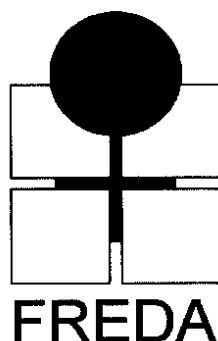


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Intersecting Inequalities: Immigrant Women of Colour, Violence & Health Care

Yasmin Jiwani
Author & Principal Investigator

Research assistance from:

Kelly D'Aoust
Suki Grewal
Benita Bunjun
Harjit Kaur
Tracy Conley

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Yasmin Jiواني

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EXECUTIVE SUMMARY

This report focuses on racialized immigrant women who have experienced intimate violence and their access to, and encounters with, the health care system. In particular, the report focuses on the formal health care system centering on physicians' private practices, walk-in clinics and hospitals where women are likely to seek services for violence-related health care. The report reviews some of the current literature in the area and identifies key variables that contribute to immigrant women's vulnerability to violence and lack of access to health care. The response of health care professionals to women who have experienced violence is also examined.

Findings of the literature review suggest that immigrant women of colour are at risk of violence, and that the risk they face stems from their structural location in society. Lack of dominant language skills, accreditation of their qualifications, and the prevalence of racism and sexism, contribute to the deskilling of these women and their subsequent ghettoization in occupations that are dangerous and unprotected. As immigrants, they experience the trauma of migration which includes dislocation, role overload, as well as role reversal. The latter occurs as a result of their more rapid employment in the labour force, albeit in occupations that are downwardly mobile and marginalized. The isolation that immigrant women experience has been identified as a key factor contributing to their risk. It is exacerbated by their dependent status on their spouses, as underscored by immigration legislation, resulting in an unequal power relation and the potential for abuse within the family.

This report details a thematic analysis of information derived from: (a) an environmental scan consisting of telephone interviews with twenty-one organizations around the province of British Columbia; (b) individual interviews with six key informants and service providers working with immigrant women; (c) focus groups with immigrant women of colour who have experienced abuse, as well as a focus group with bilingual and bicultural service providers; and (d) individual interviews with immigrant women from racialized communities. The questions asked in the interviews and focus groups were developed in concert with frontline anti-violence workers and the findings of the literature review.

In total, twenty-seven informants and service providers working in different organizations were contacted for the interviews and consultations. The interviews were conducted by telephone, while key informants were consulted in person. Twelve of the interviewees were from transition houses and shelters, three worked at rape crisis centres or at women's centres, four worked at immigrant settlement service organizations, four were in hospital-based services or clinics, two worked in social service organizations (i.e., neighbourhood houses), one worked in a program at the Ministry for Children and Families, and one was a regional health board multicultural worker.

The focus group with immigrant women who had experienced abuse consisted of five women from diverse backgrounds. The focus group with bicultural and bilingual service providers consisted of eleven women, most of whom were immigrant women of colour. In addition, ten

individual interviews with immigrant women of colour were conducted to supplement the focus group data. These data were also analyzed in terms of emergent themes.

Analysis of the results indicate that for the most part, physician response to women who have been abused is inadequate. However, the quality of physician response was considerably better in those sites where screening protocols for domestic violence were in place. For racialized women – immigrant women of colour and Aboriginal women – the response was of poorer quality and influenced by stereotypes about violence within these groups. Interviewees and focus group participants noted that physicians often attribute violence to cultural groups on the assumption that these communities are inherently violent. Cultural racism is used to explain these perceptions and the resulting differential treatment of racialized women.

Issues concerning disclosure of violence are discussed within the context of immigrant women of colour's structural location in society. Living in a society where they are constantly marginalized and excluded forces women to turn to their families and communities for support. Within such a context, disclosure becomes difficult for fear that it might result in ostracization and exclusion from the community. The situation is exacerbated by the current scrutiny of immigrants of colour and their stereotyping and criminalization. It is also aggravated by the power and control dynamics inherent in the abusive relationship whereby spouses use the threat of deportation to silence women from disclosing.

Language barriers often force women to turn to physicians who share the same cultural and racial background. The findings indicate that most women consult physicians who are chosen by their spouses. In the case of an abusive relationship, women are discouraged from disclosing for fear that their confidences might be breached by the physician who has a prior relationship with the spouse, and who may also be seeing the immediate and extended family. Service providers observed that abusive spouses and children often act as interpreters for women, thus contributing to women's reluctance to disclose abuse. Participants mentioned that male physicians who share the same cultural and racial background as their women patients are reluctant to get involved in domestic violence cases. In contrast, female physicians were more likely to be involved and tended to show greater empathy. This gender difference was also observed in the environmental scan which focused on white, Aboriginal and immigrant women.

Focus group participants and interviewees continually emphasized the lack of time that physicians provide to patients. They stated that a trusting relationship is most conducive to disclosure. In contrast they observed that physicians tend to focus on the rapid processing of patients. This effectively limits the potential of developing trust and communicates to women that their concerns are not important. The trivializing of women's health concerns and the reluctance of physicians to examine these concerns within the context of women's lives was also identified as major shortcomings. Further, the linkages between violence and mental health are not explored by most physicians in their treatment of women who have been abused.

