieve same capacity for autonomous action".

A rights based approach is therefore not enough to address the issues of individuals (Yee, 2008). This means that culturally sensitive services are paramount while serving newcomers. Paying special attention to a minority group has sometimes been seen as reversed discrimination with the services being seen as not in the public interest. Such an argument stems from a discourse of racial dominance and the inability of the racially dominant group to see how that dominance operates unintentionally through the discrimination, marginalization and systemic explanation for the exploitation (Nestel, 2006). An AOP framework approach dealing with equal access would provide more appropriate and sensitive services by responding to people's needs with consideration of their social status.

Service providers talked about the boundaries that they have to maintain when they are themselves living with HIV/AIDS. They have to provide services and also participate in peer support groups. Service providers were also "clients" and one talked about the challenges of dealing with familiar issues they were facing personally and of being part of the "they". They felt that there is no clear line between "they" the clients and "us" the service providers.

Also, for ethno-cultural agencies, the service providers are also members of the community which means their clients are also friends and acquaintances that they meet at community functions and at church. In such situations issues of boundaries and sensitivity about clients' information and activities put both service provider and client in a precarious position. Participants felt trapped because they cannot disclose their clients' HIV status or interfere in the clients' affairs even when they suspect the clients are not adhering to policies

and procedures that they have discussed with them. Their work

CONCLUSIONS AND RECOMMENDATIONS

From the above findings, the conclusion is that Canada is not importing AIDS from sub-Saharan Africa. Instead, my study suggests that Canada is importing the AIDS problem which has a lot to do with stigma, discrimination, fear, ethnocentrism and marginalization. Research shows that more than half of new infections among immigrants happen in Canada. My findings are in line with studies which show that there are barriers that prevent immigrant PHAs from seeking services. The barriers are some of the common immigrant challenges, such as language, socio-cultural, structural, discrimination, lack of knowledge and awareness and socio-economic.

The similarities in the barriers experienced by service providers and those experienced by the immigrant women PHAs that they serve suggest that work needs to be done to develop appropriate ways of providing services.

Knowledge of the barriers experienced by service providers while serving immigrant PHAs can help policy makers find ways of reducing and eliminating the barriers. The similarities of the barriers experienced by service providers and those experienced by the women living with HIV/AIDS that they service suggest that much work needs to be done to develop appropriate ways of providing services.

More research is needed to better understand the barriers that immigrant heterosexual men living with HIV/AIDS experience which make them not seek or access services. It is paramount to find ways of reaching this underserved population if the issue of HIV "gaining an immigrant face in Canada" is to be addressed.

Immigrant women will need to be empowered to be able to deal with the issues of prevention, infection and treatment. All communities need to be educated on HIV to help reduce the stigma. For this to happen, immigrant women will need to participate in administration and policy processes in agencies and work involving them.

Funding should be used to train more immigrant women to work within their community groups. Awareness training should focus on larger immigrant groups instead of those already infected with the virus. This will reduce stigma and will help in information dissemination for prevention.

References

- Alana, K. (2001). HIV/AIDS and immigration final report. Canadian Strategy on HIV/AIDS. Canadian HIV-AIDS legal network.
- Allahar, A. (1998). Race and Racism: Strategies of Resistance. In: Satzewich, Vic, Racism and Social Inequality in Canada, Toronto: Thompson Educational Publishing Inc. pp. 335-354.
- Alliance for South Asian AIDS Prevention (ASAP), (2001) Article on South Asian women living with HIV/AIDS. Canadian Woman Studies 21.2 (Summer-Fall 2001): 131(3). CPI.Q (Canadian Periodicals). Retrieved February 22, 2008.
- Anonymous (2005). Disease is not a justification for discrimination. The Lancet. London: Feb 26-Mar 4, 2005. 365(9461), p. 728.
- Anonymous (1995). Taking the nation's pulse: to help it formulate policy, the federal government talked to Canadians to get their views on immigration Canada and the World Backgrounder. Waterloo: Apr 1995. 60(6).
- Arat-Koc, S. (2008). Graduate seminar class. Course # IS8926 - Women, Immigration and Settlement, winter 2008, April 2 2008.
- Bannerji, H. (2000). The paradox of diversity: the construction of a multicultural Canada and "women of colour". Women's Studies International Forum, 23 (5), 537-560.
- Barouch, G. (1992). Support Groups. The Human Face of the HIV/AIDS Epidemic. A handbook for health care professionals, people with AIDS, Their loved ones, and the community-at-large. Long Island Association for AIDS Care, Inc, Huntington Station, New York.
- Belleau, M. (2003). Mail-Order Brides in a Global World. Albany Law Review, 67: 595-607.
- Canadian HIV/AIDS Legal Network, HIV/AIDS policy and law review, volume 11, number 1, APRIL 2006. Scaling up HIV testing: human rights and hidden costs.
- Canadian Legal Aid Network (2008). Criminal law and HIV. Retrieved on 12 August 2008 from <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1318>
- Chirimuuta, C. and Chirimuuta, J. (1987). Aids, Africa and Racism. Brethby House, Stanhope, Bretby, Nr Burton-on-Trent, Derbyshire, Britain.
- Debjani, M., Jacobsen, M., O'Conno, A., Pottie, K. and Tugwell, P. (1996). HIV/AIDS in the context of culture. The Canadian study on the determinants of ethno culturally specific behaviour related to HIV/AIDS. Canadian Journal of Public Health. 87 (Suppl. 1):33-7.

