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South Asian migrant women and HIV/STIs: Knowledge, attitudes and practices and the role of sexual power

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ABSTRACT

Differences in relationship power dynamics or migration factors may affect knowledge, attitudes, and practices (KAP) towards HIV/AIDS and sexually transmitted infections (STIs) in resettling Migrant women. A sample of 122 women and men born in India, Sri Lanka, Pakistan or Bangladesh and residing in Montreal completed questionnaires on HIV/STI KAP and decision-making power Within sexual relationships. Knowledge gaps and stigmatizing attitudes were found. STI/HIV information available in one's language and other educational strategies that consider women's Power may improve KAP among South Asian migrant women.

1. Introduction

About 18% of new permanent residents to Canada and one-quarter of the "humanitarian" class population arrive annually in the province of Quebec (Citizenship and Immigration Canada Research and Evaluation Branch, 2007). Montreal, Quebec's largest city, has the highest HIV seroprevalence rate for child-bearing women of any Canadian city (Hankins et al., 1998). Of the 251,649 new Canadian permanent residents and 21,380 humanitarian migrants in 2006, 20% were from India, Sri Lanka, Pakistan and Bangladesh combined (Citizenship and Immigration Canada Research and Evaluation Branch, 2007). Given the high numbers of migrants arriving from these areas combined with migration and socio-cultural factors that may increase the risk of HIV and STI exposure, South Asian migrant women merit attention regarding HIV/STI prevention. In order to develop appropriate health recommendations and strategies to protect these women, it is important to investigate their KAP of HIV/AIDS and STIs and how this may be related to their power in relationships.

2. Background

2.1. Women and HIV

Half of the world's people who are living with human immunodeficiency virus (HIV) are female (in 2007, 15.4 million) (Joint United Nations Programme on HIV/AIDS UNAIDS, 2007). While HIV incidence is declining in many countries (Joint United Nations Programme on HIV/AIDS UNAIDS, 2007), HIV rates among women are increasing within Canada (Public Health Agency of Canada, 2007) and many other countries, including most of Asia (Joint United Nations Programme on HIV/AIDS UNAIDS, 2007). In 2006, women accounted for approximately 28% of positive HIV test reports in Canada with the majority in women of childbearing age (Public Health Agency of Canada, 2007). Globally, there are 340 million new cases of curable sexually transmitted infections (STIs) annually; in low-income countries STIs are one of the top five complaints for adults seeking health care (World Health Organization, 2007). STIs are the main preventable cause of infertility in women, and can lead to ectopic pregnancy, cervical cancer, and death, and also increase the risk of acquiring HIV (World Health Organization, 2007). Migrants (immigrants, refugees, and asylum seekers) have been shown to be at risk of contracting HIV and STIs during and after migration (Giuliani et al., 2004; Remis et al., 1995; UNAIDS and IOM, 1998).

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2.2. Health, place, and power in migrant women

"Place" as regards migrant women can be thought of in three distinct phases (pre-migration, migration, post-migration), each associated with particular health concerns (Gushulak and MacPherson, 2004) and power issues for women passing through these phases. During pre-migration, women are living in their countries of origin with the health, health-risk profiles, and relational power dynamics of women with characteristics similar to theirs. During and post-migration, the "place" in which they find themselves and the general health status and power dynamic associated with that place will vary considerably depending on the immigration class into which they fall.

Independent- or family-class immigrants, who generally choose to re-establish themselves in another country (Gravel and Battaglini, 2000), are most likely to have the economic means for safe travel during migration and for establishing themselves post-migration. They will often have some capacity in the language of the new country and may have relatives or friends there to provide psychosocial support post-migration.

Refugees, on the other hand, have been forced to leave their countries, either due to conflict or natural disasters, to ensure their survival (UNHCR, 2004). As such, their "place" during migration is unplanned and may include lengthy periods of movement without shelter or food, few belongings, limited financial capacity, and experiences of abuse. Refugees may spend lengthy periods in UNHCR-sponsored camps where, although they are provided with food and shelter, they are at higher risk than non-migrants for infectious diseases due to the large number of people in camps. In addition, they may perform sexual favors to obtain needed resources, and may experience abuse. Receiving countries commonly prohibit refugees from working, placing them in dependent positions. If they are re-settled through UNHCR channels, they are most likely to arrive post-migration in one of about 20 countries with which the UNHCR has agreements for resettlement. The place of refugee resettlement is not selected by the refugee but rather, by the receiving country. Post-migration, refugees do not have the same financial resources as immigrants although they will have access to some government and/or private sponsorship resources. Their language skills will be limited and they are unlikely to have a support structure of family and friends in place. From pre-migration through post-migration, the experience of refugee women is not one of power, rather one of responding to events outside their control.