Recommendations arising from this research emphasize the need for health care providers to be more educated and aware of the health impacts of violence. Recommendations emerging from the focus group and interviews suggest a need for physicians to employ a socio-ecological model in understanding and treating violence. Such a model includes an examination of societal,

institutional and individual factors that impact on health. The trauma of migration, racism, marginalization and exclusion, and the dynamics of intimate forms of violence need to be considered in tandem in assessing an immigrant woman of colour's health care needs. Further, recommendations outline the need for accredited interpretation services that can be utilized by physicians to better serve the needs of immigrant women of colour. Other recommendations focus on the need to reduce risk factors such as isolation through active outreach strategies and the deployment of public health or community nurses. Fluency in the particular language combined with knowledge about the community's social and historical experiences is a necessity. As such, it is recommended that nurses and outreach workers be selected from communities of colour.

Finally, recommendations concerning the production and distribution of information about the health impacts of violence focus on the dissemination of this information in multilingual formats within schools, places of worship, community centres, specialized grocery stores, immunization clinics, as well as in spaces that are commonly frequented by women. Community and mainstream media were identified as some of the most effective ways of distributing information pertaining to violence and health.

INTRODUCTION

A punch in the eye or a kick in the stomach is probably the same no matter what colour you are or what language is being shouted at the time.

Christine Rasche (1988:165)

The conscious or unconscious behaviours of people whose culture has the power to define service policies and practice may cause those from other cultural groups to feel powerlessness, anger and humiliation often resulting in avoidance of the service. In Maori that response is called *whakam*, to make things white, an emotional whiteout.

Irihapeti Ramsden (1993:7)

This report examines the health care issues faced by immigrant women of colour who have experienced intimate violence. It seeks to locate their experiences within the nexus of the social, economic and political conditions that structure the lives of immigrant women of colour in Canada. While government policy defines immigrants as those who are *not* born in Canada (see for instance, Kinnon, 1999),¹ the focus of this investigation is narrower in that the examination is limited to racialized women of colour who are not born in Canada. Further, the investigation is limited to those women who have obtained legal status and thus does not include the barriers faced by undocumented women, migrant workers, foreign students or women who are in Canada on a visitor's visa.

While the health care system in totality is diverse in its orientations, this report focuses on immigrant women of colour who have experienced violence and their encounters with a particular domain of the health care system – namely, the medical professionals who work in the context of private practice, walk-in clinics and emergency rooms. A further objective is to outline recommendations that would ameliorate the conditions of immigrant women of colour and enhance their access to health care, and more specifically, medical care. This objective is in keeping with policies arguing for women-centred care (Hills & Mullett, 1998), the Ottawa Charter (Canadian Public Health Association, 1994),² as well as Health Canada's Population Health Framework which identifies gender as a determinant of health.

The report begins with a review of the literature focusing on the particular vulnerabilities of immigrant women. It draws on studies conducted in the United States, Britain, and Australia in order to augment Canadian studies. The review includes an identification of some of the health impacts of intimate violence and the particular barriers that women who have experienced violence encounter in accessing health care. While this review of the literature is not exhaustive,

¹ According to Ng (1993), the technical definition of an immigrant is one who has not received citizenship. Yet, recent policy documents such as the report on Health Canada's contribution to the Metropolis project, define immigrants as those not born in Canada (see Kinnon, 1999). This reflects a shift in policy and in keeping with the historical exclusion of people of colour, their continued 'otherness,' in contemporary Canadian society.

² The Ottawa Charter for Health Promotion (1986) states that: "...the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resource, social justice and equity" (cited in Kinnon & Hanvey, 1996:np).

it highlights the common problems that confront racialized immigrant women in a variety of different contexts.

Subsequent sections of this report detail the findings from an environmental scan obtained from interviews and consultations with service providers and key informants, as well as focus groups and interviews conducted with racialized immigrant women and bilingual and bicultural service providers. The report concludes with recommendations drawn from the literature, interviews and focus groups, as well as those articulated by immigrant women of colour survivors of violence who participated in this study.

STRUCTURAL VERSUS ETHNO-SPECIFIC ANALYSIS

While this report draws from the various ethno-specific studies cited in the literature, it does not focus on the cultural cosmology of particular groups or the particular expressions of gendered violence that might occur in these groups. Too often, such analyses have been used in both scholarly and popular media to reinforce stereotypes about immigrant women of colour.³ In keeping with the processes of racialization where some groups are marked because of their imputed or biological differences, and the ideology of systemic racism which attributes these groups with negatively valued traits, it becomes incumbent on those conducting socially responsible research not to feed into the stereotypes.

The tendency of ethno-specific research has been to focus on the culture of particular groups. While such an approach has validity, “culture talk is a double-edged sword” (Razack, 1994:986). It can reify cultures as static entities, obscure the relations of power within and outside of the cultural group, and fail to consider the relational aspects of cultural identity (Abraham, 1995) as emerging from a migrant, diasporic existence (Dossa, 1999). Add to this the contextual backdrop of systemic and everyday racism (Essed, 1990) and the focus on culture quickly becomes one of implicitly or explicitly comparing a backward, traditional and oppressive cultural system to the modern, progressive and egalitarian culture assumed of the West (Burns, 1986; Lai, 1986; Jiwani, 1993; Said, 1979; Thobani, 1998). Such an approach can result in the production of cultural prescriptions which further entrench stereotypic representations of particular ethnic groups (Razack, 1998).

