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**ADVANCING POLICY AND RESEARCH RESPONSES TO  
IMMIGRANT AND REFUGEE WOMEN'S HEALTH IN CANADA**

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prepared for

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## LIST OF ACRONYMS

<b>ACCESS</b>	Alliance des communautés culturelles pour l'égalité dans la santé et les services sociaux
<b>BCCEWH</b>	British Columbia Centre of Excellence for Women's Health
<b>CESAF</b>	Centre d'excellence pour la santé des femmes – Consortium Université de Montréal
<b>CERIS</b>	Toronto Centre of Excellence for Research on Immigration and Settlement
<b>CEWHP</b>	Centres of Excellence for Women's Health Program
<b>CEWH</b>	Centres of Excellence for Women's Health
<b>CIC</b>	Citizenship and Immigration Canada
<b>CLSC</b>	Centre Local de Santé Communautaire / Community Health Centre, Quebec
<b>HCWG</b>	Metropolis Health Canada Working Group
<b>I et M</b>	Immigration et Métropoles – Montréal
<b>MCE</b>	Metropolis Centres of Excellence
<b>MCEWH</b>	Maritime Centre of Excellence for Women's Health
<b>NGO</b>	Non-governmental Organization
<b>NNEWH</b>	National Network on Environments and Women's Health
<b>PCERII</b>	Prairie Centre of Excellence for Research on Immigration and Integration
<b>PWHCE</b>	Prairie Women's Health Centre of Excellence
<b>SSHRC</b>	Social Sciences and Humanities Research Council of Canada
<b>VCE-RIIM</b>	Vancouver Centre of Excellence for Research on Immigration and Integration in the Metropolis

## EXECUTIVE SUMMARY

### **Purpose**

This document presents an overview of Canadian research on immigrant and refugee women's health, drawing upon the earlier work of Kinnon (1999) and Janzen (1998), as well as research conducted by Canada's Centres of Excellence for Women's Health (CEWH) and Metropolis Centres of Excellence (MCE). The report also presents preliminary policy issues, research questions and policy implications arising from the research. It further suggests next steps to advance a strategic dialogue in policy and research development on immigrant and refugee women's health. It can serve as a tool to help decision makers assess their policies and programs. The document can be used as a catalyst for discussion and action in this area. It is intended to be of interest to policy audiences at the municipal, regional, provincial and federal levels, as well as to researchers and non-governmental organizations engaged in the policy process.

### **Approach**

In general, "immigrants" are regarded as voluntary migrants and "refugees" as involuntary migrants, but these terms also represent complex and varied social realities. In Canada, the population of immigrant and refugee women is not only distinct from the general population in many ways, but is diverse within itself. Thus, policy and research concerning the health of immigrant and refugee women needs to consider issues of gender and diversity, as well as a determinants of health perspective and population-health approach. Together these lenses offer the view that health is the result of a complex interplay of socio-economic factors, and that health issues and health care may affect different groups of women differentially.

### **Themes in the Research**

The search of recent Canadian literature on the health of immigrant and refugee women revealed a number of key themes in the research, and the findings of this document are presented along these themes:

- health status and context of immigrant women's lives
- income and employment
- mental health
- aging
- accessibility of health care services
- impacts of health reform.

Applying the analytical tools and approaches mentioned above to the research findings, brought a number of future research issues and policy implications/issues to light, that are highlighted and presented in tables at the end of each research theme area.

### **Key Policy and Research Issues**

#### *Socio-cultural Context of Immigrant and Refugee Women's Lives*

The research in this area raises questions about how variables such as country of origin, age, circumstances of migration, lifestyle changes and economic status impact health.<sup>1</sup> It is also important to know if that influence persists or changes over time, and

how. Research is needed to explore whether immigrant women under-utilize preventive services due to differences in concepts of health, health care, or because of systemic barriers. There are policy implications for the allocation of resources for health promotion and disease prevention, and for improving accessibility and the capacity in health and social services to meet the health needs of immigrant and refugee women.

#### *Income and Employment*

A significant body of research is available on the economic integration of immigrant and refugee women in Canada. However, there is a need for more research that explores the links between economic well-being and health status. The finding that health status improves with each step up the economic ladder in mainstream populations<sup>2</sup> suggests that policies and programs directed at improving the economic situation of immigrant and refugee women, such as language and employment programs, may have significant impacts on their health.

#### *Rethinking Mental Health*

Recent research has argued that, although they are usually treated as problems of the individual, there are important social dimensions to the mental health issues of immigrant and refugee women. This raises the need for more research into accessibility of mental health services, particularly for refugee women who have experienced pre-migratory trauma. Reducing social isolation through initiatives such as immigrant women's centres, networking and mentoring, language, employment and re-training programs has been identified as an important mental health policy issue. The impact of legislation, policies and programs on immigrant and refugee women's vulnerability to family violence also needs further examination.

#### *Migration and Aging*

There are still significant gaps in the research on migration and aging, particularly on aging within recent immigrant and refugee populations, and community-centred approaches to health care delivery. Targeted programs and services are needed to promote and maintain the health and well-being of this population. Women's primary role as informal caregivers also requires special consideration in the design and delivery of community-based health care and home care.

#### *Accessibility of Health Care Services*

Understanding the complex context of immigrant and refugee women's lives is critical to developing culturally appropriate and accessible health care practices and programs. Developing degrees of cultural competency at all levels of the health care system is a priority for increasing accessibility, as is investigating: language barriers; cultural diversity; the effectiveness or necessity of ethnic/gender matching between health care providers and users; the use of alternative/traditional forms of healing; and investing in outreach strategies.

#### *Impacts of Health Care Reform*

Research in this area highlights some key policy gaps, including a lack of benchmarks to capture the potential differential impact of health reform on immigrant and refugee women. Aspects of health reform need closer examination from a gender and diversity

perspective, particularly health promotion and prevention education; the effects of the shift to ambulatory care; and increasing demands on community organizations and on women as informal (unpaid) caregivers. Health reform also needs to include community-based programs that incorporate initiatives such as the use of bi/multi-cultural liaison/advocacy workers.

### *Next Steps*

It is clear that better links between research and policy, and community involvement in both processes, can better meet the health needs of immigrant and refugee women. In the complex health policy environment, this document recommends a step-by-step co-ordinated approach. The first step is to identify and bring together key players from CEWH and MCE, select federal departments, and immigrant and refugee women's groups. The second step is to establish a strategic planning approach that identifies federal policy priorities, as well as existing – or needed – mechanisms to ensure the impact of research on the development of gender- and diversity-sensitive health policy. The third recommended step is to share this overview paper with stakeholders at the regional, provincial, municipal and community levels to promote awareness dialogue and planning of appropriate policies and programs. CEWH and MCE are well placed to provide leadership in developing this integrated approach. A co-ordinated multi-level approach would improve the short- and long-term health status of an increasingly important and significant population in Canada – immigrant and refugee women.

# 1. INTRODUCTION

## 1.1 Scope and Methodology

This document provides an overview of Canadian research on immigrant and refugee women's health, drawing upon the work of Kinnon<sup>3</sup> (1999) and Janzen<sup>4</sup> (1998), as well as research conducted by Canada's Centres of Excellence for Women's Health (CEWH) and Metropolis Centres of Excellence (MCE). The report also presents preliminary policy issues, research questions and policy implications arising from the research. It further suggests next steps for advancing action in research and policy development on immigrant and refugee women's health. The document can be used as a catalyst for discussion and action, and is intended to be of interest to policy-makers at all levels of government, as well as researchers and NGOs involved in the policy process.

Section 2 details the key themes arising from the research: the health, income and employment status of immigrant and refugee women; mental health; aging; access to health care services; and health reform. Section 3 discusses ways to enhance the links between research and policy, so that research is more relevant to policy and policy is more evidence-based. Section 4 proposes a step-by-step co-ordinated approach to help stakeholders develop a strategic approach to identify policy priorities and mechanisms to facilitate the impact of research on the development of gender- and diversity-sensitive health policy.

## 1.2 Gender and Diversity Analysis

This document and its insights are guided by the principles of gender and diversity analysis. Gender analysis recognizes the systemic inequality between women and men in society; diversity analysis recognizes that different populations – including immigrant women and refugee women – have particular social, cultural and economic experiences which may require particular policy responses.

Health Canada's *Women's Health Strategy* acknowledges that gendered norms shape the nature of health issues and influence the health system's practices and priorities, and that measures to address gender inequality and gender bias within and beyond the health system will improve population health.<sup>5</sup> Health Canada has made a commitment to "ensuring that gender impacts of policy interpretations or changes are fully assessed" and that "gender impact analysis will inform Health Canada's contribution to the development of health system accountability frameworks."<sup>6</sup> Vissandjée et al. (2000)<sup>7</sup> argue that the application of gender analysis to health has been effective in revealing gender gaps among immigrants and refugees, and the social processes that reinforce them.

Like gender, diversity is a key analytical category. Immigrant and refugee women are often assumed to share the same characteristics as the general population, and are still viewed as a homogeneous group. While immigrant and refugee women share some

common experiences, they also vary in age, economic, social and political status, education, national origin, culture, and ethnic and racial identity. Consequently, the term “immigrant and refugee women” does not refer simply to legal status but encompasses a set of complex realities and experiences.

Typically, immigrants are regarded as voluntary migrants and refugees as involuntary migrants, however this distinction is sometimes blurred. The dominant role of male household members in the decision to migrate suggests women may not always be voluntary participants.<sup>8</sup> Moreover, females are often viewed as the dependents of male applicants in the migration process.<sup>9</sup> Bannerjee (1985)<sup>10</sup> observes that there are growing similarities between immigrant and refugee women who confront problems with exploitation as women and workers, the threat or reality of violence, intergenerational tensions, linguistic, cultural and economic isolation, and changing familial roles and responsibilities. Nonetheless, while significant overlap may occur between these categories, immigrant and refugee women remain distinct in a variety of ways.

It is clear that no single health strategy or program can adequately meet the diverse needs of immigrant and refugee women – underscoring the complexity of the issues and the relevance of gender and diversity analysis.

Both gender and diversity analyses require gathering qualitative and quantitative data, questioning basic assumptions, and developing an understanding of how socio-economic factors affect populations of women and men differentially. When applied to the policy process, both gender and diversity analyses begin from the recognition of these different social and economic realities and factor this recognition into the assessment of proposed and existing policies, programs and legislation.

This document is also grounded in a determinants of health perspective – the view that health is determined by the interaction of a range of factors, including individual characteristics, physical environments, social, economic and cultural factors.

## **2. KEY POLICY AND RESEARCH ISSUES**

As noted earlier, Kinnon highlights the key role being played by CEWH and MCE in relation to sex/gender and immigrant health,<sup>11</sup> and particular attention was paid to the centres’ research for this present document. It must be noted that a number of CEWH and MCE projects were underway for which findings were unavailable at the time of the present document’s printing.\*

The research findings outlined in this document were examined using gender and diversity analysis, processes that brought policy issues and research opportunities to

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\* See Appendix Three: Annotated Bibliography for a list of CEWH and MCE research projects. Appendix Four provides general information about CEWH, and Appendix Five describes MCE.

light. The material is presented according to the key themes that emerged from the research findings:

- health status and the socio-cultural context of immigrant women's lives
- income and employment
- mental health
- aging
- accessibility of health care services
- impacts of health reform
- considerations for future research.

