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Risk perception and vulnerability to STIs and HIV/AIDS among immigrant Latin-American women in Canada

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This paper describes the migratory experiences of Latin American migrant women living in Canada, their perceptions of the risk of HIV, AIDS and other sexually transmitted infections (STIs) and barriers to accessing healthcare services. We conducted 25 in-depth interviews with Latin American migrant women living in Montreal, Canada. The majority of participants were permanent residents and refugee status claimants. Women's experiences in Canada were characterised by uncertainty, deception and fraud, separation from their families and feelings of discrimination. Women's risk perception of HIV/AIDS/STIs involved relations of gender inequalities of power. Women who did not perceive themselves to be at risk were those who had a stable partner who they felt they could trust. The majority of women reported difficulties in accessing sexual and reproductive health services. Women's vulnerability to HIV/AIDS/STIs was determined by: experiences during their lifecourse; their migratory status, which was associated with sexual abuse, abuse at work, language barriers and lack of social support networks; and their ability to access health services. The provision of health services to this population must focus on sexual and reproductive health needs and should do so from a multicultural perspective that takes into account the changes associated with the migration process.

Keywords: risk; vulnerability; Latin American women; HIV/AIDS/STIs; migration; Canada

Introduction

A new trend of feminisation of migration has been occurring worldwide (Brabant and Raynault 2012). In Canada, female immigrants make up 20.3% of the female population. Canada's population of immigrant women grew by 14% between 2001 and 2006 and it is expected that this growth will continue (Statistics Canada 2012a). As a result of globalisation, migration flux is changing and the number of people in Canada with either undocumented or with precarious status is growing (Rousseau et al. 2008). In the province of Quebec, 9.16% of immigrants were born in a Latin American country (Statistics Canada 2007b) and Colombia and Mexico figure among the top 10 refugee source countries (University of Ottawa Human Rights and Education Centre 2011).

Studies on Latin American immigration HIV, AIDS and other sexually transmitted infections (STIs) have focused on exploring the epidemiology of HIV-positive immigrants (Llenas-Garcia et al. 2012; Prosser, Tang, and Hall 2012), HIV risk and prevention (Deren et al. 2011), acculturation and sexual behaviour patterns (Magana and Carrier 1991), sexuality and HIV risk in men (Carillo and Fontdevila 2011), risky sexual behaviours (Bronfman et al. 1995; Levy et al. 2005; Weiss and Tilman 2009) and qualitative needs

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assessment of HIV services (Shedlin and Shulman 2004). Few studies on immigration and HIV/AIDS/STIs have considered the gender differences unique to the experiences of Latin American women immigrants.

The migrants' lifecourse

Three phases of migrant women's trajectory render them vulnerable to STIs and HIV: a troubled past in their country of origin, the migration journey and their precarious status when they arrive in Canada (Brabant and Raynault 2012).

Leaving their country behind

The migration of people from South and Central America to Canada did not gain significant importance until the early-1970s (Simmons 1993). In recent years, the Latin American community has quickly grown. Between 1996 and 2001, the number of people reporting Latin American origins rose by 32%, while the overall population has only increased by 4% (Statistics Canada 2007c). Several factors explain why Latin Americans choose to migrate to Canada: the slow erosion of their quality of life, limited economic opportunities, generalised situations of political violence, crime and public insecurity, as well as situations of domestic violence (Berhard, Landolt, and Goldring 2008). Although the male-headed household is still the most predominant structure in Latin America, it is becoming more common to see women at the head of households (Socio-economic Database for Latin America and the Caribbean 2012). As a result, many women are becoming the sole providers for their families, pushing them to search for better economic opportunities. A number of characteristics of their countries of origin put migrant women at a disadvantage compared to Canadian women, including higher mortality rates, higher burden of communicable diseases and more reproductive complications (Llácer et al. 2007).