This is not to suggest that an ethno-specific analysis would not yield a representative rendering of the issues and barriers faced by a particular group of women. However, an adequate ethno-specific analysis would have to employ interpretive methodologies grounded in a theoretical framework that would draw out the ‘thick’ description (Geertz, 1973) of immigrant women’s lives (e.g. Dossa, 1999). Such a methodology requires time and has its own issues with regard to representational politics (Bannerji, 1987; 1993). That is not the purpose of this report. The aim in the present context is to outline the impact of structural forces and the barriers they produce which impede and curtail racialized immigrant women’s access to formal health care (medical care).

³ For an example of the ways in which occurrences of gender-based violence have been used to entrench stereotypes about particular groups, see Jiwani (1998), and Jiwani & Buhagiar, (1997).

PART I: RACE, GENDER, VIOLENCE & HEALTH CARE: A REVIEW OF THE LITERATURE

SITUATING IMMIGRANT WOMEN OF COLOUR

Immigrant women have been the focus of numerous scholarly investigations from diverse disciplinary traditions. Yet, although constructed as a group, the needs, realities and lives of immigrant women are not homogenous nor are they a monolithic group. 'Race' and class are major factors influencing immigrant women's choices and degree of access to shelter, employment, and services (Anderson et al., 1993; Bolaria & Bolaria, 1994; Lee with Harrison, 1999; Ng, 1993). Immigrant women of colour are racialized in terms of their construction as 'others' as well as their subordinate status within Canadian society (Iyer, 1997; Ocran, 1997; Thobani, 1998). Legislation and policies concerning immigration have a tremendous impact on settlement and access to services. Hence, whether a woman immigrates as an 'independent,' a 'sponsored dependent' in the family class, a convention refugee, or has received 'landed status' after serving time as a domestic worker or live-in caregiver, determines her subsequent status and access to services (Thobani, 1998).⁴ The same situation applies to undocumented women, migrant workers, and foreign students whose access to services may be further impaired by the degree of legality ascribed to their status.

Even prior to immigrating, applicants have to demonstrate that they are in good health and will not pose a risk to public health, or impose a burden on the health care system. Should they fail the medical exam on either one of these conditions, they will not be admitted into the country. According to the 'excessive demands' clause, an applicant will not be admitted if their health demands "exceed that of the average Canadian (evaluated as \$2,500 per year); if their admission may displace a Canadian resident from obtaining services; or if the required services are not available and/or accessible" (Laroche, 2000:53). The popular perception of immigrants as a drain on the health care system or as endangering public safety has a long history (Beiser 1998).⁵ Historically, the threat of people of colour bringing over strange diseases was used to rationalize their exclusion as citizens and immigrants (Anderson & Kirkham, 1998). That fear still remains and continues to inform policy decisions around screening mechanisms for the detection of diseases among potential immigrants (Beiser, 1998; Shroff, 1996/97).

⁴ According to the 1976 Immigration legislation, there are three categories under which immigrants can come into the country: independent, family class, or refugee. The independent category is applicable to those who have the necessary skills, or who are willing to invest, and/or those who can show their economic self-sufficiency. The family class refers to those individuals who are sponsored by a family member or who are dependent on the independent applicant.

⁵ This perceived threat has, in recent times, generated considerable empirical analysis focusing on the health expenditures of immigrants. Chen, Ng & Wilkins (1996) found that immigrants tend not to suffer from chronic illnesses or diseases, and further have lower levels of physician visits. The exceptions occurred for those who were in the low income brackets and for women who reported more frequent physician contacts (Dunn & Dyck, 1998).

Many immigrant women come to Canada as dependents of their spouses or as 'sponsored' individuals who are sponsored by families or spouses (Abu-Laban, 1998). In either case, their dependency on the sponsoring spouse is underscored by the legislation (Ng, 1993). As dependents, they have little access to services. The sponsoring spouse or family has to demonstrate they are economically able to support the sponsored person for a period of 10 years. If the sponsorship agreement breaks down, the woman involved can obtain hardship assistance but she would have to verify her changed circumstances and inform the authorities (see Janovicek, 2000). Her status would then be reviewed, and she could potentially risk deportation (Dosanjh et al., 1994). Even if the sponsorship agreement is intact, should the woman's spouse be deported, she will be deported as well. The situation is often complicated by the reality that women are involved in the joint sponsorship of their own and their spouse's extended family members. The coercive pressure to keep the family together compels women to remain in abusive relationships.

THE RACIALIZATION OF WOMEN

According to Citizenship and Immigration Canada, immigrants constitute 17.4% of the population, totaling 4,971,070 individuals. One out of every six Canadians is an immigrant (Kinnon, 1999). Asia and the Pacific constitute the source of 54% of all recent immigrants, followed by Africa and the Middle East (18%), Europe and the UK (18%), and the US, Caribbean, South and Central America (10%). Thus, it is safe to assume that most of the recent immigrants are people of colour or in the terminology of the government, 'visible minorities.' According to Statistics Canada, the 'visible minority' population in Canada totals 3,197,480 and in BC, the figure is 660,545, constituting approximately 18% of the total provincial population (Statistics Canada, 1996).