Applying the analytical tools and approaches mentioned above to the research findings, brought a number of future research issues and policy implications/issues to light that are highlighted and presented in tables at the end of each research theme area.

It should be emphasized that this organization reflects the state of the selected Canadian research on immigrant and refugee women's health, not the state of the issue itself, nor any particular framework.

## **2.1 The Socio-cultural Context of Immigrant and Refugee Women's Lives**

### *Impact on Health Status*

Results of the 1994-95 National Population Health Survey suggest that recent "voluntary" migrant or immigrant women are, on average, healthier than their Canadian-born counterparts. Researchers have identified a number of possible explanations for this, including:

- the greater likelihood of healthier people to emigrate
- health standards required of immigrants by the Canadian government and verified by medical examination
- lower prevalence of smoking among immigrant women
- the effect of research tools and methodologies that may not be cross-culturally equivalent.<sup>12</sup>

Researchers have explored the relationship between health and length of time since emigration. Chen, Ng and Wilkins (1996)<sup>13</sup> report that immigrant women who had lived in Canada for less than 11 years were healthier than immigrant women who had been residents longer. This association may be partly a function of differences in regions and countries of origin among immigrant women over time, but it indicates a need for more analysis of the extent to which various factors (i.e. social, cultural, psychological, behavioural and/or economic) are linked with changes (positive and negative) in the health status of immigrant women over time.<sup>14</sup>

Vissandjée et al. (2000)<sup>15</sup> raise a key issue for policy- and decision-makers by arguing that the critical question is not so much whether immigrant women are in better health than Canadian-born women, but rather what living conditions in Canada increase the incidence of various diseases among immigrants. From their review of the literature, Vissandjée et al.(2000) conclude that it is not clear how much of the relative decline in

the health of immigrants is due to the adoption of harmful North American habits, and how much is due to inadequacies in North American health care systems and their approaches, particularly for immigrants from non-European cultures. This signals an important gap in the literature that needs to be addressed.

#### *Understanding Variabilities in Health Status*

Janzen's (1998) review concludes that "research examining the variability of health among immigrant and refugee women is needed. In particular, research needs to explore how social, economic, behavioural and psychological factors are associated with changes in the health status of immigrant and refugee women over time."<sup>16</sup> Recent research indicates that progress is being made toward filling this gap in the literature.

Bowen's (1998)<sup>17</sup> work with Salvadoran women in Winnipeg – whose country of origin was torn by civil war from 1979-92 – probed how the women define health, how they maintain their health and what they identify as the major causes of illness. Key findings include:

- Women made clear links between psychological health and physical symptoms.
- Psychological concerns and family problems were perceived as major causes of illness.
- Stress and depression were major factors in the women's lives and many believed they were key sources of health complaints.
- Participants used the health service system confidently for physiological complaints, however they shared little of their past lives and were frustrated in finding solutions for problems they felt were emotionally based.
- In general, the women stated they would prefer to use "Canadian" rather than "Spanish" professionals for psychological or sensitive family concerns.
- Distrust regarding confidentiality within the Salvadoran community remained.
- Continuing community polarization and mistrust linked to pre-migratory experiences were described as affecting current health more than past trauma.<sup>18</sup>

By documenting health issues from the perspective of Salvadoran women themselves, the study provides useful information for the design of effective and culturally competent health services and health promotion programs for this group of women. In addition, by rooting the study in a broader determinants of health perspective, the study uncovers the need for community-based solutions to address problems that originate in past events but continue to affect present health.

The benefits of a broader-based analysis of health status is also demonstrated by Battaglini, et al.'s (1999)<sup>19</sup> work identifying vulnerability factors among recent immigrant and refugee women and their families in Quebec. The key findings of this work include:

- Most current psychological and socio-economic assessment tools are inadequate in identifying risk factors among immigrant women as they do not take into account the migration process or cultural differences.
- In the general population social isolation is often related to low revenue, low education levels and economic dependence. Among immigrant and refugee women factors related to the migration process, such as communication barriers, lack of knowledge of the host country, loss of socio-economic and family networks, and lack of recognition of foreign educational or professional credentials are the most likely causes of social isolation.
- The most common barriers to social integration cited by immigrant women were isolation and lack of social relations within the host community, racism and discrimination, cultural difference, and lack of knowledge of Canada's official languages.
- The biggest concern reported by recent immigrant women was fear of insufficient revenue. Most women reported difficulty finding adequate work, adequate housing and available health care resources.
- In general, immigrant women show no more problems with childbirth than the general population, and in some respects, the health status of newborns of immigrant women is often better than for the general population.
- Country of origin does not present a risk in itself. However, circumstances of departure are important – involuntary migrants report high levels of stress, worry and anxiety.
- Un-sponsored refugee women were much more likely to report a deterioration in their health than other categories of immigrant women, and involuntary immigrants and their babies were most likely to present at community health centres with health problems.<sup>20</sup>

This work demonstrates the need to consider the economic, cultural, social and psychological context of immigrant and refugee women's past and current lives, and their particular migration experiences within health assessments and in the delivery of programs and services.

#### *Implications for Health Care and Health Promotion Initiatives*

The importance of the context of immigrant women's lives is clear in the results of a recent study<sup>21</sup> that examined immigrant women's definitions of health, their health maintenance patterns and their experiences with health care services. The findings indicate that immigrant and refugee women have health needs similar to Canadian-born women but far fewer resources (e.g. employment, income, family and support networks, language skills), pointing to the need for public policy and programs that support immigrant women in their need.<sup>22</sup>

The study concludes that public policy and funding practices need to reflect a concern with sex, gender and culture, and to place more emphasis on programs related to

determinants of health. Findings also indicate the need for development and/or enhancement of:

- language and employment programs
- health and social support programs
- cultural/language interpreters and culturally sensitive services.<sup>23</sup>

In addition, new immigrants and refugees need access to information about the health care system, Canadian laws and women's rights. The study also identifies the need for further research on:

- best practices in interpreter programs
- the influence of language ability on health
- the impact of social determinants in immigrant women's health.<sup>24</sup>

Overall, the research findings on the socio-cultural context and immigrant women's health are still inconclusive and at times contradictory. While some studies indicate immigrant and refugee women tend to have similar health needs and concepts of health promotion and prevention as Canadian-born women, others suggest significant differences exist. It is unclear, for example, whether immigrant and refugee women under-utilize preventive services due to differences in their concepts of health and health promotion, or systemic barriers, including those in the health system, and other socio-economic and linguistic factors.<sup>25</sup>

***The Socio-cultural Context of Immigrant and Refugee Women's Lives: Policy and Research Implications***

<b>Key Research Findings to Date</b>	<b>Future Research Issues</b>	<b>Policy Implications/Advice</b>
<p>The 1994-95 National Population Health survey indicates that recent immigrant women are, on average, healthier than their Canadian-born counterparts.</p> <p>Un-sponsored refugee women were much more likely to report a deterioration in health than involuntary immigrants and other categories of immigrant women.<sup>20,26</sup></p>	<p>What is the relationship between health status and:</p> <ul style="list-style-type: none"> <li>- different countries/regions of origin</li> <li>- circumstances of migration</li> <li>- entry status into Canada</li> <li>- age at migration</li> </ul> <p>What are the potential health effects of different adaptation and integration experiences for immigrant women and for refugee women? Do particular experiences enhance, maintain or diminish health?</p> <p>What are the factors that promote/inhibit adoption of healthy/unhealthy North American habits/lifestyle?</p> <p>What are the health-promoting knowledge and behaviours that can be learned from immigrants and refugees?</p> <p>What major accessibility and capacity needs of immigrant and refugee women do existing health and social services not successfully meet? What is the potential health impact over time?</p> <p>The health of "un-sponsored" refugee women has been understudied and more research is required.</p>	<p>Research indicates recent immigrant women may be a good health promotion investment. Resources given to disease prevention and health promotion – e.g. resisting unhealthy North American habits/lifestyles – may be cost-effective in the short and long term.</p> <p>Effective disease prevention and health promotion strategies require more detailed information about:</p> <ul style="list-style-type: none"> <li>- diversity in the immigrant and refugee population</li> <li>- factors that promote and inhibit adoption of unhealthy North American habits/lifestyles</li> <li>- health impacts of differences in adaptation and integration experiences</li> </ul> <p>More information about the health impacts of current gaps in services on immigrant and refugee women would help policy- and decision-makers allocate scarce resources, aiming to fill the most serious gaps.</p>

Key Research Findings to Date	Future Research Issues	Policy Implications/Advice
<p>Sex and gender are particularly important determinants to consider in health research on immigrant and refugee women given: policies can create bias against women; barriers women face in access to services; and the cultural conflict that may occur for women immigrating from countries with different gender-role expectations.<sup>27</sup></p>	<p>There is a need to clarify the significance of gender as a determinant of health alongside other social characteristics, such as socio-economic status, paid and unpaid work, age, exposure to stressors (and ability to cope) and social support networks available to women.<sup>28</sup></p> <p>Analysis of Canadian research on immigrant and refugee women's health indicates a strong need for more research on the context of immigrant and refugee women's lives. A recent overview of immigration and health research concluded that, where feasible, new research should provide female/male comparative analyses and a gender analysis.<sup>29</sup></p> <p>There is a need for ongoing gender-comparative research and gender analysis in order to understand the influence of gender on health and to identify important differences and similarities between women and men regarding the major determinants of health.<sup>30</sup></p> <p>CEWH and MCE are beginning to address this gap in the research with a number of in-progress studies.</p>	<p>A continued focus on gender as a determinant of health by both CEWH and MCE has the potential to make a significant contribution to advancing the health of immigrant and refugee women.</p>

## 2.2 Income and employment

Access to income and employment is a central element in the lives of immigrant and refugee women and a significant body of research is available on factors related to their economic integration in Canada. The research provides details on particular groups of immigrant and refugee women, and demonstrates differences between and among immigrant and refugee women. A review of this literature was outside the scope of this document, but a scan did not yield any recent published work relating employment and/or income to the health of immigrant and refugee women.

The lack of recent work on the relationship between income and/or employment and immigrant and refugee women's health is a significant research gap in light of the findings of the *Second Report on the Health of Canadians*, prepared by the Federal, Provincial and Territorial Advisory Committee on Population Health, which states that "Canadians with low incomes and low levels of education (which are often related) are more likely to have poor health status, no matter which measure of health is used. They are also more likely to die earlier than other Canadians, no matter which cause of death is considered."<sup>31</sup>

Though there are relatively few overall differences between immigrant and non-immigrant women in Canada with respect to education level, percentage employed and average income, vulnerable sub-groups of immigrant women have been identified. About 20 percent of immigrant women in Canada have incomes which fall below Statistics Canada's low-income cutoffs, compared to 16 percent of other Canadian women.<sup>32</sup> Janzen (1998) has argued that "research literature has demonstrated a robust relationship between SES (socio-economic status) and health status."<sup>33</sup> A similar impact might be expected in relation to low income immigrant women.