The migration journey

For many migrant women, the process of migration involves dangers to their physical and mental health (Llácer et al. 2007). This is especially true of irregular migrants who travel outside of routine patterns of controlled mobility (Macpherson and Gushulak 2001). Many Latin American migrant women who travel by land to North America often stop at transit stations, where they encounter many risks. This term refers to the multiple stops in countries that the migrant women make on the journey to their final destination (the USA or Canada). In these transit stations, women stock up on provisions, change their clothes and meet more people to continue on with their journey. The precarious situation of mobile populations increases the likelihood of transactional sex, sex for survival, rape and non-professional commercial sex, and condom use negotiation is often not an option (Bronfman et al. 2002).

The immigration experience

Upon arrival in Canada, the new physical and socioeconomic environment confers challenges to resettlement and affects health. Entry status determines access to the labour market, residency and employment rights, ability to require legal citizenship, access to social and health services, social security and language training programmes (Llácer et al. 2007). New immigrants to Canada are among the five groups most likely to experience

persistent poverty in Canada (HRSDC 2007). In addition, as a result of being illegally employed, migrants with precarious status frequently work under abusive and unacceptable working conditions (Brabant and Raynault 2012). The precarious status of migrants has consequences on their mental health: permanent fear of being denounced, stress and anxiety, isolation, violence and lack of control (Brabant and Raynault 2012). Newly arrived immigrant women also face challenges with regards to their sexual and reproductive health. Many previous studies have documented the barriers experienced by immigrants or refugee claimants when trying to access healthcare resources in Canada (Brotman 2003; Gagnon et al. 2011; Oxman-Martinez et al. 2005; ter Kuile et al. 2007). Refugee claimant women in Montréal and Toronto face barriers in accessing health and social services during the post-birth period, including difficulty in being reached by health professionals postpartum, language barriers, low health literacy, lack of psychosocial assessments, support and referrals, and find the refugee health benefits limited and confusing (Gagnon et al. 2011). Language is a fundamental barrier in accessing healthcare services.

Changes in gender roles

Changes in gender roles are an important aspect of the resettlement process of immigrant and refugee women. Gender roles in Latin America still often assign women submissive and obedient attitudes towards their partners and sexual relations are associated with women's reproductive function (Raj and Silverman 2002). Men are viewed as providers and masculinity is equated with roles of domination, authority and paternity (Raj and Silverman 2002). Women who immigrate are confronted with different gender roles in Canada and they experience changes in family and gender relationships (Poggio and Woo 2000). As immigrant women acculturate to the new gender role ideology, their changes in behaviour are often met with resistance from their male partners, resulting in increased efforts to control women, including the use of violence (Raj and Silverman 2002). In addition, many migrant women leave their children behind with the hope of eventually reuniting with them in Canada. Berhard, Landolt and Goldring (2008) found that Latina mothers in Toronto are uncertain about when they will be reunited with their children and feel that they lose maternal status as a result of long periods of separation from them. These experiences of separation produce feelings of shame, guilt and hopelessness.

Against this background, our study aims to explore the experiences of Latin American immigrant women living in Montreal, their perceptions of HIV/AIDS/STI risk and their experiences in accessing sexual and reproductive health services.

Methods

We conducted a qualitative study using an ethnographic approach (Boyle 2003). Research was conducted between July 2011 and March 2012 in the city of Montreal, Canada. We collected data through both in-depth interviews and non-participant observations. The inclusion criteria were being a woman born in a Latin American country, having immigrated to Canada within the last five years and being at least 18 years of age. The exclusion criteria were having lived in Canada for more than five years, being in Canada for tourism purposes and having arrived in Canada with a work visa. We interviewed 25 participants to reach data saturation (Corbin and Strauss 1990).

All women were informed of the purpose of the study and their informed consent was obtained. All women participated in the study on a voluntary basis. We ensured the women understood that their participation in the study would have no effect on their access to social or health services. The location of the interview was chosen by the participant to ensure that they would feel comfortable and in confidence. The principal investigator conducted all interviews in Spanish, the language all participants felt most comfortable in.