The identity of groups that are racialized varies according to the particular society being examined and is reflective of a group's social status in a given historical period (Miles, 1989). Within Canada, Aboriginal peoples, people of colour, the Jewish, Irish and Ukrainian peoples have been racialized at various times in the history of the nation. Today, Aboriginal people and people of colour still remain on the outskirts of Canadian society as racialized groups who are visibly identifiable and subject to racism, exploitation, marginalization and criminalization (Bannerji, 1993; Das Gupta, 1996; Henry et al., 1995; Jiwani, 2000).⁶ Racialization refers to the "processes by which meanings are attributed to particular objects, features, and processes, in such a way that the latter are given a special significance and carry or are embodied with a set of additional meanings" (Miles, 1989:70). Women of colour are racialized in the sense that their skin colour serves to demarcate them and imbues their representation with negative valuations. These meanings are grounded in an ideology of racism which Bulhan defines as:

... the generalization, institutionalization, and assignment of values to real and imaginary differences between people in order to justify a state of privilege, aggression and/or violence. Involving more than the cognitive or affective content

⁶ See also Reitz & Sklar (1997) for an examination of the impact of exclusion experienced by 'visible minorities' in terms of their economic mobility.

of prejudice, racism is expressed behaviourally, institutionally, and culturally. The ideas or actions of a person, the goals or practices of an institution and the symbols, myths or structure of a society are racist if (a) imaginary or real differences of race are accentuated; (b) these differences are assumed as absolute and considered in terms of superior, inferior; and (c) these are used to justify inequity, exclusion or domination. (1985:13)

As Bulhan notes, racism can be communicated in a variety of ways and can take different forms in different historical periods. Thus, there may be many 'racisms', and the task at hand is to "[understand] racisms as modes of exclusion, inferiorization, subordination and exploitation that present specific and different characters in different social and historical contexts" (Anthias & Yuval-Davis, 1992:2). The discourse of immigration itself has become racialized. Hence, the term 'immigrant' is popularly constructed as referring to a person of colour (Henry et al., 1995). This point is echoed by Ng (1996) who states:

... technically, the term, 'immigrant women,' refers to women who are landed immigrants in Canada. In everyday life, however, women who are white, educated, and English-speaking are rarely considered to be immigrant women. The term conjures up the image of a woman who does not speak English or who speaks English with an accent; who is from the Third World or a member of a visible minority group; and who has a certain type of job (e.g., a sewing machine operator or a cleaning lady). (cited in Lee & Harrison, 1999:16)⁷

Canadian society has long been described by scholars as a vertical mosaic (Hamilton, R., 1996; Porter, 1965). The description highlights the stratified nature of the society and the ranking of groups within it on the basis of their class and race, as well as the particular structures of domination exerted on the basis of sexuality and ability to maintain the hegemonic power of the elite and reinforce the normative glue of social cohesion. Within this structure, women constitute a subordinated group. Their inequality is defined on the basis of institutionalized economic, socio-cultural and political devaluation, all of which are underpinned by historical and contemporary social forces. Similarly, people of colour are subordinated by institutionalized racism, and largely occupy the lower rungs of the society (Henry et al., 1995). Thus, the very institutions that women look to for protection and services are themselves structured on hierarchies based on race, class, gender, sexuality, age, and ability. These forces are evident also in the organization and structure of the formal health care system in Canada (see Varcoe, 1997).

However, within the category of 'women', a similar hierarchy exists. Class, race, sexuality and ability engender a ranked order and influence women's autonomy, access to services and economic mobility. As Spelman argues, there is no 'universal woman' (Bannerji, 1993; Spelman, 1988). To submit to an essentialist notion of woman is to negate the differences within women and erase the power and privilege exercised by some women over others (Razack,

⁷ While it is true that immigrant women of European background are an increasingly significant presence in the Canada, the stereotype of the immigrant woman as a woman of colour prevails in the media and the public imagination.

1998).⁸ It is to erase the impact of racism, classism, heterosexism and ableism in the lives of women.

Immigrant women of colour who have experienced violence are positioned at the juncture of multiple and intersecting systems of domination. Not only are they located in the lower echelons of the social stratification system of the wider society because of their race and gender, but they are also located at the bottom of the hierarchy of preferred clients of the health care system. Compounding this situation is the reality of their subordinate status within their own communities as a result of patriarchal forces that are heightened by State policies of immigration. As women who are classed and raced, their needs and realities have and continue to remain invisible, and their voices confined to the realm of advocacy and survival.

THE IMMIGRANT EXPERIENCE: RESILIENCE AND SURVIVAL IN A HIGH RISK CONTEXT

Immigrants come to Canada for a variety of reasons. Principal among these is to secure a better future for themselves and their children. Coming to a western country from a developing nation has always carried connotations of upward mobility, economic betterment and a more secure future. Certainly, the picture that western countries have advanced, through various channels, to the developing worlds of the South is framed in the racially inscribed language of colonialism where the south is constructed as backward, traditional and in need of modernization (read westernization), and the North by contrast is presented as the realm of democracy, economic prosperity, individual freedom and equality. Implicit in this language is the promise of acceptance, integration and equality for those groups migrating to the north. Hence, many immigrants of colour come to Canada expecting that they will be able to participate fully and enjoy the fruits of their labour in economic and social terms. They bring with them their social, cultural and in many cases, economic capital.