Evidence that "health status improves for all Canadians with each step up the economic ladder"<sup>34</sup> suggests that the relationship is an active one that will likely respond to interventions that improve income and education level. More research is needed into the links between the economic well-being of immigrant and refugee women and their health status, and the impact of changes (i.e. self-initiated and/or through program intervention) over time.

It is also important to note that lack of consensus among professional, educational and government agencies with respect to the recognition and/or equivalency of foreign credentials, and employers' demand for Canadian work experience create barriers to employment and income for immigrant and refugee women.<sup>35</sup>

Language skills are an important factor in the economic and social integration of immigrant and refugee women. Several studies have documented that the paid labour experiences of women who did not speak one of Canada's official languages was characterized by poor earnings and long hours at physically demanding jobs, often in manufacturing or service industries.<sup>36</sup>

***Income and Employment: Policy and Research Implications***

<b>Key Research Findings to Date</b>	<b>Future Research Issues</b>	<b>Policy Implications/Advice</b>
<p>About 20 percent of immigrant women living in Canada fall below Statistics Canada's low-income cut-offs, compared to 16 percent of Canadian-born women.<sup>32</sup></p> <p>Research indicates there is a key correlation between income and health status<sup>33</sup>.</p>	<p>A significant body of research is available on factors related to the economic integration of immigrant and refugee women in Canada. However, more research is needed on the links between the economic welfare and health status of immigrant and refugee women.</p>	<p>Policies and programs directed at promoting the economic situation of immigrant and refugee women, such as language and employment programs, can have significant impacts on their health and well-being.</p> <p>Conversely, health services and health promotion policies and programs for immigrant and refugee women may have limited effect unless accompanied by strategies that address un/under-employment and poverty.</p>
<p>Language skills in English or French are clearly a health determinant for immigrant and refugee women<sup>36</sup>.</p> <p>Language skills are an important factor in the economic and social integration of immigrant and refugee women.</p>	<p>There is a need for specific research on the health effects of education in general, and English/French as a second language.</p> <p>The links between education, un/under-employment, earnings, health and well-being need to be explored, as well as the influence of education on the health and disease prevention behaviours of immigrant women and refugee women.<sup>37</sup></p>	<p>Enhancing access to ESL/FSL programs and facilitating their participation by providing easements (such as childcare and opportunities for social interaction) can have a positive impact on both integration and health and well-being.</p> <p>Initiatives that incorporate health promotion activities and information into language classes could have the potential to enhance health promoting behaviours and appropriate use of a broad range of health services.</p>

### **2.3 Rethinking Mental Health**

As Janzen<sup>38</sup> and Kinnon<sup>39</sup> noted, research on the health of immigrant women has focused largely on mental and emotional well-being – a trend that continues.

The research confirms that the context of women's migration is an important variable<sup>40</sup> as researchers have documented societal and structural dimensions of what are often perceived to be individual psychological issues. This finding is particularly relevant for immigrant and refugee women from countries marked by political and economic instability and civil strife.

A recent study of immigrant women in the Maritimes argues that immigrant women's isolation is often constructed as a psychological problem when in fact it is a sociological one.<sup>41</sup> The study outlines how immigrant women's isolation is reinforced by: lack of employment opportunities; non-recognition of foreign education and work experience; gender segregation in the labour market; the nature of housework; the way neighbourhoods are organized; the predominance of large centralized shopping centres; and the Canadian climate. These social factors can have mental health implications for immigrant women, particularly those with exclusive childcare responsibilities.

Similar points are made in several other studies. Parin Dossa argues that Iranian immigrant women maintain their mental health and well-being through an active process of "meaning-making" and "reconstruction of lives."<sup>42</sup> The work highlights the importance of social interaction and the need to establish social arenas where life experiences are understood and validated. A 1998 study of Salvadoran women in Winnipeg questions "the emphasis on individual diagnosis of psychological disorder, and suggests that efforts should be addressed to the social and behavioural effects of mistrust and violence."<sup>43</sup> Participants described a community marked by intense and sometimes debilitating distrust, the apparent legacy of civil conflict and terrorism in their homeland.

In a study of the impact of violence on the mental health of refugee Latin American women from Peru and Chile, the authors examined both pre-migratory and post-migratory experiences.<sup>44</sup> They found that exposure to violence in the pre-migratory context, lack of familiarity with their new environment, and the isolation that Latin American refugee women experience upon their arrival in Canada increase their vulnerability to domestic violence, single parenthood and mental distress. Other studies confirm that isolation and vulnerability are often exacerbated by dependence on a spouse, resulting in unequal power relations and the potential for abuse.<sup>45</sup>

Recent work on delivering health care to immigrant and refugee women suggests a need for providers to be more aware of, and educated about, the health impacts of violence, and suggests that physicians employ a socio-ecological model in understanding and treating the health effects of violence.

There is consistent evidence that many refugee women suffer mental health problems attributable to multiple trauma such as rape and torture experienced prior to emigration.

Developing and enhancing accessible mental health services for this group is a key policy and program priority.

It is difficult to capture the complex impact of pre- and post-migration factors on mental health in large-scale quantitative analysis; however, the importance of these variables has been raised in small-scale qualitative studies. It is clear the field of immigrant and refugee women's mental health would benefit from increased integration of these two research approaches.

***Rethinking Mental Health: Policy and Research Implications***

<b>Key Research Findings to Date</b>	<b>Future Research Issues</b>	<b>Policy Implications/Advice</b>
<p>Many immigrant and refugee women endure significant stress and anxiety that may have a negative impact on their mental health.</p> <p>Additional challenges are faced by women who are:</p> <ul style="list-style-type: none"> <li>- involuntary migrants</li> <li>- fleeing war and violence and the related threats or realities of sexual assault, torture, loss of loved ones, etc.</li> <li>- isolated due to language barriers, poverty, geographic location</li> <li>- living in immigrant/refugee communities in Canada that still suffer the effects of systemic violence in the country of origin (e.g. mistrust, ongoing ethnic conflict)</li> </ul> <p>Psychiatric symptoms attributable to multiple traumas such as rape and torture experienced prior to emigration are an important mental health issue for many refugee women.</p> <p>Many immigrant and refugee women migrate under spousal sponsorship which may limit their independence and make them more vulnerable to family abuse and violence.</p>	<p>More research is needed into the concept of mental health promotion in immigrant and refugee communities, particularly to address the impact of conflicts or issues rooted in countries of origin. What types of interventions would work for women facing these issues?</p> <p>What are the particular needs of women with these experiences in terms of access to mental health services and appropriate care, treatment and support?</p> <p>What are the critical characteristics of accessible mental health services for immigrant and refugee women?</p> <p>Research is required in the area of mental health and family violence as they relate to immigrant and refugee women, including information specific to sponsored and unsponsored women.</p> <p>Studying best practices for health promotion programs in the country of origin could help identify effective ways to reduce isolation and stress involved in the integration process.</p>	<p>Many immigrant and refugee women cope with enormous stress yet ably adapt and integrate into Canadian society. There is still a need to support their efforts and to provide accessible mental health services for those facing particular challenges.</p> <p>Programs and strategies aimed at reducing social isolation and acknowledging the life experiences of immigrant and refugee women will have a positive impact on their mental health (e.g. immigrant women’s centres, networking and mentoring, language, employment and re-training programs).</p> <p>Developing and/or enhancing accessible mental health services for refugee women is a key policy and program priority.</p>

## 2.4 Migration and Aging

The study of older immigrants is relatively new. In 1999, the Québec-based Alliance des communautés culturelles pour l'égalité dans la santé et les services sociaux (ACCESSS) made a significant contribution to Canadian research in this area by conducting a study on migration and aging with a particular focus on immigrant women. Key findings from this work include:

- The most significant challenges for older immigrants are language and communication barriers, and difficulties accessing the health care system.
- Older immigrants and refugees face changes in all aspects of their lives at a time when they are often more vulnerable and less resilient.
- Adaptation is particularly difficult if the migration was involuntary and/or if the differences between Canadian society and the country of origin are pronounced.
- Loss of social support networks may be more debilitating for older women than for older men as these networks are usually more central to women's lives.
- Immigrant and refugee women over age 65 are among the poorest people in Canada and are more likely to be poor than immigrant men.
- In 70-80 percent of families women perform the role of informal caregivers.
- The role of aging immigrant caregivers in the context of their adaptation to a new country needs to be studied.
- Family-focused strategies are needed for seniors' care, particularly with respect to mental health care and cases of major or terminal illnesses.
- The capacity of institutions, such as seniors' residences, to meet the needs of immigrants requiring institutionalization needs to be assessed and improved.<sup>46</sup>

This work makes an important contribution to the field of immigrant and refugee women's health by highlighting the vulnerability of older immigrant women with respect to social isolation, poverty and their role as informal caregivers. Further studies on this and other areas of migration and aging are needed,<sup>47</sup> with particular attention to recent immigrant populations (post-1970), aging in the refugee population, and the impact of immigration on seniors.

***Migration and Aging: Policy and Research Implications***

<b>Key Research Findings to Date</b>	<b>Future Research Issues</b>	<b>Policy Implications/Advice</b>
<p>Older immigrant and refugee women are particularly vulnerable to social isolation, poverty and to carrying the burden of informal caregiving.</p>	<p>More research is needed on the issue of aging and migration in general and on community-centred approaches to health care delivery.</p> <p>Also of interest:</p> <ul style="list-style-type: none"> <li>- aging in recent immigrant populations (post-1970)</li> <li>- aging in refugee populations</li> <li>- the impact of immigration on seniors</li> </ul>	<p>It is important for policy- and decision-makers to recognize the diversity of seniors in Canada.</p> <p>In order to maintain the health and well-being of older immigrant and refugee women, targeted programs and services – such as availability of formal interpreters – are required to overcome communication/cultural barriers and isolation.</p> <p>The design and delivery of community-based health care, home care, and early childhood education programs needs to ensure against over-reliance on this population as a source of unpaid caregivers.</p>

## 2.5 Accessibility of Health Care Services

### *Multiple Roles and Complex Realities in Immigrant and Refugee Women's Lives*

Kinnon's overview of migration and health research found that the family and job responsibilities of many immigrant women make it difficult for them to use existing health care resources.<sup>48</sup> Recent studies also show that many immigrant women in Canada face ethnocultural and sex/gender discrimination and experience cultural and role conflict. These complex circumstances can create barriers to accessing health care and result in immigrant and refugee women often placing the health concerns of other family members before their own.