Through in-depth interviews we explored the following themes: risk perceptions of STIs, HIV and AIDS, measures taken to deal with the risk of HIV/AIDS/STIs, knowledge of HIV/AIDS/STI prevention and transmission, and barriers and facilitators experienced when accessing health services for sexual and reproductive health concerns. We recruited participants in different and complementary locations at two health and social service centres of the Montreal Metropolitan Area that were attended by Latin American immigrant women, and used the snowball sampling technique. We obtained permission to recruit participants from the health and social service centres in question. Women were afraid of revealing their true migration stories, as for many this process was painful. Sexual and reproductive health is a sensitive topic and many women felt ashamed to speak about certain issues. Moreover, as many women received social welfare support from the government and also worked clandestinely, many preferred not to reveal details about their personal lives. For these reasons, it was especially important that the principal investigator establish a trusting and empathic relationship with participants. Trust was achieved due to the fact that the principal investigator was Latina and presented herself as an immigrant woman living in a similar situation as the migrant women: far away from home and family. Another aspect that helped establish trust with the participants was that the principal investigator participated in activities with the migrant women, such as cultural activities, lunches, French classes and so on, prior to interviewing them. Furthermore, validity was achieved by asking the interviewed women to read a first draft in Spanish to make sure that the document accurately reflected their experiences and feelings.

We also carried out non-participant observations in places where Latin American immigrant women socialised, for example, at community centres that provide services for immigrants. The principal investigator conducted a total of 96 hours of non-participant observation over a four-month period. All hours of observation were recorded through fieldnotes.

We recorded, transcribed and processed all interviews. For data processing we used Atlas-ti software (Corbin and Strauss 2003). We first employed open coding (i.e., the interpretative process by which data are broken down analytically [Corbin and Strauss 1990]) and, subsequently, axial coding (i.e., the process of relating categories to their subcategories and testing these relationships against the data [Corbin and Strauss 1990]). We used the interview guide for the data analysis and, when appropriate, we employed in Vivo coding (Glaser and Strauss 1967). The information was classified according to the following dimensions: migratory experience, risk perceptions of HIV/AIDS/STIs and barriers and facilitators to accessing health services for sexual and reproductive health concerns. The study was approved by the Ethics Committee of the Nursing Faculty of Universidad de Antioquia in Medellin, Colombia.

Results

Profile of participants

Of the 25 participants, 11 were permanent residents, 1 was a Canadian citizen, 10 were refugee status claimants, 2 had been denied refugee status and 1 was in Canada on a tourist

Table 1. Socio-demographic profile of study participants.

	Permanent resident/ Canadian citizen $n = 12$	Refugee status claimant/ denied refugee/tourist visa $n = 13$	Total $n = 25$	%
Age in years				
20 or less	0	1	1	4
21–29	5	7	12	48
30–39	6	4	10	40
40–49	1	1	2	8
Time in Canada				
Less than 6 months	0	0	0	0
6 months to 1 year (1 year inclusive)	2	4	6	24
Between 1 and 2 years (2 years inclusive)	1	2	3	12
Between 2 and 3 years (3 years inclusive)	2	6	8	32
Between 3 and 4 years (4 years inclusive)	1	1	2	8
Between 4 and 5 years (5 years inclusive)	6	0	6	24
Schooling				
Primary complete	0	0	0	0
Secondary incomplete	0	4	4	16
Secondary complete	2	5	7	28
Technical studies	4	2	6	24
Professional studies	6	2	8	32
Number of children				
0	4	4	8	32
1	4	6	10	40
2	2	2	4	16
3	1	0	1	4
4 or more	1	1	2	8
Occupation before arriving to Canada				
Homemaker	0	0	0	0
Paid work	9	10	19	76
Student	3	3	6	24
Occupation in Canada				
Homemaker, French language programme	6	12	18	72
Paid work	5	1	6	24
Student	1	0	1	4
Relationship status				
With a partner	10	9	19	76
Without a partner	2	4	6	24
Languages				
Spanish	5	8	13	52
Spanish and English	0	2	2	8
Spanish and French	5	3	8	32
Spanish, English and French	2	0	2	8
Principal reason for migration				
Domestic or family violence	1	2	3	12
Under threat in country of origin	1	4	5	20
Illegal status in the USA	2	2	4	16
Looking for better life conditions	2	3	5	20
Partner living or moving to Canada	4	2	6	24
To study	2	0	2	8

Note: data collected from in-depth interviews conducted in 2011 with Latin American women living in Montreal.