THE REALITY OF RACISM

Since 1976, many immigrants who were selected on the basis of their qualifications and skill-sets (as determined by the Canadian immigration point system), find themselves, upon arrival, deskilled and devalued (Ervin, 1994; Ng, 1993). Their qualifications are not recognized and they are required to obtain 'Canadian experience' in order to qualify for jobs more suited to their abilities. Not having any Canadian experience because of the lack of accreditation and the reluctance of employers to hire them, they experience downward mobility. For racial minorities, this factor is compounded by the pervasive racism in Canadian society (Billingsley & Muszynski, 1985; Bolaria & Li, 1988; Boyd, 1989; Henry & Ginzberg, 1985; Henry et al., 1995). The overt and covert nature of racism in Canada has been documented extensively by advocates and academics. As Henry & Tator confirm: "In a white dominated society, the colour of your skin is the single most important factor in determining life chances, as well as your dignity, identity, and

⁸ The history of slavery and colonialism are quintessential reminders of the very real differences among women and how these differences were used by the governments of the time to maintain patriarchal power (Mohanty, 1991; Strobel, 1993).

self-esteem” (cited in Fleras & Elliot, 1996:35). In a context of intense and prevalent anti-immigrant sentiments, the reality of immigrants of colour is one of constant negotiation, adjustment, and retreat into the cultural community. And in the Canadian context where racism is more ‘polite’ and insidious, the processes of negotiation are more nuanced and confounding leaving many people of colour doubting their own realities. This situation of being a perpetual ‘other’ exacts its toll on the mental health of immigrants of colour. As one immigrant woman interviewed by MacKinnon & Howard put it:

... We are living in the community but it’s just like water and oil, you shake the bottle, they mix together, you cannot tell the difference and I say ‘Hello, hi Joe, how are you?’ and then the bottle settles down, oil and water separates. We don’t feel we are really mixed with the neighbours, with the community. ... (2000:28)

Fanon (1967) and Memmi (1965) have poignantly described the psychological impact of being a perpetual outsider and being ‘othered.’ Additionally, Black feminist scholars have further elucidated on the psychological and sociological impact of racism (e.g., Davis, 1990; hooks, 1995; Williams, 1991). As people of colour who are also immigrants, the trauma of migration combined with the experience of being ‘othered’ contributes to a greater sense of alienation and marginalization.

THE IMPACT OF MIGRATION

In his study of the Southeast Asian boat people, Beiser (1998) observes that immigrants go through three distinct stages during their process of resettlement in Canada. Initially, they experience a period of euphoria. This is followed by a period of disillusionment during which depression is common. Finally, a period of adaptation follows. These periods accentuate the stresses of migration that mark the lives of all immigrants resulting in a sense of loss, helplessness and alienation (Choi, 1997; Moussa, 1994; Schneller, 1981; Vega et al., 1987; Zulman, 1996). MacKinnon & Howard state that, “Immigration itself is associated with increased morbidity. ... These factors include: language difficulties, multiple responsibilities; financial and employment stressors; lack of acceptance by their host communities; culture conflict; and a perceived lack of social support” (2000:25). For refugees, these stresses are more intense as a result of witnessing or being victimized by violence. However, in the case of immigrants of colour, the harsh reality of racism and its constancy make the settlement process more difficult, if not traumatizing. American studies have underscored the negative health impact of racism (e.g. David & Collins, 1991 as cited in Cameron et al., 1996). Combined with the poverty resulting from deskilling, under-employment and unemployment, the disruption of social ties and the lack of immediate supportive networks, the health impact of migration is more severe for immigrants of colour (Brice-Baker, 1994). A Canadian study indicates a high suicide rate among Asian women (Kinnon, 1999). Anderson (1987) notes that for the immigrant women in her study, loneliness and depression were a daily feature of life.

GENDER, RACE & RISK

MULTIPLE ROLES

Immigrant women have been identified as a high risk population (Meleis, 1991). Meleis defines their vulnerability as stemming from the multiple roles they are required to play within the home and the external society, as well as the constant negotiation of competing demands that results from their bi-cultural existence. The notion of 'role overload' has been documented in the US, UK, and Canadian literature as one of the defining stressors in the lives of immigrant women (Anderson, 1987; Choi, 1997; Li & May, 1997; MacKinnon with Howard, 2000; MacLeod & Shin, 1990; Rhee, 1977). Some authors have detailed the multiple work that immigrant women do in terms of constructing a transnational community, transmitting cultural knowledge, and providing support to their immediate and extended kin (Alicia, 1997; Lutz, 1995; Ng, 1993). This is in addition to the double load that most women carry with respect to working outside the home and child-rearing and house work. However, the negotiation of multiple roles occurs within a larger social context, and it is the responsiveness of the receiving society which plays a critical role in exacerbating role overload. Part of this responsiveness lies in the kinds of services and programs that are available to immigrant women to facilitate their integration into the economic and cultural spheres. Yet another part deals with the attitudes that are directed at immigrant groups in general and racialized groups in particular (Bald, 1995; Henry et al., 1995). Exclusion from the larger society as a result of racism increases immigrant women's role overload in terms their responsibilities as nurturers providing a space within the home that is affirming and that provides a sense of belonging through cultural continuity.