A recent scan of the literature on accessibility to health care by different income and/or ethnic groups in the Atlantic region<sup>49</sup> produced these key findings:

- Health care systems and delivery of health care services reflect the perceptions, values and priorities of dominant cultures, and need to improve their responses to the needs of existing ethnic communities and the increasingly diverse population of recent immigrants. The result is unequal access to health care and lower-quality health care experiences for visible ethnic minorities.
- Language and communication barriers often mean immigrant minorities are not well informed about available health care services and their benefits, which in turn reduces use and access.<sup>50</sup>

The report also identifies key areas for future research, including:

- Additional systematic quantitative and qualitative work on the determinants of health care accessibility across the broad spectrum of health care services and programs, focusing on the relationships among income status, location, culture, short- and long-term immigration experience and health care use.
- More information on the varying health problems and needs of ethnic minorities, particularly recent immigrants, that pays attention to the role of gender.
- More analysis of the emerging problems of home care and how they relate to low income, location (rural or less-populated areas), ethnicity and gender.

### *Impact of Culture and Language*

Culture and language have a profound impact on how one experiences and accesses health care. Similar concerns are echoed among a variety of cultural communities and in a variety of health care settings. For example, focus group research in the Arab community in Toronto identified the following barriers: too few health care providers who speak Arabic, particularly female physicians; a lack of interpretation services in Arabic; and a need for culturally sensitive mental health services.<sup>51</sup> The need for Arabic-speaking physicians was also expressed by Arabic-speaking women in Montréal.<sup>52</sup>

Research also demonstrates the complexity of the language barrier and the need to recognize that age, sex/gender and class dynamics are central to the process of interpretation.<sup>53</sup> Even when efforts are made to overcome language barriers, institutional settings can present an impediment to communication; hospitals, especially emergency rooms, are often intimidating, lacking in intimacy and rushed.<sup>54</sup> When

interpreters are used information filtering often occurs, especially when family members act as informal interpreters.<sup>55</sup>

Cultural distance may add another layer of complexity to intercultural communication and the provision of adequate care to immigrant and refugee women. Focus group research with Somali women in the Lower Mainland of British Columbia<sup>56</sup> found particular concern about access to appropriate, skilled and respectful reproductive health care for women who have undergone circumcision/female genital mutilation.

#### *Enhancing Accessibility of Health Care Services*

Improving access to health care for immigrant and refugee women is an important area of study. A search of recent Canadian research identified 13 new publications on the subject.<sup>57</sup> The overriding message of this research is that culturally appropriate health care practices and health promotion initiatives enhance both the accessibility of health services, and the health status/behaviours of immigrant and refugee women. It also demonstrates how an understanding of the context of immigrant and refugee women's lives – e.g. language proficiency, level of acculturation, pre-migration trauma<sup>58</sup> – is crucial to developing culturally appropriate and accessible health care practices and programs.

Studies also demonstrate the need for outreach and health promotion initiatives that allow women to come together in ways that break down isolation, promote sharing of experiences and build social support networks.<sup>59</sup> These initiatives often take time and require facilitators, language translators and cultural interpreters. They also benefit from a community development approach that focuses on building trust and supporting the group's capacity to identify priorities issues and implement initiatives to address them.<sup>60</sup>

#### *Ethnic/Gender Matching*

In a recent article, Vissandjée et al.(2000).<sup>61</sup> argue that culturally sensitive health care must take into account the gender-specific experiences and needs of women within each ethnic or immigrant group for users and providers. The concept of ethnic match is taken from the mental health literature and according to Weinfeld (1998)<sup>62</sup> can be conceptualized along three dimensions: the ethnic origin of professional personnel; the ethnic auspices of the organization delivering care; and the actual practice. This model could be extended to include sex/gender, though this raises some issues for research and practice.

Little quantitative Canadian research has been published on ethnic/gender matching. Investigation is needed to determine whether women from a given ethnic group are best served by a professional of a similar ethnic origin, and/or an ethno-specific organization, and/or by gender-sensitive practices.<sup>63</sup> A central question is whether ethnic/gender and sex matching leads to significant long-term positive impacts on health.

The advantages of ethnic/gender and sex matching must be weighed against research indicating a preference by immigrant and refugee women for "Canadian" professionals, particularly where issues of confidentiality and cultural/gender-norm conflict are

important. For example, Gastaldo et al.'s (1998) research with immigrant Muslim women in Québec found that while the women were equally divided concerning the sex of their gynaecologist, the overwhelming majority (80 percent) preferred "Canadian" over "Arab" doctors.<sup>64</sup> Bowen (1998) also found a preference for "Canadian" mental health professionals.<sup>65</sup>

An Edmonton-based action-research project<sup>66</sup> provides an example of the potential of ethnic matching and the value of research partnerships. In an effort to improve Chinese and Vietnamese families' access to perinatal and well-child services, an Edmonton Community Health Promotion and Prevention Services program hired three nurses, immigrants themselves, to work with the families. The nurses became known as the Dragon Rise Health Team. Key findings of the project include:

- a strong preference by Chinese and Vietnamese families for the team's services
- a shift in staff attitudes toward the team from resistance to integration, followed by acceptance, and finally recognition and appreciation of their skills
- an increase in staff understanding of the immigrant experience, specific ethnocultural beliefs and practices, and cross-cultural communication.

The project demonstrates the importance of addressing cultural and linguistic barriers to care and the value of culturally competent care.<sup>67</sup> It also illustrates the issues that ethnic minority care providers who are immigrants, can face in gaining acceptance and credibility with their colleagues. It also highlights the need for support to facilitate their integration which, in turn, helps to ensure that all staff benefit from the skills and experience they bring to the workplace.<sup>68</sup>

#### *The Importance of Family and Community*

Research also points to the need to understand the importance and centrality of family and community in maintaining the identity and well-being of immigrants.<sup>69</sup> This suggests that family-focused strategies should be considered rather than the more common individualist approach in Canada. Similarly, institutions, such as residences for seniors, often do not respond well to the needs of immigrants because their operating principles are drawn from dominant care models.

Health promotion strategies involving community ethnocultural organizations are among the proposed approaches to improve service delivery. Mayetela et al. (1999)<sup>70</sup> submit that a sensitive and responsive health care system must ultimately become multicultural, whereby cultural diversity is integrated at the policy level in a manner that influences the entire social services and health care system.

**Accessibility of Health Care Services: Policy and Research Implications**

Key Research Findings to Date	Future Research Issues	Policy Implications/Advice
<p>Research indicates that family and job responsibilities make it difficult for many immigrant and refugee women to use existing health care resources</p> <p>Culturally appropriate health promotion and health care enhance both the accessibility of health services, and the health status/behaviours of immigrant and refugee women.</p>	<p>A key area for future research is the context of immigrant and refugee women's lives and how it impacts access to health services and programs. Variables include:</p> <ul style="list-style-type: none"> <li>- age</li> <li>- length of time since immigration</li> <li>- country of origin</li> <li>- circumstances of migration</li> <li>- migration experience</li> <li>- level of acculturation</li> <li>- culturally specific values and concepts of health and health promotion</li> <li>- migration status</li> <li>- eligibility for settlement and integration programs</li> <li>- education, social class and/or occupation in country of origin, change in that status upon migration</li> <li>- location of immediate and extended family</li> </ul>	<p>Better understanding will contribute to the development of new health care services, and the modification of existing ones, that are more culturally appropriate and accessible.</p> <p>Given the diversity of immigrant and refugee women, a range of culturally appropriate strategies and services is needed.</p> <p>Understanding and addressing barriers to health care services is key to:</p> <ul style="list-style-type: none"> <li>- maintaining and improving immigrant and refugee women's health</li> <li>- ensuring health care is "accessible" as required by the <i>Canada Health Act</i>.</li> </ul> <p>Strategies and services that enhance access for immigrant and refugee women are likely to improve access for other groups as well.</p>
<p>Language barriers and cultural differences may make it difficult for some groups of immigrant and refugee women to be well informed about available health care services and their benefits.</p>	<p>Gender-based analysis and diversity analysis are needed at all levels of the health care system. Research can help identify and/or develop models and best practices of gender-sensitive and culturally competent training, policy and program development, and service delivery.</p>	<p>Policy- and decision-makers can make an important contribution to maintaining and/or enhancing the health status of immigrant and refugee women by supporting the development of gender-sensitive and culturally appropriate health care practices, promotion, programs, policies and service delivery.</p>

Key Research Findings to Date	Future Research Issues	Policy Implications/Advice
<p>Interpretation is a complex process which can be coloured by factors such as age, sex/gender and class dynamics.</p>	<p>Further research is needed into the effectiveness of ethnic/gender matching of care provider and user, and the long-term impacts on health.</p> <p>More research is needed on the use of alternative/traditional forms of healing: Who uses it, when and why? What is the interaction with “Western” medicine and the impact on health?</p> <p>Further research can be undertaken to assess immigrant and refugee women’s knowledge of the Canadian health care system, document key gaps and identify strategies to fill the gaps.</p> <p>Research is needed to examine the interaction among the physician/health worker, informal interpreter and service user to determine how selective interpretation affects or compromises health care, e.g. in cases of domestic violence.</p>	<p>Policy- and decision-makers can begin by focusing on priorities identified by immigrant and refugee women in the research literature:</p> <ul style="list-style-type: none"> <li>- appropriate, skilled and respectful reproductive health care, particularly for women who have undergone female genital circumcision (also known as female genital mutilation)</li> <li>- mental health services</li> <li>- cultural and language interpretation services</li> <li>- outreach and health promotion initiatives that allow women to come together in ways that break down isolation, promote sharing of experiences and build social support networks</li> </ul> <p>There is a need to enhance gender sensitivity and cultural competence at all levels of the health care system. Health care workers and the health care system need to:</p> <ul style="list-style-type: none"> <li>- become more informed about and culturally sensitive to the needs and health care perceptions of a culturally diverse clientele</li> <li>- acquire adequate knowledge of diseases and/or medicines specific to minority ethnocultural groups and sub-groups</li> </ul> <p>Trained language and, if possible, cultural interpreters are required for clear, confidential communication in a health care setting.</p>

## 2.6 Impacts of Health Reform

Any discussion of the health needs of immigrant and refugee women needs to consider the context of recent health care restructuring and the competition for scarce resources. It is important to consider that health care reform may have differential impacts on immigrant and refugee women as compared to the general population.