visa but intended staying past her visa expiration (Table 1). A permanent resident in Canada is someone who has acquired permanent resident status by immigrating to Canada, but is not yet a Canadian citizen (Minister of Citizenship and Immigration Canada 2012). Permanent residents are eligible for health insurance and enjoy the same benefits as Canadian citizens (Minister of Citizenship and Immigration Canada 2006). In the province of Quebec, these benefits include medical services considered medically necessary, dental services in the event of trauma or illness and certain optometric services. Those who receive last-resort financial assistance (social welfare) are also covered for prescription medications. A refugee claimant is someone who has applied for refugee status and is waiting for an answer on whether refugee status will be granted (Minister of Citizenship and Immigration Canada 2012). Refugee claimants are covered under the Interim Federal Health Program (Minister of Citizenship and Immigration Canada 2006). Benefits are limited to emergency and essential healthcare coverage: prenatal, contraception and obstetrical care, essential prescription medications, emergency dental treatment and treatment and prevention of serious medical conditions. Other services covered, but which require pre-approval from Citizenship and Immigration Canada, are counselling, psychotherapy, diagnostic procedures, ambulance services (unless emergency) and corrective eyewear devices (Minister of Citizenship and Immigration Canada 2012).

Ages of participants ranged from 20 to 48, with the average age being just over 29 years. Before immigration, 19 participants combined domestic work with paid work outside the home. After immigrating to Canada, the majority of women stayed at home to care for children. Many were also enrolled in French language programmes and some reported occasional paid work. Most participants had one or two children or no children at all. Three women migrated while pregnant and six women were pregnant at the time of the interview.

The majority of women took between two weeks and a month to prepare for departure from their country of origin. During this time, they sold their possessions, resigned from their jobs, looked for caretakers for their children if they were to travel alone and prepared their tickets and documentation for travel. Seven participants arrived in Canada via the US border. Of these seven participants, most had been illegal in the USA, crossed the border by foot and then submitted a claim for refugee status at the Immigration Canada post. Other respondents entered Canada by plane with a tourist visa, with permanent residency status or claiming refugee status. Fourteen women arrived alone, however in several cases they had stable partners who stayed behind or who were waiting for them in Canada. Sixteen participants were in a stable relationship at the time of migration. The majority of participants were receiving financial assistance from the Canadian government for various reasons: as refugee status claimants, because they had children under the age of 18, because they were participating in a French language programme or as permanent residents eligible for last-resort financial assistance (social welfare).

Reasons for migrating

The main reasons for migration were: having been a victim of physical sexual abuse, being under threat in their country of origin, the desire to seek better life opportunities both for themselves and for their children, involvement with a partner who was residing or planning on residing in Canada and being an illegal resident of the USA. Of the 25 respondents, 8 had a history of physical and sexual violence and abuse before coming to Canada, 5 participants were being supported by a psychologist and 2 had had experiences

of inter-partner violence while in Canada and had sought refuge in shelters for women in situations of abuse. Overall, 9 women of the 25 interviewed had experienced physical, sexual or psychological abuse.

The migratory experience

Respondents described changes in their lifestyle upon arrival in Canada. Participants reported that from the moment they left their home country and throughout the migration and immigration experience, they felt uncertain about their status in Canada and about whether they would be capable of adapting to a new life. We found that legal status upon arrival in Canada was closely related to the degree of uncertainty felt by participants – those who arrived with permanent residency knew that they would have access to legal work opportunities, health coverage and education for their children. Refugee claimants did not enjoy such certainty – they were afraid of being refused refugee status and of not having access to subsidised daycare for their children. The waiting period for a decision about acceptance to Canada is about three to four years. During this time, the refugee claimants are not allowed to leave the country, are not given the same rights as the rest of the population and immigration authorities hold their passports until their case is settled.