RACISM & SEXISM: ECONOMIC EXPLOITATION & GHETTOIZATION

Canadian social policy has tended to view immigrant women as dependents of their spouses or families and to erase their social, economic and cultural contribution to the economy (Thobani, 1999). Despite having higher qualifications, immigrant women are unable to practice in their fields because of language barriers and the lack of accreditation of their qualifications. Further, they are often diverted from language instruction and economic integration programs on the assumption that they are not the principal breadwinners of the family (Ng, 1993; Roberts, 1990). As an evaluation report conducted by the Windsor Occupational Health Information Service (1995) demonstrates, immigrant women are not provided language instruction or education in terms of their employment rights. This renders them a pliant and cheap labour force, which can be easily exploited. Bolaria & Bolaria (1994) note that immigrant women tend to work in occupational areas that are dangerous and hazardous to health. Further, many of these sectors are unprotected by unions, rife with economic exploitation, seasonal or part-time in the kind of work they offer, and render women working within them vulnerable to all forms of violence (Anderson, 1985; 1987; Jiwani, 1994; MacLeod et al., 1994; Philippine Women Centre, 1997; Savary, 1998). Lack of dominant language skills serves to stream women into low paying, low mobility and seasonal jobs (Ng, 1993; Ocran, 1997). This has a direct bearing on the kinds of stresses they experience, their vulnerability to violence, and their ability/inability to access adequate services.

Ghettoized in particular jobs (Iyer, 1997; Ocran, 1997), many of these women also experience gender role dislocation in the family. The deskilling and unemployment of men combined with more rapid employment of women in low paying jobs (Ng, 1993), e.g. domestic work, create additional tensions in the family. In a series of focus groups convened by the MOSAIC immigrant settlement society, women from the Kurdish, Somali, Vietnamese, Polish and Latin American communities in Vancouver discussed the gender shifts in their family and the potential for violence. The focus group participants, "... felt that immigration and the resulting changes in the family roles and expectations, appear to increase men's insecurity in the relationship, and that insecurity, in turn, resulted in dysfunctional behaviour" (1996:4-5).

LEGAL STATUS

By far the most common thread cited in the literature dealing with immigrant women who have experienced violence centres on the implications of the legality of their status (e.g., Abraham, 1995; Brice-Baker, 1994; Calvo, 1996; Choi, 1997; Choudry, n.d.; Dosanjh et al., 1994; MacLeod & Shin, 1990; MacLeod et al., 1994; Narayan, 1995; Rasche, 1988; Rhee, 1977). As indicated previously, most immigrant women enter Canada as sponsored spouses. Their dependency on their spouses is underscored by the sponsorship requirements and reinforced by the State. Sponsorship obligations are often used as instruments of power and control by abusive spouses to reinforce their authority within the family (MacLeod & Shin, 1990; Moussa, 1998). In essence, the dependent designation subordinates women in the relationship and accentuates their dependency on sponsors to meet basic needs (Ng, 1993). For women, this translates into a feeling of indebtedness (NAWL Brief, 1999), a fear of deportation, fear of having their children taken away from them, and fear of poverty and destitution should they leave the abusive relationship.

In British Columbia, social assistance policies known as BC Benefits exacerbate the situation by holding the sponsoring spouses accountable for any social assistance given to women. This contributes to a continual harassment of immigrant women by their abusive spouses, who use it to threaten women not to disclose abuse and/or leave the relationship. For many women, the situation is compounded by their lack of knowledge regarding their legal rights. Language barriers, dependency and lack of dominant cultural knowledge, contribute to their inability to access information about their rights or the resources that may be available. Studies focusing on 'mail order' brides are illustrative of the impact of isolation, lack of knowledge of the dominant language and systems, and dependent status as factors contributing to violence (Choi, 1997; Narayan, 1995; Philippine Women Centre & GAATW, 1999).

In addition to their legal and economic dependency, the lack of accreditation of skills and qualifications for both themselves and their spouses contribute to immigrant women being streamed into specific jobs which are 'dead end' (Ng, 1993:289). The decline in their spouse's status leads to the use of other means by which spouses attempt to exert power and control within the home.

ISOLATION

In describing the situation of immigrant women in the US, Pinn & Chunko (1997) identify isolation as a key risk factor for domestic violence. Social, structural and cultural isolation contribute to women's marginalization and vulnerability to violence. Lack of dominant language skills can in effect make women more dependent on their families and communities to negotiate their survival. The lack of cultural knowledge and frameworks of meaning within the dominant society increases the sense of isolation experienced by many immigrant women (Wiik, 1995). Exclusion from the dominant culture as a function of racism exacerbates the isolation and sense of loneliness they experience (MacLeod et al., 1994; Rasche, 1988; Sidhu, 1996). Many women don't know where to turn when they are victims of violence.

ACCESSING SERVICES

Existing studies indicate that lack of dominant language skills is a key barrier exacerbating the situation of immigrant women (Calvo, 1996; Chin, 1994; Choudry, n.d.; Dyck, 1992; Eastal, 1996; MacLeod & Shin, 1990; MOSAIC, 1996; Perilla et al., 1994). Inability to communicate in the dominant language permeates interactions with service providers leading to feelings of frustration and heightened dependency on those who can translate. Too often, the interpreters are other immediate members of the family. This serves to compromise confidentiality and can engender feelings of shame and embarrassment (MacLeod & Shin, 1990, 1994; Sasso, 2000). Lack of adequate and appropriate interpretation can lead to misdiagnosis thereby endangering the lives of immigrant women (Sasso, 2000).