Vissandjée et al. (2000) argue that there is a need for gender- and culture-specific research that captures the contextual and environmental factors inherent in the changing living conditions of immigrant women. Health care reform is an important component of these changing living conditions. Key research and policy issues include:

- the effects of the progressive shift to ambulatory care
- the increasing demands on community organizations and on women as informal (unpaid) caregivers
- the transformation of the economy and growing poverty.<sup>71</sup>

There is evidence that “the impact of health care reform in hospital obstetrics wards places a greater burden on the services delivered to minority women, due to time constraints and hospital policies that limit access to nursing care and information.”<sup>72</sup> Hospital health reform initiatives that parcel out standard interactions with patients equate equal with equitable treatment, a formula that fails to acknowledge the heterogeneous nature and differential needs of hospital clients. In this context, immigrant and refugee women become increasingly marginalized and there is a greater need for innovative community-based programs such as bi-cultural and/or bilingual liaison/advocacy workers to work with women from early pregnancy through the post-partum period.<sup>73</sup>

Anderson et al. (1999)<sup>74</sup> and Weinfield (1997) demonstrate the importance of analyzing the cultures of health care organizations themselves and the broader societal context. The findings in Anderson et al. (1999) indicate that, in order to develop culturally responsive health care, it is necessary to focus not only on health care providers, but to look at the social and cultural context of health care organizations and the broader social and cultural environments, a point echoed by Mayetela et al.(1999)<sup>75</sup>

As in Spitzer’s (2000) work, Anderson et al. ’s (1999) study highlights the current tension between trying to make the health care system more accessible to groups that have been under-serviced and the goals of cost containment.<sup>76</sup> In this climate, it is important to repeat the evidence-based reality that “immigrants are net contributors to government programs” and that “new immigrants contribute more in taxes and productivity than they consume in government transfers and health care resources.”<sup>77</sup>

***Impacts of Health Reform: Policy and Research Implications***

<b>Key Research Findings to Date</b>	<b>Future Research Issues</b>	<b>Policy Implications/Advice</b>
<p>Health care restructuring can have differential impacts on immigrant and refugee women.</p> <p>For example, hospital health reform initiatives geared to limiting and standardizing access to information and care do not take into account the diversity and different needs of hospital clients. In this context, it is particularly difficult to meet the needs of immigrant and refugee women, especially those from non-European cultures.</p>	<p>What are the specific impacts of health care restructuring on immigrant and refugee women in relation to:</p> <ul style="list-style-type: none"> <li>- their use of health care services, including health promotion and prevention services, and diagnostic and treatment services</li> <li>- the capacity of the health care system to meet their major health care needs</li> <li>- their roles as informal (unpaid) caregivers</li> </ul>	<p>Health care restructuring may have particularly adverse effects on immigrant and refugee women, especially those who face language and communication barriers, and those who are isolated and without extended family nearby. Consequently there is a greater need to support community-based programs that include the use of bi/multi-cultural workers, bilingual liaison and advocacy workers, and culturally competent and language-appropriate health programs.</p> <p>There is a need to balance the goals of cost containment with the need to make the health care system more accessible to groups that have been and are currently under-served. Otherwise the short-term savings of health care restructuring may be subsumed by the long-term costs of failing to meet current health care needs of significant populations.</p>

## **2.7 Emerging Issues**

This overview of Canadian research demonstrates a growing understanding of the obstacles immigrant and refugee women encounter in accessing the health care system and possible remedies for removing barriers to accessibility. Significant inroads in understanding have been made on issues such as mental health, aging and the impacts of health reform. Initiatives have been introduced to increase cultural sensitivity among health care practitioners, including cultural awareness and intercultural communication training, but more work is required.

Findings point to the importance of gender and diversity analyses in research and policy development. The literature also indicates that effectively addressing the health issues of immigrant and refugee women requires a culturally competent approach that includes consultation and active participation from these communities in research and policy development.

There are a number of emerging issues, which fell outside the scope of this document, that are relevant to future research on the health of immigrant and refugee women. They include:

- complementary and alternative health care
- recruiting immigrant and refugee women to clinical trials
- genetic testing for particular medical conditions
- trafficking of women
- HIV/AIDS and immigrant and refugee women (e.g. proposed mandatory HIV/AIDS testing of immigrants as an ethics and human rights issue)
- reactivation of Tuberculosis following immigration to Canada

## **3. ENHANCING THE POLICY IMPACT OF RESEARCH**

Benefits clearly derive from improved links between research and policy, i.e. policy-oriented research and evidence-based policy. The challenge is to find effective, efficient, and culturally congruent ways to promote and maintain collaboration and co-ordination in research and policy development. Such synergy has the potential for a substantial positive impact on immigrant and refugee women's health.

Notably, the mandates of the Centres of Excellence on Women's Health (CEWH) and the Metropolis Centres of Excellence (MCE)\* enable these centres to function as conduits for research and policy work on these women's health issues.

The importance of policy-relevant research is a recurrent theme in the mandates and programs of each CEWH. They support "policy-based research," "policy analysis" and "development of policy and program recommendations" – work geared to promoting

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\* See Appendix Four for information on CEWH and Appendix Five for information on MCE.

action and positive change. Issues relevant to immigrant and refugee women's health are part of the centres' core work and research priorities. In addition, the centres work in partnership with a wide range of groups and individuals: academics from multiple disciplines, a diversity of community-based organizations, health service providers, and policy advisors and policy makers at various levels of government. The importance of creating and maintaining networks, and dissemination of research results is an undercurrent in all of the centres' work.

Policy-relevant research is also a key objective of the Metropolis Project whose goal is to increase government capacity for making evidence-based policy decisions in the area of immigration and settlement. All of the Metropolis centres are conducting some form of health research. An inventory of MCE research relevant to the health of immigrant and refugee women indicated that at least one quarter of the projects completed or underway include analysis by sex, are women-specific and/or incorporate a gender analysis.<sup>78</sup>

The Metropolis centres also support multidisciplinary research and work with a wide range of partners including NGOs, settlement agencies, and provincial and municipal governments. In addition, the Canadian Metropolis Project is supported by a significant number of federal government departments or agencies;\* however, translating this support into access to the policy fora and decision-makers of these departments is a key challenge.

Project reports from CEWH and MCE indicate that the centres are making some inroads into the policy development process at the local and provincial levels but they have been less successful at the federal level. Health Canada's Centres of Excellence for Women's Health Program (CEWHP) and Metropolis Working Group (HCWG) have begun to collaborate to identify and develop mechanisms to facilitate research and information uptake by policy- and decision-makers in the policy development process. Researchers from both CEWHP and MCE are also interested in developing or enhancing research partnerships and policy initiatives.

For the 4<sup>th</sup> National Metropolis Conference in March 2000, a synthesis was prepared of CEWH research on immigrant and refugee women's health and an inventory compiled of MCE projects that include analysis by sex, are women-specific and/or incorporate gender analysis. CEWHP presented the synthesis paper and some research projects at a conference workshop, raising the profile of immigrant and refugee women's health and women's health researchers within the Metropolis Project.

Following the workshop the Women's Health Bureau commissioned this document. It can be used by researchers as a source of potential projects; by policy analysts and

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\* Federal government departments or agencies supporting the Canadian Metropolis Project (Phase 1) include: Citizenship and Immigration Canada, Health Canada, Human Resources Development Canada, Canadian Heritage, Status of Women Canada, Social Sciences and Humanities Research Council of Canada, Correctional Service of Canada, Statistics Canada and Canada Mortgage and Housing Corporation.

health policy makers at the institutional, municipal, regional, provincial and federal levels as they select priority policy issues, set desired policy outcomes and develop strategies; and by NGOs in their policy work.

This overview of Canadian research on immigrant and refugee women's health demonstrates that the application of gender and diversity analysis yields new information. Yet, having sources of research, information and knowledge is only part of the solution; it is also important to generate maximum exposure and use of research, information and knowledge in the policy-making process and in community settings.

#### **4. MOVING TO ACTION: SUGGESTED NEXT STEPS**

The greatest challenge facing both researchers and policy-makers is the effective and timely exchange of information. Good research helps to inform the development of effective public policy and vice versa. This is nowhere more true than in the field of health policy. Moreover, this overview has demonstrated that change is required at all levels of the health system and policy development if the experiences of immigrant and refugee women are to be taken into account and their health needs met.

A step-by-step approach can help meet the challenges:

##### *1) Identify Key Players*

It is impossible to move an agenda forward without the participation of key players from the outset. As a first step, this document recommends bringing together health researchers from CEWH and MCE working on (immigrant and refugee) women's health issues with representatives from select government departments and representatives from immigrant and refugee women's groups. This research overview indicates that such persons, groups and departments are readily identifiable.

##### *2) Strategic Planning Process*

The recommended purpose of this stakeholder meeting should be three-fold:

- i. to establish good communication patterns and a shared mission
- ii. to identify policy priorities at the federal level
- iii. to identify existing mechanisms or consider the creation of new mechanisms to ensure the ongoing impact of research on the development of health policy.

It would be useful for such mechanisms to be linked to the agenda proposed by Citizenship and Immigration Canada and SSHRC to develop and refine policy research programs to be funded in Phase 2 of the Metropolis Project, culminating in the 2001 national conference in Ottawa.

##### *3) Parallel Planning Processes*

The changes need to serve the health needs of immigrant and refugee women implicate multiple jurisdictions, institutions and key constituencies. In such a complex policy

environment, a co-ordinated approach is crucial to long-term success. This document suggests that a strategic dialogue could be undertaken by sharing the report with stakeholders and other levels of government as a way of promoting awareness, dialogue and planning appropriate policies and programs. Clearly, any co-ordinated and multi-level initiative will take time to develop. However, the work can and must begin with first significant steps.

CEWH and MCE are well situated to spearhead strategic interchanges and provide expertise in developing co-ordinated research and policy work on immigrant and refugee women's health in Canada. They are important sources of research, information and knowledge and together they have mandates from, and access to, a large number of government departments and policy fora. Consequently, they have the potential to provide strong leadership in a range of policy settings relevant to immigrant and refugee women's health.

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## APPENDIX TWO: ALPHABETICAL LIST OF REFERENCES

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## APPENDIX THREE – ANNOTATED BIBLIOGRAPHY, CEWH AND MCE RESEARCH ON IMMIGRANT AND REFUGEE WOMEN'S HEALTH

### CENTRES OF EXCELLENCE FOR WOMEN'S HEALTH RESEARCH PROJECTS

#### BRITISH COLUMBIA CENTRE OF EXCELLENCE FOR WOMEN'S HEALTH (BCCEWH)

Adam, H., et al. (1998). **"The health needs of Somali women in the Lower Mainland: focus group report."** Vancouver: BCCEWH.

Female Genital Mutilation is a common practice among Muslims in several East African, Arabic and Southeast Asian countries, but it is illegal in Canada. Most immigrant women from Somalia have undergone some form of genital mutilation prior to their arrival. This study focused on Somali women's health needs and concerns regarding the health care services they receive, particularly perinatal care and doctor-patient relations.

BCCEWH (in progress). **"Mobilizing the community to address the prenatal health needs of Punjabi women."** Vancouver: BCCEWH.

Formal prenatal classes offered to this Vancouver-area community in the past were cancelled due to poor attendance. Using a wide range of strategies, including partnerships with governmental and non-governmental agencies, and using principles of community development, this project focuses on mobilizing the community on this issue.

Christensen, C. and Dibiri, P. (in progress). **"Assessing barriers to health care for visible minority immigrant women."** Vancouver: BCCEWH.

A central concern in women-centred care is the lack of appropriate measurement tools to determine barriers to health care for visible minority populations. The purpose of this study is to develop and test an instrument to measure the barriers visible minority immigrant women experience and/or perceive in their attempts to access health care services.

Jiwani, Y. (2000). **"Developing a holistic framework for the delivery of violence-related health care and information to immigrant women from racialized communities."** Vancouver: BCCEWH.