Two respondents described that their biggest challenge in the migration process was the experience of being deceived by someone or being a victim of fraud. In both cases, the women experienced domestic abuse and sought to escape by immigrating to Canada. Both participants travelled with the illusion that their lives would improve once in Canada, that they would find work, make a decent salary and enjoy fair working conditions. Leidy (38 years old, refugee claimant) had worked as a waitress in the Dominican Republic. One of her clients offered her work as a waitress for special dinners in his home in Canada and made all travel arrangements. Once in Canada, he did not respect the number of work hours they had agreed upon. Leidy felt that he exploited and abused her rights. She was given no days off, had no means of transportation, lived an hour from the closest city and felt isolated as she was not able to communicate in either French or English:

> Look, I am waking up at 5:30 in the morning, and I am going to bed at one in the morning just to go to work … I was stressed to the point of going crazy. Without family, without a telephone, without a day off, not knowing the language, it was a disaster.

A second participant, Lexis (33 years old, permanent resident) was a victim of fraud by a travel agent in Mexico. She paid the travel agency for all travel, living and work arrangements:

> It was very sad because you wouldn't believe that there are heartless people that throw you in an apartment without a single piece of furniture, without any dishware, without you even knowing the languages, we suffer from the cold, we go hungry.

These experiences recount situations of abuse and deception where people in the countries of origin took advantage of the women's vulnerable situations and their need to escape situations of domestic abuse.

For three participants, the most challenging aspect of migration was leaving their children behind to be cared for by their families. One respondent had not seen her children in seven years. Most women sent remittances home, hoping that they would eventually be able to sponsor their children and reunite with them in Canada. In order to send money home they accepted long hours and difficult work conditions. The women expressed that their motivation for better life conditions is what made the separation from their families bearable.

Table 2. Sexual and reproductive health events while in Canada according to immigration status of study participants.

	Number of permanent residents/Canadian citizens	Number of refugee status claimants/denied refugees	Total	%
Planned pregnancy(s)	6	5	11	44
Unplanned pregnancy(s)	1	2	3	12
Spontaneous abortion(s)	3	3	6	24
Sexually transmitted infection(s)	0	2	2	8
Birth(s)	7	4	11	44
Pap test(s)	10	6	16	64

Note: data collected from in-depth interviews conducted in 2011 with Latin American women living in Montreal.

Another migratory challenge expressed by the women was discrimination. Respondents waiting to receive permanent resident status have felt discriminated against for being immigrants and Latino women. They believed that the discrimination was associated with not speaking English and/or French, especially when seeking health and social services. They also reported feeling that they were not treated equally and that they were not attended to as quickly. Furthermore, those who did speak English and/or French felt discriminated against in the workplace because they were expected to work longer hours, were treated poorly and were given fewer opportunities. Women also expressed the feeling of being discriminated against because of their refugee-claiming status:

> Here they say that there is no discrimination, well this is the easiest way to be discriminated against, because you have no status. In all situations, you need to take out your papers and they see that you are not a tourist, nor are resident, you are nothing. You are floating because it's like you are nothing, you are not here in your country. (Martina, 34 years old, refugee claimant)

A common challenge for all women was the loss of social networks. In many cases, staying at home to care for their children was an obstacle to social integration and learning French or English. Without a social network, women reported feeling that they had little support and few people that they could trust and rely upon. They expressed a deep sentiment of solitude.

Perception of risk and vulnerability to HIV/AIDS/STIs

All respondents possessed general knowledge about STIs, methods of transmission and how to protect themselves. One woman had an STI that she had contracted in Canada, another woman was waiting for STI screening results as she had symptoms. All other respondents did not disclose any history of STIs or HIV since arrival in Canada (Table 2). Of the 25 respondents, 11 perceived themselves to be at risk of STIs or HIV. This perceived risk was frequently justified by the fact that their partners were older and had had many previous sexual partners. Women also expressed the belief that there is more sexual freedom in Canada and more people are infected with STIs and HIV. Women's perceived risk was increased if their partners had been residing in Canada for a long period of time. Interviewees also perceived themselves to be more at risk if they did not have a stable partner living in Canada – they believed this made them more easily approached sexually by Latin American men, especially at work.