However, language barriers are only one of many issues impeding immigrant women's access to services (Anderson & Kirkham, 1998). Given immigrant women's concentration in the lower, unprotected echelons of the labour force and the piecemeal nature of work they are required to perform, women cannot afford to take time off to access services. Should they take the time off, they often have to find transportation and accompaniment by someone who can interpret their request. And further, inability to communicate in the dominant language compounds the difficulties of negotiating with government and health care and social service bureaucracies (Gany & Thiel de Bocanegra, 1996). Thus, aside from language, other barriers also influence immigrant women's access to health care. In her study of immigrant communities and their access to health care, Christensen (2000) found that the inability to speak in the dominant language was mentioned by only 27% of the individuals she surveyed. Similarly, Anderson (1987) found that immigrant women of colour who speak English fluently experienced barriers to services based on the stereotypes that health care providers had of their particular cultural groups.

SILENCING VIOLENCE

Immigrant women's marginalization in the social, cultural, political and economic spheres of society also contributes to their sense of 'otherness' and lack of belonging. The retreat into their cultural communities exacts a price for immigrant women of colour who experience violence. When the community becomes the only site for a sense of belonging and self-esteem, jeopardizing one's reputation incurs social costs which could amount to stigmatization and

exclusion (Dasgupta, 1996; Health Canada, 1994; Huisman, 1996; MacLeod & Shin, 1990; Rasche, 1988; Rhee, 1977; Wiik, 1995). In this sense, the plight of immigrant women who experience violence parallels that of rural women whose only choice in leaving a violent relationship is to leave their community (Jiwani et al., 1998). However, in a racist milieu where men of colour are increasingly criminalized, reporting violence can in effect be construed as 'race treason' (Flynn & Crawford, 1998; see also Davis, 2000; Razack, 1998). Communities are labeled and constructed as being inherently violent resulting in negative social implications for other members and children. Fear of deportation and criminalization leads many immigrant women of colour to avoid authorities and any form of official documentation that could potentially jeopardize their legal status.

SUMMARY

The subordinate status of immigrant women as dependents, combined with their streaming into occupational ghettos that are hazardous, underpaid and unprotected, and their diversion from language classes (and concomitantly occupational and economic mobility), contribute to their inferiorization, isolation and marginalization. Given the racism and sexism they face from the broader society, and the sexism they face from within their own communities into which they retreat in order to maintain a sense of self, immigrant women of colour are indeed in a high risk category. However, as a vulnerable population, their access to services is limited. Their gender, race, and class form a juncture where multiple forces of domination intersect. The negative health effects emanating from the stresses of migration, economic exploitation, stigmatization and marginalization worsen the situation. The negative health effects emanating from spousal abuse are further accentuated by the institutionalized racism and sexism that immigrant women of colour encounter in the formalized health care system, namely at the hands of medical professionals.

WOMEN, VIOLENCE & THE MEDICAL SYSTEM

As a social institution, the health care system is stratified. The system is 'raced, classed, and gendered' in the way in which services and labour are organized. While the janitorial, kitchen and laundry staff occupy the bottom echelons of the system, nurses are located above them, and physicians along with hospital administrators account for the elite. The concentration of people of colour occurs at the lower end of the hierarchy, namely in the cleaning sector. Within this tiered context, there are varying levels of violence perpetrated against those who have relatively little power and control (Varcoe, 1997).

The medical professions' response to women who have been abused has been described as inadequate (Kinnon & Hanvey, 1996). According to studies cited by Kinnon and Hanvey, "medical personnel identify one battered woman in 25" (1996). The absence of an effective response to the screening and treatment of battered women has been attributed to a lack of knowledge about violence among medical personnel, their unease with dealing with issues of violence, the implications of violence in terms of their own experiences of abuse, stereotypes about women, and preconceived notions about woman abuse. Further, identification of abuse tends to depend on the visibility of symptoms and the lack of alternative explanations by which

to understand the injuries. For women whose symptoms are not visible, the possibility of effective identification and intervention is further reduced. The political economy of medical care is also undoubtedly an influential variable, given that physicians are paid on the basis of the number of patients they treat. The time required to deal with woman abuse is greater than the time taken to simply prescribe medication.

HEALTH CARE COSTS OF VIOLENCE

It has been estimated that the medical and health related costs attributed to violence against women amount to \$408,357,042 nationally (Greaves et al., 1995). These include the costs of emergency visits, consultations with doctors, ambulance services, psychiatric ward care, and some treatments. They do not include the costs to patients, e.g., transportation, prescription drugs, time-off from work, child-minding, or anything else that is required to obtain medical services. Nor do they include the entire spectrum of health issues associated with the psychological forms of abuse which may result in self-harm.