This project focused on racialized immigrant women who have experienced intimate violence, and their access to and encounters with the health care system. It examined the responses of physicians in private practice, walk-in clinics and hospitals. Research results indicate that, for the most part, physicians' response to women who have been abused is inadequate. Recommendations emphasize the need for health care providers to be more aware of and educated about the health impacts of violence, and suggest physicians employ a socio-ecological model in understanding and treating violence.

#### PRAIRIE WOMEN'S HEALTH CENTRE OF EXCELLENCE (PWHCE)

Bowen, S. J. (1998). **"Resilience and health of Salvadoran women in Manitoba."** MA Thesis. Winnipeg: PWHCE.

This qualitative study describes, from the perspective of Salvadoran women, their health, their understanding of the causes of health and illness, and their strategies to maintain health and cope with health problems. These women had fled extreme violence and many had been exposed to war-related trauma. Results indicate that solutions to deal with the effects of organized pre-migration violence can be found at the community level. The research also found that isolation is one of the main barriers to the women's healing.

Janzen, B. L. (1998). "**Gender and health: a review of the recent literature.**" Manitoba: PWHCE.

This study presents a broad overview and synthesis of the recent research literature on the major psycho-social influences on women's health. It identifies a number of general gaps in knowledge, particularly with respect to the Canadian context. The research reviewed in this study suggests that to document and understand the variability of health among women, attention to the particular circumstances of women's lives is required. This point is further highlighted in sections describing the health issues of older women, Aboriginal women, and immigrant and refugee women.

**CENTRE D'EXCELLENCE POUR LA SANTÉ DES FEMMES — CONSORTIUM UNIVERSITÉ DE MONTRÉAL (CESAF)\***

Battaglini, A., et al. (1999). « **Identification des facteurs de vulnérabilité propres aux mères immigrantes en période périnatale, rapport d'étape.** » Montréal: CESAF.

This study explored cultural variability in terms of perceptions and practices regarding child development and the impact of immigration on immigrant and refugee women in the perinatal period. The project will review existing vulnerability-assessment tools in preventive care programs to adapt them to the needs of immigrant and refugee women.

Berteau, G., et al. (2000). « **Empowerment et femmes immigrantes.** » Montréal: CESAF.

This research explored the factors that facilitate or hinder the empowerment of immigrant women. Using a participatory approach, the project encouraged service providers and immigrant women to reflect on their own perspectives and practices in relation to empowerment to help address issues such as isolation, poverty and lack of knowledge of existing resources. While the study found notable variations in the service providers and immigrant women's perceptions, the experience was considered promising, and could be strengthened through training, awareness-building and reducing institutional barriers.

Bibeau, G., et al. (1999). "**Impact of immigrant women on the development of multicultural health policies, programs and services in Quebec.**" Montréal: CESAF.

This project sought to study the impact of immigrant women, ethnocultural associations and community organizations in Montréal on the processes connected with the development of multicultural health services. The project was also aimed at identifying the macro-social context surrounding the dynamic interactions between ethnocultural communities and the state, leading to innovations in formal and informal health services.

Gastaldo, D., et al. (1998). "**Immigrant women, reproductive and sexual health, and religion: how Muslim immigrant women perceive the quality of health care they receive in Quebec.**" Montréal: CESAF.

In this research, recent immigrant Muslim women from the Middle East and North Africa were encouraged to voice their concerns about health care services they receive. The project sought to highlight the diversity of views among Muslim women and break down stereotypes of Muslim women as a monolithic group. The women were generally satisfied with the care they receive, but common complaints include lack of Arab-speaking female doctors, long waiting periods to see physicians, and inadequate quality time with doctors.

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\*CESAF completed its mandate in 2001. Its publications are available from the Canadian Women's Health Network [cwhn@cwhn.ca](mailto:cwhn@cwhn.ca).

Labrie, A. and Girard, L. (1998). « **Inventaire des politiques et programmes gouvernementaux ayant une incidence sur la santé des femmes.** » Montréal: CESAF.

The focus of this project was to prepare an inventory of government policies and programs relevant to women's health. A thorough analysis of their impact on immigrant women's health is expected in a later phase.

Lajoie, A., et al. (1999). "**Adequacy of the health system in relation to the needs of immigrant women and Aboriginal women in Quebec.**" Montréal: CESAF.

This project aimed to: identify the needs of Arab-speaking women in relation to Quebec's health care system; review existing policies; and provide recommendations to policy-makers. The exploratory phase of this project focused on a literature review, establishing partnerships and developing a comprehensive research proposal.

Mayetela, R.-M., et al. (1999). « **Vieillir en contexte migratoire.** » Montréal: CESAF and ACCESSS.

This study examined the access and adequacy of social and health care services for aging immigrants in Quebec. It provides an overview of theories on aging and ethnicity, explores the reality of aging in the context of migration (women in particular) and the specific services needed for that population, as well as the role of ethnic communities in providing health care and social services to their members.

Rousseau, C., et al. (in progress). "**Tortured bodies, broken spirits – rebuilding strategies for refugee women who have been victims of organized violence.**" Montréal: CESAF.

This project examined the personal, cultural and contextual factors, as well as individual processes, that refugee women from West Africa, Southeast Asia and Central America use to make sense of the traumas they have experienced and to reconstruct their lives. The results will help to develop interventions that meet the needs of these women.

Talbot, L. R., et al. (1998). « **Vers l'utilisation des services de réadaptation adaptés aux familles multi-ethniques dont une personne présente une déficience motrice ou sensorielle.** » Montréal: CESAF.

Communication barriers, lack of knowledge of the health care system, different cultural practices and religious beliefs – all can contribute to the social isolation of immigrant women. When these women care for a person with a disability, the isolation is even greater. This project aimed to identify the principles that should guide the development of services to meet their needs; 14 families (Haitian, Italian and Asian) participated in the study.

Vissandjée, B., et al. (in progress). "**Adequacy of Info-Santé CLSC to meet the needs of immigrant women.**" Montréal: CESAF.

This qualitative research aims to address the gap in previous research and suggests strategies to better meet the needs of immigrant women through Info-Santé, a 24-hour CLSC-based telephone service which provides the public with answers to health-related questions. It is expected that this project will contribute to meet the needs of a culturally diversified population with respect to services such as Info-Santé CLSC.

Vissandjée, B. and Weinfeld, M. (1999). "**Gender and ethnicity: how do they affect health promotion and health services utilization by immigrant women in Canada?**" Montréal: CESAF.

This study of the interplay of ethnicity and gender with the health of newly settled Canadian immigrant women explored the pros and cons of matching sex/ gender and ethnicity of health care professionals with their patients, and whether gendered "ethnic matching" is

likely to lead to better health for Canadian immigrant women. No definite conclusions regarding the benefits of gendered ethnic matching emerge from the study but the researchers point to the need to make general – and immigrant-specific – health research and practice traditions sensitive to issues of gender and ethnicity.

Weinfeld, M., et al. (1998). **"Barriers to care and issues of ethnic/gender match, final report."** Montréal: CESAF.

This research examined ethnic matching as a means to reduce barriers for immigrant women in the health care system. Ethnic/gender matching rests on the assumption that outcomes will be optimized when those providing a service share identities with those needing the service (e.g. ethnicity, race, geographic area, language and gender).

### **MARITIME CENTRE OF EXCELLENCE FOR WOMEN'S HEALTH (MCEWH)\***

MacKinnon, M. (1999). **"Affirming immigrant women's health: building inclusive health policy."** Halifax: MCEWH.

This project explored the health beliefs, health maintenance and health-use patterns of immigrant and refugee women in Prince Edward Island. It examined the women's experiences in using health care services and focused on the significance of gender, language and culture in order to improve accessibility of health care services and increase awareness among health care providers, and to provide guidelines to policy-makers related to the health, health care delivery and service needs of immigrant and refugee women.

Sharif, N.R., et al. (2000). **"Ethnicity, income and access to health care in the Atlantic Region: a synthesis of the literature."** Halifax: MCEWH.

This study consisted of a scan of a variety of documents (academic and non-academic) on the relationships between socio-economic status, ethnicity and health care accessibility in the Atlantic Region. The study focused on various immigrant groups whose beliefs differ from the dominant culture as well as ethnic populations such as Blacks, Aboriginals and Acadians. It concludes that there is a shortage of research-based literature on the role of ethnicity and low-income status as they relate to health care accessibility in the region. It also points to a paucity of gender-based analysis and calls for a strategic investment in health-related research in immigrant and refugee populations in the Atlantic region.

Weerasinghe, S. (2000). **"Equitable access to health care, promotion and prevention by immigrant women in Nova Scotia."** Halifax: MCEWH.

The long-term goal of this project is to educate immigrant women about health care programs and policies, and to identify the unique problems and needs that these women experience when they access health care. This exploratory phase focused on strategies to reach immigrant women and to encourage their participation in research. Focus groups were conducted with 23 women from 13 different countries in order to explore their experiences, feelings and beliefs.

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\* As of April 1, 2002, the Maritime Centre of Excellence for Women's Health became the Atlantic Centre of Excellence for Women's Health.

## **METROPOLIS CENTRES OF EXCELLENCE RESEARCH PROJECTS**

### **VANCOUVER CENTRE OF EXCELLENCE FOR RESEARCH ON IMMIGRATION AND INTEGRATION IN THE METROPOLIS (RIIM)**

Anderson, J.M., et al. (1999). **"Health system renewal: writing in cultural plurality."** Vancouver: RIIM.

Health care delivery systems in Western nations are undergoing major restructuring. This project examined how three health care organizations in Greater Vancouver respond to government policy initiatives aimed at making health care services equally accessible to diverse client populations. It also identified organizational and structural factors that facilitate or hinder organizational responses to multicultural patients.

Dyck, I. and McLaren, A. (in progress). **"Women/mothers, daughters and schools."** Vancouver: RIIM.

This project focuses on the immigration and settlement patterns of mothers of teenage daughters, particularly with respect to schooling and the local community, and how mothers and daughters negotiate their identities through the discourses and practices available to them. The analysis looks at teenage girls' bodies as sites of family concerns and negotiation, the interplay of popular culture and the coding of girls' bodies as "Canadian."

Dossa, P. (1999). **"The narrative representation of mental health: Iranian women in Canada."** Vancouver: RIIM.

This study used the settlement narratives of two Iranian women to illustrate how newcomers draw upon competing discourses and practices to reconfigure the meaning of their lives.

### **PRAIRIE CENTRE OF EXCELLENCE FOR RESEARCH ON IMMIGRATION AND INTEGRATION (PCERII)**

Meadows, L. (in progress). **"Immigrant women and health: Phase II of WHEALTH."** Edmonton: PCERII.

This research uses a grounded-theory approach to identify and describe patterns of variation related to immigrant women's health status characteristics. The project begins from the assumption that health issues of immigrant women may differ significantly from those of Canadian-born women.

Neufeld, A., et al. (in progress). **"Immigrant women's experience as family caregivers: support and barriers."** Edmonton: PCERII

This study examines the nature of the material and social conditions within which immigrant women give care; how they access support; and the barriers to support they encounter. It also examines their experience in accessing health and social service resources. The study includes immigrant women who are recent or past immigrants from China and India, and who are caring for a relative with a chronic health condition or disability.