- Elliott, R. (2008). AIDS: Canada missing in action. Government squanders opportunity to redeem itself on world stage at Mexico conference. *Toronto Star*. AA8. Saturday August 9, 2008.
- Fowler, N. (1998). Providing primary health care to immigrants and refugees: The North Hamilton experience. *Canadian Medical Association Journal*, 159(4), Academic Search Premier.
- Goffman, E. (1963). *Notes on the Management of the Spoiled Identity*. New York: Simon and Schuster.
- Health Canada Website, (2008). Retrieved on 12/ HIV/AIDS Global Engagement Grants Programme - <http://www.hc-sc.gc.ca/dc-ma/aids-sida/index-eng.php>
- HIV/AIDS Epi Update (2007). Public Health Agency of Canada. HIV/AIDS in Canada among Persons from Countries where HIV is endemic. Centre for Infectious Disease Prevention and Control – November 2007. Pg 89-104. www.phac-aspc.gc.ca/hast-vsmt/ Retrieved from http://www.phac-aspc.gc.ca/aids-sida/publication/epi/pdf/epi2007_e.pdf on 11 August 2008.
- Hyman, I. (2003). Canada's 'Healthy Immigrant' Puzzle - A Research Report. *Women & Environments International Magazine*. Toronto, 60/61, p31.
- Jimenez, M. (2004, October 2). "Coming to Canada with dreams and HIV: SATURDAY SPECIAL: Public health officials are reeling from an increase in infection rates among immigrants from Africa and the Caribbean, Marina Jimenez writes." *Globe & Mail* (Toronto, Canada) (Oct 2, 2004): A1. CPI.Q (Canadian Periodicals). Retrieved February 22, 2008 from <http://proquest.umi.com/pqdweb?index=0&did=1054761191&SrchMode=1&sid=2&Fmt=3&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1207611804&clientId=10120>
- Konkle-Parker, D. Erlen, J. and Dubbert, P. (2008). *Journal of the Association of Nurses in Aids care*. Vol 19, No. 2, pg 98-104.
- Larkin, J. (2000). Women, poverty and HIV infection. *Canadian Woman Studies* 20.3 (Fall 2000): 137(5). CPI.Q (Canadian Periodicals). Retrieved February 22, 2008, from <https://pi.library.yorku.ca/ojs/index.php/cws/article/viewFile/12678/11761>.
- Lawson, E., Gardezi, F., Galzavara, L., Husbands, W., Myers, T. and Tharao, W. (2006). HIV/AIDS stigma, denial, fear and discrimination: Experiences and responses of people from African and Caribbean communities in Toronto. The African and Caribbean Council of HIV/AIDS in Ontario (ACHCHO), and The HIV social, behavioural and epidemiological studies unit, University of Toronto.