Respondents expressed the belief that women enjoyed a higher level of respect in Canada compared to their country of origin and that they could call the police in cases of sexual abuse. However, many respondents did not feel they had this option. As they were paid 'under the table' and had to send remittances home, they feared losing their jobs. Moreover, as many were receiving last-resort financial assistance (social welfare), their work was undeclared and illegal. They were afraid that men at work would report them to the government if they did not accept the work conditions and any other conditions that the men imposed. They perceived this to put them at higher risk of being victims of all types of abuse. Three women reported sexual harassment at work. For example, Ana (24 years old, refugee claimant) worked in a chicken-packing company. She reported that she had been sexually harassed by her supervisor and lost her job after refusing to sleep with him:

> He told me, I am going to get to the point, what I want is to sleep with you whether you want it or not, I told him no, that I wanted to work, if you want to sleep with me you are mistaken and you can go pay for the woman you want but I am no prostitute, he got so angry with me that he fired me.

Without social networks, women felt isolated and alone and tended to easily trust anyone who spoke Spanish and offered them help. Most women interviewed had only been in relationships with Latin American men. They perceived that their ease in trusting someone who spoke their language put them at risk of contracting HIV/STIs. In many cases, those Spanish-speaking people who participants initially trusted were the ones who abused them. Carmen's (31 years old, permanent resident) experience illustrates this. She met a much older Latino man who helped her find an apartment and make a refugee status claim. They became partners and she found out that he did drugs and was abusive. Eight days after her first sexual relationship with him, she started experiencing gynaecological symptoms. She did not seek health services because she did not know how and did not speak French or English. Her symptoms worsened. She finally sought medical attention and was diagnosed with genital herpes. When she confronted her partner about the STI, he accused her of being promiscuous:

> The doctor told me: you have herpes. He told me it is a disease that I will have for life … I did not know what to do, I was left in shock. When I left to talk to Carlos, he made himself to be the victim. He made it seem like I was the one being needy, he treated me really poorly and made me feel ashamed.

Before her sexual relationship with the man, Carmen had asked that they use condoms to prevent pregnancy and infections. Her partner refused this request, 'He did not like condoms and told me not to take birth control pills because I was going to gain weight and that they were bad, and that he would take care of me.' Carmen also had an unplanned pregnancy with the same partner and lost the baby due to physical abuse from him.

Women's risk perception of HIV/AIDS/STIs was related to relations of gender inequalities of power. These inequalities occurred both in the women's work environments and in their personal relationships. In this context, negotiating safe sex was challenging or not an option. As a result of their precarious status, inability to communicate in French or English and lack of knowledge about social and health services, women lacked the resources to deal with situations of abuse. Women who did not perceive themselves to be at risk ($n = 14$) were those that had a stable partner whom they could trust. They reported that they knew their partners well and believed that their personal knowledge and level of education made it easier for them to protect themselves against infections.

Difficulties in accessing sexual and reproductive healthcare services

Three main obstacles in accessing sexual and reproductive healthcare services emerged from our analysis: language barriers, discrimination and difficulty obtaining appointments. The interviews revealed that women were afraid to ask for help and did not know how to seek healthcare services. Participants perceived language as a big obstacle. Health centres sometimes offered translating services but when unavailable, women had to find someone who could accompany them to their appointments, which created confidentiality issues. Moreover, many women felt uncomfortable talking about sexual and reproductive health matters in the presence of a translator. As a result of language barriers, women often avoided seeking health services. In addition, many participants felt reproached by healthcare professionals because they did not speak French. Most respondents expressed the desire to learn French, but explained that they could not participate in a French language programme because they had no one to care for their children.

Participants perceived that there was a shortage of doctors and long delays in care and, as a result, viewed the healthcare system as precarious. They related difficulty in obtaining appointments with specialists – they first needed a referral from a family doctor, which in itself was difficult to obtain. From their experiences, they could be wait-listed for years and access to diagnostic testing and medication was limited:

> We signed up for a family doctor since we arrived four years ago, and they still have not called me. The other day, they called to ask me if I was still interested … and I told them that I had already had two miscarriages and I had a baby with a high-risk pregnancy and I am still waiting today after four years. (Dani, 32 years old, permanent resident)