Ogilvie, L., et al. (2000). **"Minority nurses for minority populations: a pilot study in public health nursing."** Edmonton: PCERII

This action-research project explored the potential roles and responsibilities of three nurses, who are immigrants themselves, employed to work with Chinese and Vietnamese immigrant families receiving services from four health centres. It tracked the process of introducing the change, benefits to clients, cultural knowledge relating to perinatal beliefs and practices, and knowledge of the power of action research in mediating change.

Tastsoglou, E. and Miedema, B. (2000). **"Immigrant women organizing for change: integration and community development by immigrant women in the Maritimes."** Edmonton: PCERII.

Using a qualitative approach (i.e. focus groups and oral life histories), this project examined how immigrant women are integrated, what integration means to them, barriers to equitable integration, which activities facilitate integration, and the role ethnic-specific and multicultural organizations play in the integration process.

### **TORONTO CENTRE OF EXCELLENCE FOR RESEARCH ON IMMIGRATION AND SETTLEMENT (CERIS)**

Collins, E., et al. (1998). **"Research toward equity in the professional life of immigrants: a study of nursing in the metropolis."** Toronto: CERIS.

In an effort to raise awareness of issues related to workplace racism in nursing, this qualitative study investigated the way immigrant women nurses of several visible minority groups spoke about their experiences with racism and examined formal redress and grievance proceedings. Findings focus on the description of racism, and identification of formal and informal policies pertaining to access, participation, promotion, inclusion, and conflicts. Other findings include: reactions and responses to discrimination; financial and other costs; and implications for immigrant nurses and their profession, and for how the health care system is structured and regulated. A goal of the project is to effect policy changes so that incidences of grievances related to workplace racism can be decreased.

Coté, A., et. al. (in progress). **"Qui prend pays...l'impact du parrainage sur les droits à l'égalité des femmes immigrantes francophones."** Toronto: CERIS.

A large number of women immigrate through the spousal sponsoring program. This study examines the discriminatory nature of this system, as it denies immigrant and refugee women access to equality and other human rights set out in the *Canadian Charter of Rights and Freedoms*. It argues for legal reforms to the *Immigration Act*.

Meana, M., et al. (1998). **"Identifying barriers and incentives to breast-screening behaviour in Tamil immigrant/refugee women 50 years old and over."** Toronto: CERIS.

There is evidence that only a minority of immigrant women regularly use breast self-examination, clinical breast examination and mammograms. This study examined the barriers and incentives influencing the extent to which older Tamil immigrant and refugee women engage in potentially life-saving breast cancer screening behaviours. Findings point to the need for specific areas of intervention to enhance the breast cancer screening behaviour of this group of minority women.

Yuan, L., et al. (1998). **"The study of the health status and health care access for the Arab community in Toronto: a pilot study to assess health needs."** Toronto: CERIS.

During 1997-98, this study collected and analyzed data from the 1991 census to produce a socio-demographic profile of Arab immigrants in Canada. Seven focus groups were conducted with members of the Arab community in Toronto to determine their health needs. The focus groups included: boys and girls, aged 13-19 years; two groups of men, aged 20-64 years; two groups of women, aged 20-64 years; and, community and religious leaders. The research found that too few health care providers speak Arabic; interpretation services in Arabic are lacking, as are Arabic-speaking female physicians. There is also a need for culturally sensitive mental health services. Generational and cultural gaps between young people and their parents, and unemployment are significant problems.

## **IMMIGRATION ET MÉTROPOLIS (I ET M) – MONTRÉAL**

Damaris, R. (in progress) « **Réseautage avec d'autres chercheurs intéressés à la question femmes, familles et réseaux sociaux dans une problématique d'intégration sociale.** »

Montréal: I et M

Recent research shows that women play a central role in the creation of links which give immigrant families access to social capital, a factor previously overlooked in the integration process. This project aims to develop a network of researchers interested in women's social networks in order to share expertise and collaborate on future research projects.

Juteau, D., and Ly-Tall, A. B. (in progress). « **Pour une citoyenneté participative des femmes réfugiées au Canada : quelles politiques?** » Montréal: I et M.

This exploratory research aims to identify the barriers refugee women face in the selection process, and in relation to socio-economic benefits associated with the status of immigrant. Using a gender-analysis framework, the study examines the sponsorship program and its socio-economic and psychological impact on refugee women.

Oxman-Martinez, J., et al. (in progress). « **La violence conjugale et les femmes de minorités ethnoculturelles : un examen des présupposés relatifs à l'ethnicité et à la 'race'.** »

Montréal: I et M.

Anticipating differences between the general population and ethnocultural groups, the project aims to offer insights into developing culturally sensitive policies, practices and responses in shelter, police and hospital settings. It studies how mainstream professionals in health, social services, law enforcement and shelter settings construct the problems of conjugal violence and effective responses to it. The study focuses on Arab-West Asian and Latin American communities in Montréal.

Vatz-Laroussi, M. and Charbonneau, J. (in progress). « **Les rapports hommes/femmes et leurs transformations chez les immigrants de première et deuxième génération.** »

Montréal: I et M.

Using a gender-analysis framework, this feasibility study aims to develop data collection tools to study intergenerational changes among immigrants. The gender perspective is expected to allow the researchers to go beyond recording the different experiences of women and men and will generate new knowledge on gender analysis and immigration in Canada; demonstrate how policies, programs and practices hinder or encourage the participation of immigrant women and men in building Canadian society; and propose public and social policy options in that area.

## APPENDIX FOUR: CENTRES OF EXCELLENCE FOR WOMEN'S HEALTH

In March 1995 the Minister of Health allocated \$12 million to the Centres of Excellence for Women's Health Program (CEWHP) to "improve the health status of Canadian women by enhancing the health system's understanding of, and responsiveness to, women's health issues." CEWHP is managed by the Women's Health Bureau of Health Canada. Five Centres of Excellence for Women's Health (CEWH) were established across the country, four hosted by universities and one by a women's hospital and health centre, to meet the following goals, individually and collectively:

- identify key women's health issues and research them
- produce health data that is sensitive to gender differences
- communicate the knowledge they generate
- build local and national networks that bring together researchers, community and policy partners working to improve the health of women
- provide analysis, advice and information to governments, agencies and individuals involved in health and policy
- help define a women's health research agenda for Canada.

The Canadian Women's Health Network (CWHN) was also funded to co-ordinate the national networking component of CEWHP and to build national information storage, dissemination and communication functions. Each of the six CEWHP sites, described below,\*\* has been awarded \$2 million over the six-year life of the program (i.e. approximately \$333,000 per year).

### **Maritime Centre of Excellence for Women's Health (MCEWH)**

[www.medicine.dal.ca/mcewh](http://www.medicine.dal.ca/mcewh)

MCEWH is hosted by Dalhousie University and the IWK Grace Health Centre. The Centre's mission is "to promote social change through research on women's health." MCEWH supports research with a particular focus on: the process of inclusion, which empowers women to take control of their lives and encourages the development of personal security, support networks and self-reliance; the design and implementation of new tools and practices with a gender-equity lens; and initiatives that address the issues of Black or rural women and caregivers. Priority areas for the next three years are social determinants of health, women's social and economic security, and women's health and the environment.

As of April 1, 2002, the Maritime Centre of Excellence for Women's Health (MCEWH) became the Atlantic Centre of Excellence for Women's Health (ACEWH) [www.medicine.da.ca/acewh](http://www.medicine.da.ca/acewh).

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\* South House Exchange (March 2000), *Mid-Term Program Review: Centres of Excellence for Women's Health*, p. 1.

\*\* Descriptions are taken from the 1999 Spring and Fall "Centres of Excellence for Women's Health Update," Women's Health Bureau: Health Canada.

**Centre d'excellence pour la santé des femmes – Consortium Université de Montréal (CESAF) [www.cesaf.umontreal.ca](http://www.cesaf.umontreal.ca)**

CESAF is hosted by the University of Montréal but has created a network of partners from a wide coalition of community, academic, and health and social services organizations. Some 200 members participate in various CESAF activities with a view to improving women's health, particularly that of informal caregivers, and immigrant and Aboriginal women. Activities include analytical and exploratory studies on aspects of women's health experiences, information activities and the dissemination of research results, and steps to create and consolidate networks in the women's health care sector. Increasingly, CESAF is gearing its research and activities toward home care policies and programs which play a critical role in the restructuring of health care services.

Note: CESAF completed its mandate in 2001. For its publications contact [cwhn@cwhn.ca](mailto:cwhn@cwhn.ca).

**National Network on Environments and Women's Health (NNEWH)**

[www.yorku.ca/nnewh](http://www.yorku.ca/nnewh)

NNEWH, the only nationally oriented Centre of Excellence for Women's Health, is housed within the Centre for Health Studies at York University, NNEWH is a multidisciplinary network of social researchers and community partners working collaboratively to develop social measures and appropriate strategies for a new kind of health research by, on and about women. NNEWH's partners, drawn from across Canada, include scholars from anthropology, ethics, history, sociology, political science and law, and community partners from local and national agencies. NNEWH projects explore women's health practices, perceptions of risk, and strategies for change in three key environments that shape women's health: workplaces; health systems; and policy. Assessing the impacts of health reform on women has become a major research focus.

**Prairie Women's Health Centre of Excellence (PWHCE) [www.pwhce.ca](http://www.pwhce.ca)**

PWHCE's administrative host is the University of Winnipeg and it has offices at the University of Regina and the University of Saskatoon. The Centre recognizes that health concerns and needs vary greatly among women and its focus is to assess and address that diversity. Priority research areas are: impacts of selected determinants of health on women; effects of health reform on women; and policy program models to improve women's health. Building on its research and analysis, the Centre develops gender-sensitive policy and program recommendations that promote women's health. PWHCE brings individuals and organizations based in the community together with academic researchers and policy-makers to increase knowledge of the factors that influence women's health and well-being.

**British Columbia Centre of Excellence for Women's Health (BCCEWH)**

[www.bccewh.bc.ca](http://www.bccewh.bc.ca)

BCCEWH is hosted by the BC Women's Hospital and Health Centre in Vancouver and a satellite office is hosted by the University of Northern British Columbia in Prince George. The Centre fosters innovative, multidisciplinary action research on health policy, women's health initiatives and women-centred programs. A key focus is research on the social determinants of health, especially for marginalized women. Thus, projects geared to improving the health of women who face disadvantages due to socio-economic status, race, culture, age, sexual orientation, geography, disability, and/or addiction are particularly encouraged. Research teams are usually community/academic partnerships conducting action research around three main themes: healthy women in healthy communities; health status and health determinants; and women-centred care.

## APPENDIX FIVE: METROPOLIS CENTRES OF EXCELLENCE

The Metropolis Project is a six-year international initiative geared to increasing government capacity for making evidence-based policy decisions in the area of immigration and settlement. The objective of the Project is “to promote and support research on immigration and integration which is policy-relevant, city-focused, comparative and multidisciplinary.”