- Litorp, H., Franck, M. and Almroth, L. (2008). *Female genital mutilation among antenatal care and contraceptive advice attendees in Sweden*. *Acta Obstetricia & Gynecologica Scandinavica*. Vol. 87 Issue 7, p716-722 Retrieved on August 19, 2008 from <http://www.informaworld.com.ezproxy.lib.ryerson.ca/smpp/section?content=a793697454&fulltext=713240928>
- Long, R. and Boffa, J. (2007). Why internationally adopted children should be screened for tuberculosis. *CMAJ*. 177(2), 172–173.
- Longitudinal Survey of Immigrants to Canada: Process, progress and prospects. Released September 4, 2003. Retrieved <http://www.statcan.ca/english/freepub/89-611-XIE/index.htm> on 11 August 2008.
- McDonald, J. and Steven, K. (2004). Insights into the ‘health immigrant effect’: health status and health service use of immigrants to Canada. *Social Science & Medicine*. Vol. 9, No. 8, 1613-1627.
- McIntosh, Peggy, (1990). White privilege: Unpacking the invisible knapsack. By: McIntosh, Peggy. *Independent School*, Vol. 49 Issue 2, p31
- Montoya, I., Bell, D., Richard, A., Goodpastor, W. and Carlson, J. (1998). Barriers to social services for HIV-infected urban migrators. *AIDS Education and Prevention*. New York: Aug 1998. Vol. 10, Iss. 4; pg. 366-380
- Morris, M. and Sinnott, J. (2003). Immigrant and Refugee Women. Fact Sheet. Canadian Research Institute for the Advancement of Women (CRIAOW). Retrieved on 22.10.2006 from http://www.criaw-icref.ca/iindexFrame_e.htm.
- Ndiwane, A. (2008). Laying down the knife may decrease risk of HIV transmission: cultural practices in Cameroon with implications for public health and policy. *Journal of Cultural Diversity*. Vol. 15 Issue 2, p76-80. Retrieved on August 19 2008 from <http://web.ebscohost.com.ezproxy.lib.ryerson.ca/ehost/pdf?vid=7&hid=16&sid=71a94165-7214-48e3-ad71-ac6837211ac3%40SRCSM1>.
- Nestel, S. (2006). Narratives of Exclusion and resistance of Women of colour. In: *Constructed Labour: Race and Gender in the Re-Emergence of Midwifery*. Vancouver and Toronto: UBC Press, 2006, Pp. 125-159 Ch. 5).
- Okoth, M. (2000). Positively Women. A voice for HIV positive women in the United Kingdom. *International Conference on AIDS*. Int Conf AIDS. 2000 Jul 9-14; 13: abstract no. WePeE4839. 347 - 349
- Pollack, S. (2004). Anti-oppressive social work practice with women in prisons: Discursive reconstructions and alternative practices. *British Journal of sociology*, 34, 693-707.

- Public Health Agency of Canada (2008). Retrieved on 12 August 2008 from –
<http://www.phac-aspc.gc.ca/aids-sida/info/index.html>
- Randall, R. and Vernillia, A. (1993). "Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African-Americans." *Health Matrix* (3), 127-194.
- Remis, R. (2003). The Epidemiology of infection among persons from HIV endemic countries in Ontario: update to 2002. Department of Public Health Sciences, University of Toronto retrieved on 29 June 2008 from
<http://www.phs.utoronto.ca/ohemu/Presentations.html#2002>
- Remis, R. and Whittingham, E. (1999). The HIV/AIDS epidemic among persons from HIV-endemic countries in Ontario, 1981-98: Situation report. Department of Public Health Sciences, University of Toronto.
- Shirwadkar, S. 2004. Canadian domestic violence policy and Indian immigrant women. *Violence Against Women*, 10(8): 860-879.
- Simich, L and Este, D. (2007). Meeting multilevel challenges of Sudanese Wellbeing and social integration in Canada. 12th International Metropolis Conference, October 2007, Melbourne, Australia.
- Sinnema, J. (2007, December 1). The changing face of HIV/AIDS; As doctors and others on the front line in Alberta mark World Aids Day, they wonder if complacency has set in; (Final Edition), *Edmonton Journal*, Alta: P. A3.
- Statistics Canada Study: The Daily: Remittances by recent immigrants 2001 to 2005. Wednesday, July 23, 2008. Accessed from:
<http://www.statcan.ca/Daily/English/080723/d080723b.htm> on 10 August 2008
- Tharao, E. and Massaquoi, N. (2001). "Black women and HIV/AIDS: contextualizing their realities, their silence and proposing solutions." *Canadian Woman Studies* 21.2 (Summer-Fall 2001): 72(10). CPI.Q (Canadian Periodicals). Retrieved February 22, 2008 from
http://www.stopaids.ca/content/pub_details.cfm?ID=179&CAT=1&lang=e
- Tharao, E., Calzavara, L. and Myers, T. (2000). "What Service Providers Need to Know to Provide Effective HIV/AIDS Programs and Services for African Immigrants in Canada: East African HIV/AIDS Study." Oral/ Poster Presentation, 13th International AIDS Conference, Durban, South Africa. July 9-14, 2000. Retrieved February 22, 2008 from
<http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102238216.html>