Participants feared that they would not be seen by a healthcare professional when they experienced serious medical problems. This anxiety led some women to consider returning home. At the time of the interview, two participants had returned to their home countries to receive health services. Moreover, the perception that they were not being prescribed the medication that they needed led some women to acquire medication and oral contraceptives through acquaintances who brought them back from their home countries. Many women changed their family planning practices when they arrived in Canada as they had not been able to obtain an appointment with a general practitioner and had not been able to access oral contraceptives. One participant obtained an appointment for an oral contraceptive prescription but the appointment was so far-off that she became pregnant before she was seen. Another participant related that she had requested an intrauterine device (IUD) while at the hospital after giving birth. She reported that after six months she was still waiting for test results before the IUD could be inserted, and had become pregnant again. Many women found it very difficult to negotiate condom use with their partners and resorted to the calendar method of contraception. Many women reported unplanned pregnancies.

Women reported waiting two to three months for prenatal care. For example, Margarita, (22 years old, refugee claimant), arrived in Canada six months pregnant. She waited two months for a medical consultation, but lost the twins while waiting:

> When we arrived here, the first doctor's appointment had to be given within two months of our arrival, but since there were two [babies] and they were in the same sac, they choked, they became entangled with the cord, and when it came time for the appointment, I had already lost them.

Dani's, (32 years old, permanent resident) case is similar: she arrived in Canada one-month pregnant and lost her baby at four months. During the three months of high-risk

pregnancy that she spent in Canada, she waited for an appointment with a gynaecologist, which was never given to her:

> I had a high-risk pregnancy, they told me that I had to see a gynaecologist, and that there was a waiting list. … Many women tell me that they come to term in their pregnancy without ever seeing a gynaecologist. I was under a lot of stress because I was already four months pregnant and no one had seen me. I was bleeding eight days in my home, I would go to the health centre and they told me to go home, until the eighth day, I lost the baby.

Of the 25 women interviewed, 14 had been pregnant while in Canada. Many women reported that they wanted to have a Pap test done but were discouraged by the difficulty in accessing health services. Among respondents, only three women reported having received sexual and reproductive health education since settlement in Canada.

Discussion

Our findings provide an overview of HIV/AIDS/STI risk perceptions and general situation of vulnerability of Latin American women who migrate to Canada. The vulnerability of women in a migratory context is not sufficient to solely consider risk perceptions. Other factors, such as interactions with their environments, power dynamics in relationships, their ability to make independent decisions and their precarious situations, are also important determinants of their vulnerability to HIV and STIs. Our findings show that migrant Latin American women's vulnerability to HIV and STIs was shaped by: experiences during their lifecourse (history of inter-partner violence, inequality in gender roles); their migratory status, which is associated with sexual abuse, abuse at work, language barriers, lack of social support and the use of shelters for victims of abuse; and the current healthcare system, more specifically, accessing sexual and reproductive health services and mental health services.

Our findings are consistent with Delor and Hubert's (2000) earlier discussion of social vulnerability to HIV, which states that social vulnerability is shaped by three categories: life trajectory, social context and social interactions. Whereas women in our study felt that they had the resources to deal with situations of vulnerability in their home countries, in Canada they often did not understand how the healthcare system worked, could not communicate in the official languages and had little social support. This also led women to easily trust people who spoke their own language. Participants in our study reported that they mostly socialised with other Latin American immigrants, with whom they shared the same cultural identity.

It is important to recognise that in many cultures, such as Latin America, women have little power over their sexuality and over the sexual practices they engage in. With regards to gender roles, we found that most women still identified with typical gender roles in their countries of origin, which are marked by inequality. Many women found it too difficult to negotiate safe sex with their partners and, as a result, they continued to engage in risky sexual practices. These findings are consistent with multiple studies on Latin American immigrants in the USA that discuss the relationship between gender roles and cultural beliefs and the lack of condom use (Moreno 2007; Shedlin et al. 2006).

Barriers to accessing sexual and reproductive health services, such as discrimination, language and delays in receiving medical appointments also increased migrant women's vulnerability. Many delays in accessing care occurred as a result of the three-month delay to which newcomers to a province are subjected before they can be insured. Our findings are consistent with the reports of healthcare workers and community organisation workers who feel that patients with precarious status and experiencing acute health crises often

delay seeking care (Rousseau et al. 2008). In our study, the inability to access health services led to miscarriages, unplanned pregnancies and STIs. There is a need for more STI screening and preventive health education.