The Metropolis Project is supported by a number of federal government departments and agencies including Citizenship and Immigration Canada, Health Canada, Human Resources Development Canada, Canadian Heritage, Status of Women Canada, Solicitor General of Canada, Immigration and Refugee Board of Canada, Canada Mortgage and Housing Corporation, and the Social Sciences and Humanities Research Council of Canada.

Four university-based Metropolis Centres of Excellence were established to generate policy-relevant research on the effect of immigration in the broad context of cities. Research at the Centres is organized according to domains (i.e. citizenship and culture, economics, education, physical infrastructure, political and public services, and social domains). All of the Centres conduct health research and at two health has been designated as a separate domain.

A Health Canada working group, including a representative of the Women's Health Bureau, guides the department's participation. The Working Group: identifies Health Canada's strategic objectives and policy interests in relation to Metropolis and communicates these to the Metropolis Centres; promotes opportunities for researchers, policy-makers and other stakeholders to work collaboratively; and creates and/or identifies mechanisms and opportunities for communicating the results of research, conducted through the Metropolis Project, back to policy-makers within Health Canada.\*\*

### **Vancouver Centre of Excellence for Research on Immigration and Integration in the Metropolis (VCE-RIIM) [www.riim.metropolis.net](http://www.riim.metropolis.net)**

VCE-RIIM is a joint initiative of Simon Fraser University and the University of British Columbia. The Centre's principal objective is to provide databases, analyses and research findings from a multidisciplinary team that address a wide range of immigration and integration issues affecting the Vancouver region. VCE-RIIM interacts and collaborates with NGOs, research institutes, immigrant settlement agencies, and private and public sector organizations at the municipal and provincial level. Its research program covers five areas: economy; education; housing and neighbourhood; social; and religion. Health research is funded through the social and economic domains, and includes research related to health care restructuring, the mental health of elderly Muslims and Iranian women, and health care utilization by immigrant populations.

### **Prairie Centre of Excellence for Research on Immigration and Integration (PCERII) [www.pcerii.metropolis.net](http://www.pcerii.metropolis.net)**

PCERII, a consortium of the universities of Alberta, Manitoba, Calgary, Regina, Saskatchewan and Winnipeg, emphasizes immigrant and integration research in medium-size cities, where immigrants' experiences are different than in large metropolitan centres. Its research program covers five areas – economy, education, health, social and cultural, citizenship and politics – and is guided by these assumption: immigrant and host communities exert reciprocal influence;

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\* Kinnon, Dianne (1999), *Canadian Research on Immigration and Health*, Ottawa: Health Canada, p. 3.

\*\* Kinnon (1999), pp. 3-4.

integration is a process rather than a static end-state; the magnitude, speed or ease of immigrant integration may vary by gender, social class, immigrant group and domain; and, integration has visible effects that must be isolated and studied. Research in the health domain includes studies on: variations in perceptions and significance of health issues among immigrant women; support and barriers immigrant women experience as family caregivers; enhancement of public health services through ethnic matching in nursing; differential mortality rates among immigrants in Canada; child rearing practices; and the stress of living in ethnocultural isolation.

### **Toronto Centre of Excellence for Research on Immigration and Settlement (CERIS) [www.ceris.metropolis.net](http://www.ceris.metropolis.net)**

CERIS's main partners are the University of Toronto, York University and Ryerson Polytechnic. Its research focuses on the effects of immigration on both the new settlers and the receiving society. One of the Centre's major objectives is to inform immigration policy and practice, through an "integrative" research model. CERIS's research program covers five areas: economy; education; housing and neighbourhood; health; and community. Health research focuses primarily on the health status and health care access of vulnerable groups. Issues covered include: respiratory health; barriers and incentives to breast cancer screening in Tamil immigrants; settlement issues for ethno-racial immigrants with disabilities; visible minority nurses' experience of workplace racism; food security and culture; the health status and health care access for the Arab community; the impact of hospital closures in southeast Toronto; and the mental health of Ethiopians in Toronto.

### **Immigration et métropoles (I et M) – Montréal [www.im.metropolis.net](http://www.im.metropolis.net)**

*Immigration et métropoles* is a research consortium jointly managed by McGill University and the University of Montréal and the National Institute for Scientific Research at University of Montréal. The centre's objectives are to: intensify collaboration and co-ordination of research on immigration and integration; promote innovative, multidisciplinary research in the Quebec and Canadian context; undertake comparative research with other metropolitan centres in Canada and abroad; intensify and/or formalize collaboration with the public and the NGO sector; and ensure the effective dissemination of research results to better inform policy-makers, service providers and the public. *I et M* undertakes research in five major areas: demographic and linguistic aspects of immigration; neighbourhood life, residential patterns, social networks and management of collective facilities; education and training; health, social services, public safety and justice; citizenship, culture and social climate. Health-related research has included: women's health; senior's health; the mental health of refugees; culturally appropriate mental health services; communication between health care providers and patients; conflict prevention in family reunification; the role of churches in the integration process; intergenerational relationships; conjugal violence; youth gangs; and trans-national crime (trafficking of women).

## END NOTES

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- <sup>1</sup> Janzen, B. (1998), *Gender and Health: A Review of the Recent Literature*, Winnipeg: PWHCE, pp. ii, 22.
- <sup>2</sup> Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH) (1999), *Toward A Healthy Future: Second Report on the Health of Canadians*, Ottawa: Health Canada, p. 31.
- <sup>3</sup> Kinnon, D. (1999), *Canadian Research on Immigration and Health*, Ottawa: Health Canada.
- <sup>4</sup> Janzen, B. (1998), *Gender and Health: A Review of the Recent Literature*, Winnipeg: PWHCE.
- <sup>5</sup> Health Canada (1999), *Health Canada's Women's Health Strategy*, Ottawa: Health Canada, p. 35.
- <sup>6</sup> Ibid., p. 26.
- <sup>7</sup> Vissandjée, B., et al. (2000), *Gender, Ethnicity and Health: Research and Policy Challenges for Immigrant Women in Canada*, Montréal: CESAF, p. 9.
- <sup>8</sup> Boyle, P. and Halfacree, K. eds. (1999), *Migration and Gender in the Developed World*, London: Routledge Press, pp. 10-11.
- <sup>9</sup> Spitzer, D., et al. (2001), "The Impact of Immigration Policy on Women's Health and Well-being: A Synthesis of Workshop Findings," Proceedings of the 5th International Metropolis Conference, web site.
- <sup>10</sup> Bannerjee, L. (1985), *Shaming the World : The Needs of Women Refugees*, London: Change.
- <sup>11</sup> Kinnon, D. (1999), p. 37.
- <sup>12</sup> Janzen, B. (1998), pp.18-19.
- <sup>13</sup> Chen, J., et al. (1996), "The Health of Canada's Immigrants in 1994-1995," *Health Reports* 7(4), pp. 33-44.
- <sup>14</sup> Janzen, B. (1998), p. 23.
- <sup>15</sup> Vissandjée, B., et al. (2000), *Gender, Ethnicity and Health: Research and Policy Challenges for Immigrant Women in Canada*, Montréal: CESAF, p. 6.
- <sup>16</sup> Janzen, B. (1998), *Gender and Health: A Review of the Recent Literature*, Winnipeg: PWHCE, pp. ii, 22.
- <sup>17</sup> Bowen, S.J. (1998), "Resilience and health: Salvadoran women in Manitoba," M.A. thesis, Winnipeg: PWHCE.
- <sup>18</sup> Bowen, S. (1998), pp. xxi-xxv.
- <sup>19</sup> Battaglini, A., et al. (1999), « Identification des facteurs de vulnérabilité propres aux mères immigrantes en période périnatale, rapport d'étape. » Montréal : CESAF.
- <sup>20</sup> Ibid., pp. 4, 5-6, 9, 35,38, 42, 50-51, 54, 56.
- <sup>21</sup> MacKinnon, M. (1999), "Affirming immigrant women's health: building inclusive health policy," Halifax: MCEWH.

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- <sup>22</sup> Ibid., p. 12.
- <sup>23</sup> Ibid., pp.14-16.
- <sup>24</sup> Ibid., p. 17.
- <sup>25</sup> Vissandjée, B., et al. (1998), pp. 129-130.
- <sup>26</sup> Battaglini, A., et al. (1999), « Identification des facteurs de vulnérabilité propres aux mères immigrantes en période périnatale, rapport d'étape, » Montréal : CESAF. pp. 4, 5-6, 9, 35, 38, 42, 50-51, 54, 56.
- <sup>27</sup> Kinnon D. (1999), pp. 52-53.
- <sup>28</sup> Janzen, B.(1998), pp. ii-iii.
- <sup>29</sup> Kinnon, D. (1999), pp. 52-53.
- <sup>30</sup> Ibid., pp. ii-iii.
- <sup>31</sup> Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH) (1999), *Toward A Healthy Future: Second Report on the Health of Canadians*, Ottawa: Health Canada, p. 31.
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- <sup>37</sup> Kinnon, D. (1999), pp. 38-39.
- <sup>38</sup> Janzen, B. (1998), p.19.
- <sup>39</sup> Kinnon, B. (1999), pp. 24-25.
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<sup>41</sup> Tastsoglou, E. and Miedema, B. (2000) *Immigrant Women Organizing for Change: Integration and Community Development by Immigrant Women in the Maritimes*, Edmonton: PCERII, pp. 7, 11, 23, 56, 74.

<sup>42</sup> Dossa, P. (1999), *The Narrative Representation of Mental Health: Iranian Women In Canada*, Vancouver: RIIM, pp. 5, 28, 33.

<sup>43</sup> Bowen, S. (1998) “Resilience and health: Salvadoran women in Manitoba,” (M.A. thesis), Winnipeg: PWHCE, p. xxvi.

<sup>44</sup> Rojas-Viger, et al. “Impact of violence on mental health of Latin American women,” Montréal: CESAF, pp. 20-21.

<sup>45</sup> Jiwani, Y. (2000). "Developing a holistic framework for the delivery of violence-related health care and information to immigrant women from racialized communities," Vancouver: BCCEWH. Coté, Andrée., et al. (in progress) « Qui prend pays...l'impact du parrainage sur les droits à l'égalité des femmes immigrantes francophones, » Toronto Ceris. Juteau, D. and Ly-Tall, A. (in progress). « Pour une citoyenneté participative des femmes réfugiées au Canada : quelles politiques? » Montréal: I et M

<sup>46</sup> Mayetela, R.-M., et. al. (1999), « Vieillir en contexte migratoire, » Montréal : CESAF and ACCESS, pp. 12, 49, 54, 61, 71, 124.

<sup>47</sup> Mayetela, R.-M., et. al. (1999), p. 124.

<sup>48</sup> Kinnon, D. (1999), p. 53.

<sup>49</sup> Sharif, N., et al. (2000), *Ethnicity, Income and Access to Health Care in the Atlantic Region: A Synthesis of the Literature*, Halifax: MCEWH.

<sup>50</sup> Ibid., pp.13-15.

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