- Tharao, E., L. Calzavara and T. Myers (2001). "To Test or Not to Test: Factors Influencing HIV Testing in East African Communities in Toronto." Paper Presented at the 10th Annual Canadian Conference on HIV/AIDS Research. Toronto, Canada, May 3- June 3, 2001. Retrieved February 22, 2008 from <http://cahrerv.ca/english/resources/abstracts/abs/abs408.htm>
- Thobani, S. (2000). Closing ranks: racism and sexism in Canada's immigration policy. *Race and Class*, vol. 42, no. 1, p. 35-55.
- UNAIDS (2008). Global Report 2008. http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp
- UNAIDS website (2008) Retrieved on 12 August 2008 from http://data.unaids.org/pub/GlobalReport/2008/JC1511_GR08_ExecutiveSummary_en.pdf
- UNAIDS website (2008). Retrieved on 12 August 2008 from http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp
- Wayland, Sarah. (2006). *Unsettled: Legal and Policy Barriers for Newcomers to Canada and the Law Commission of Canada*. Toronto. Community Foundation of Canada and the Law Commission of Canada. Available on-line at www.cfc-fcc.ca, www.lcc.gc.ca
- Wayland, Sarah. (2006). *Unsettled: Legal and Policy Barriers for Newcomers to Canada and the Law Commission of Canada*. Toronto. Community Foundation of Canada and the Law Commission of Canada. Available on-line at www.cfc-fcc.ca, www.lcc.gc.ca
- Wente, M. (2006, August 15). A few down-home truths about HIV/AIDS in Canada. *The Globe and Mail*. Toronto, Ont.: p. A.17.
- Yee, J. (2008). Graduate Seminar class. Course # IS 8902 - The Settlement Experience in Canada. Required course for MA program in Immigration and Settlement, winter 2008.

Table 1.**Study Sample**

	Male	Female	Total
Age bracket			
25-30		1	1
26-30	1		1
31-35	1		1
36-40	2		2
41-45		1	1
Highest Education			
College Diploma	1	1	2
Bachelor Degree	2	1	3
Master's Degree	1		1
Ethnicity			
African	2	1	3
East Asian	1		1
Canadian/European		1	1
Mixed-race	1		1
Residential/Immigration Status			
Convention Refugee	1		1
Permanent resident	1		1
Canadian citizen	2	2	4
Job Title			
Prevention Coordinator		1	1
ISAP Coordinator	2		2
Support Services - Coordinator	2		2
HIV/AIDS Advocacy	2		2
Type of Agency			
Ethno-cultural	3		3
Mainstream	1		1
Regional		1	1
TOTAL	4	2	6

Appendix A

Interview Questions

- 1) What services do you provide?
- 2) Who are your clients?
 - i. A certain age group?
 - ii. Male
 - iii. Female
 - iv. Francophone
 - v. Gay/Lesbians
 - vi. Newcomers to Canada
 - vii. Other
- 3) How do you find your clients?
- 4) How do your clients find you?
 - i. Are they referred to you?
 - ii. Are you involved in outreach?
 - iii. Are they simply walk-ins?
- 5) What barriers do you encounter when:
 - i. Reaching clients or the clients finding you?
 - ii. Connecting with clients?
 - iii. Serving clients?
- 6) Are the barriers related to:
 - i. Stigma
 - ii. Language
 - iii. Socio-economic
 - iv. Religion
 - v. Race
 - vi. Immigration status
 - vii. Education
 - viii. Other?
- 7) Why do these barriers exist?
- 8) What do you do to reduce the barriers?
- 9) What needs to be done to eliminate the barriers?
- 10) Who should be involved in removing the barriers?
- 11) Are immigrants women involved in HIV/AIDS
 - i. prevention
 - ii. treatment
 - iii. support
 - iv. advocacy
 - v. policy
 - vi. other