One theme that emerged during our analysis was the protective function of the mental health services received. Five women had been diagnosed with depression while in Canada, had been prescribed medication and had been referred to a psychologist. Women reported that these services were either provided directly by centres for immigrant women or facilitated through the intermediary of workers at centres and shelters.

Immigrant Latin American women's HIV and STI risk perception was influenced by their life trajectories, including their migratory experience and social interactions within a new environment, where social and gender inequalities exist. It is important that this social context be taken into consideration when formulating public health policies that concern women, immigration and prevention of HIV and other STIs. The number of Latin American women immigrating to Quebec is rising, making it all the more important to understand how women's migratory experiences affect their sexual and reproductive health. The provision of healthcare services to this population must focus on sexual and reproductive health needs and should do so from a multicultural perspective that takes into account the changes associated with the migration process, as much before and during migration as during resettlement. Finally, a greater emphasis on health promotion and prevention practices is called for.

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Résumé

Cet article décrit les expériences migratoires des migrantes latino-américaines au Canada, leurs perceptions sur les risques liés aux VIH/sida/IST et les obstacles à leur accès aux services de santé. Nous avons conduit 25 entretiens en profondeur avec des migrantes latino-américaines vivant à Montréal. La majorité d'entre elles bénéficiaient du statut de résidentes permanentes ou de demandeurs d'asile. L'expérience de ces femmes au Canada est caractérisée par l'incertitude, la tromperie et la fraude, la séparation d'avec leur famille et le sentiment d'une discrimination à leur endroit. La perception du risque lié aux VIH/sida/IST par ces femmes était associée aux relations basées sur les inégalités de pouvoir entre genres. Les participantes qui ne se percevaient pas comme étant à risque étaient celles qui avaient un partenaire stable en qui elles considéraient qu'elles pouvaient avoir confiance. La plupart de ces femmes ont rapporté des difficultés à accéder aux services de santé sexuelle et reproductive. La vulnérabilité des femmes aux VIH/sida/IST était déterminée par leurs expériences de vie ; par leur statut migratoire, associé aux abus sexuels, aux abus dans le cadre professionnel, aux barrières linguistiques et à l'absence de réseau de soutien; et par leur capacité à accéder aux services de santé. La dispensation de services de santé à cette population doit se concentrer sur les besoins en santé sexuelle et reproductive, et le faire dans une perspective multiculturelle qui prenne en compte les changements associés au processus de la migration.

Resumen

Este artículo examina las vivencias experimentadas por mujeres latinoamericanas que migraron a Canadá, analizando sus ideas respecto a los riesgos asociados al vih/sida/its y a las barreras que deben enfrentar para tener acceso a los servicios de salud. Los autores realizaron 25 entrevistas a profundidad a mujeres latinoamericanas residentes en Montreal, Canadá. La mayoría de las participantes se encuentra en calidad de residente permanente o ha solicitado reconocimiento como refugiada. En Canadá, las vivencias de las mujeres son caracterizadas por la incertidumbre, el engaño y el fraude, así como por la separación de sus familias y por la percepción de que son discriminadas. En relación a los riesgos de contraer vih/sida/its, sus ideas se relacionan con la desigualdad de poder basada en el género. En este sentido, cabe destacar que aquellas que tienen una pareja estable en la que pueden confiar no se consideran expuestas a dicho riesgo. La mayoría de las mujeres opina que es difícil tener acceso a los servicios de salud sexual y reproductiva. Su vulnerabilidad al vih/sida/its es determinada por sus vivencias; por su condición migratoria, a la que se vincula el hecho de estar expuestas al acoso sexual, al acoso en el trabajo, a las dificultades del idioma y a la falta de redes de apoyo social; y por la facilidad que tengan para recibir servicios de salud. La dotación de servicios de salud a esta población deberá enfocarse en sus necesidades en torno a la salud sexual y reproductiva, desde una perspectiva multicultural que tome en cuenta los cambios derivados del proceso migratorio.