Asylum-seekers or refugee claimants are migrants in the process of seeking the protection of a country other than their country of origin. Those successful in receiving asylum in the new country are those with histories similar to those in the refugee class. Prior to receiving an evaluation of their claims, however, they live in a precarious situation, not knowing whether they will be allowed to stay or forced to return home. As a result, the degree to which they are able to enter into the new society and find their place post-migration, is limited; their experience is often not one of power.

2.3. Migrant knowledge, attitudes, and practices (KAP) regarding HIV

Despite the vulnerability of women during their migratory process to western industrialized countries, few studies have looked at HIV/AIDS or STI knowledge, attitudes or practices (KAP) in this population (Gras et al., 2001; Lazarus et al., 2006; Loue et al., 2003; Rosenthal et al., 2003; Tori and Amawattana, 1993). Previous Canadian work focused on Haitians in Montreal (Adrien et al., 1989a, 1989b, 1989c, 1994, 1996b; Adrien and Tousignant, 1989) and in the mid-nineties a tri-city (Montreal, Vancouver and Toronto) study was conducted that examined HIV-related KAP in several different ethnic groups (Adrien et al., 1996a; Cappon et al., 1996; Godin et al., 1996; Manson Singer et al., 1996; Maticka-Tyndale et al., 1996; Willms et al., 1996a, 1996b). Results showed that AIDS was perceived as a gay white man's disease, as not relevant to one's own ethnocultural community, was highly stigmatized, and that there was poor knowledge of HIV transmission. Women reported a lack of power to require their male partners to use safe sex practices (Manson Singer et al., 1996). South Asians were also the only cultural group in this study to exclude female participants. This was done on the advice of the male participants from the same cultural group who felt it would be culturally inappropriate for women to partake in discussions about sex.

When migrant women's KAP regarding HIV/AIDS and STIs are considered together with the power dynamics surrounding them during all phases of migration, it becomes clear that they are at increased risk for HIV/AIDS and STIs for many reasons. These include lower status in home and host countries; isolation and poverty; high rates of rape, sexual abuse, and exploitation; and separation of families leading to risky sexual behaviour by partners (Ali Khan et al., 1997; Benjamin et al., 1996; Carballo et al., 1996; Llacer et al., 2007; Nuwaha et al., 1999). Refugee women and those from conflict situations may be particularly vulnerable (Hankins et al., 1998; Hankins et al., 2002; Khaw et al., 2000; Remis et al., 1995; Weir, 2000). Power dynamics within relationships can limit women's abilities to negotiate safe sex with their partners (Amaro, 1995; Blanc, 2001; Jenkins, 2000). In many cultures, men have more dominant roles within sexual relationships, including decisions concerning when and how sexual activities will occur (Amaro, 1995; Blanc, 2001; Jenkins, 2000) and the use of condoms (Bhattacharya, 2004; Khan et al., 2004; Kumar et al., 1997; Thomas et al., 2004). No literature could be identified which examined decisional power and HIV/STI KAP in South Asian migrant women in Canada.

3. Research question

How do gender disparities in decision-making power affect knowledge, attitudes, and practices (KAP) regarding prevention of HIV and STI transmission in South Asian migrant women of childbearing age?

4. Methods

4.1. Study population and recruitment

We recruited (Feb 2004–Feb 2005) South Asian migrants using two strategies: hospital recruitment, (i.e. two postpartum units) and community recruitment, (e.g., restaurants, markets, community centers). All migrants born in India, Sri Lanka, Pakistan or Bangladesh and speaking any of the study languages (English, French, Hindi, Urdu, Tamil) were eligible. Consenting individuals were offered the choice of self- or interviewer-administered questionnaires. Research assistants contacted appropriate interpreters as needed. The McGill University Institutional Review Board and the research ethics committees of the hospital recruitment sites gave ethical approval before recruitment.

4.2. Measures

We modified the UNAIDS General Population Survey (the HIV/AIDS Prevention Indicator Survey) based on feedback from focus