In a recent survey conducted by Statistics Canada, 40% of the women who had experienced violence reported being physically injured and requiring medical attention (General Social Survey on Spousal Violence, 1999). The 1993 Statistics Canada Survey on Violence against Women revealed that 45% of the victims of spousal violence had been physically injured (Johnson, 1996). Further, in 21% of the cases, the abuse took place during pregnancy (Varcoe, 1997). Injuries among women who had been abused included burns, cuts, scratches in 33% of the cases, and miscarriages and internal injuries in 10% of the cases (Wilson, 1998). According to Archer, "seventy percent to eighty percent of women who are psychiatric inpatients have a history of physical or sexual abuse. Fifteen to 30 percent of women presenting to emergency rooms have a history of current abuse" (1994:975). The Domestic Violence Program at the Vancouver General Hospital reported a 15% disclosure rate among women presenting to the emergency department (Chambers, 1998). As Chambers notes, most women do not disclose the violence to the police or other authorities. Rather, they tend to confide in friends and family. Nevertheless, the health impact of chronic stress and violence compels many women to seek medical attention.

For women who are experiencing violence, the doctor's office may be the only place they can go unaccompanied, as medical visits tend to be more sanctioned and normalized. It may also be the only place in which they can disclose abuse if asked by a concerned physician. Yet, as a study by Trute et al. (1988) of general practitioners in Manitoba revealed, most physicians do not ask questions about violence. Trute et al. found that physicians who are male and who have been in practice for a long time period were less likely to detect abuse. The Violence against Women Survey (1993) found that 23% of the women who had been injured by a male partner had approached a doctor. Bullock et al. (1989) found that 8.2% of the women who had visited the four planned parenthood sites in their study were victims of physical battering. While hospitals are the sites which women turn to in emergencies, the chances of the family physician being the first line of refuge for an abused immigrant women is much higher. Community-based research underscores this point (e.g. Sidhu, 1996). The role physicians can play in detecting abuse and providing referrals is therefore critical, as is the role of nurses working within clinics and

hospitals (Henderson & Eriksen, 1994; Varcoe, 1997). Nevertheless, even in this context, anecdotal and community research suggests that disclosures are not given serious consideration.

HEALTH EFFECTS OF VIOLENCE

The health effects of violence are manifold and complex. They include Post Traumatic Stress syndrome which groups a range of symptoms (Abbott et al., 1995; Archer, 1994; Argüelles & Rivero, 1993; Chuly, 1996; Ristock et al., 1995); bronchitis and upper respiratory infections (Abbott et al., 1995); depression, anxiety, fear, mood swings and dissociative states (Argüelles & Rivero, 1993); chronic pain, fibromyalgia, chronic pelvic pain, headaches, gastrointestinal disorders, irritable bowel syndrome, and pelvic inflammatory disease (Radomsky, 1995), to name just a few of the more common symptoms. Other mental health issues arising from being victimized by violence include sleep disorders, sexual dysfunction, anxiety disorders, alcohol and substance abuse, low self-esteem, suicide ideation and obsessive-compulsive disorders. Archer (1994) notes that in a study of women who had attempted suicide, 83% had experienced intimate violence. Kurz & Stark (1988) found that women who had experienced intimate violence were five-times more at risk of committing suicide. Women who are sexually assaulted are eight-times more likely to commit suicide, six-times more likely to attempt suicide, and five-times more likely to have a nervous breakdown (Boyчук Duchscher, 1994).

While this list identifies some of the longer term health sequelae of violence, it does not locate these within a socio-ecological model (Perilla et al., 1994) that outlines the intersections and compounding factors of race, class, sexuality and ability/disability, as well as the larger and more immediate social context of the individual and group (Stark et al., 1979). To this end, Ristock et al., note that factors such as “racism, isolation, lack of services, language barriers, geographical barriers, and religious beliefs” can amplify the impact of violence (1995:9). This observation is echoed in other literature focusing on immigrant women in the US (e.g., Bohn, 1993; Brice-Baker, 1994; Champion, 1996; O’Keefe, 1994).

THE MEDICALIZATION OF VIOLENCE: SYSTEMIC SEXISM

As an institution, the health care system reproduces social inequalities by privileging those who have power and subordinating others. In so doing, the health care system draws upon the dominant language of biomedicine to categorize, manage and process patients. Symptoms become the categorical referents which are then organized to generate the ‘appropriate’ prescriptions. As a system of thought, western biomedicine embraces a Cartesian dualism focusing on the physical manifestation rather than the social, psychological and economic reality of the patient. To some degree, this dualism has been tempered by recent discoveries that point to the links between ‘mind’ and ‘body.’ However, in the case of woman abuse, the incorporation of a socio-ecological model which begins with a recognition of patriarchal power and the systemic violence of racism and classism has yet to occur. While Health Canada’s population framework model signifies a beginning in its recognition of gender and class as determinants, it has not permeated the dominant medical discourse of the health care system.

In an insightful analysis of the treatment of woman abuse by the health care system, Ahluwalia & MacLean (1988) note that the medical encounter is a hierarchical one in which power inequalities between the patient and the physician are asserted and reinforced. The physician assumes the role of the expert, deciphers the symptoms of the patient, and prescribes an antidote to eliminate or control the symptoms. In keeping with the dominant ideology of capitalism and liberalism, the patient is seen as being responsible for her/his ailment and hence, compliance becomes a way for the patient to assume responsibility. This kind of processing of patients and the commodification of their symptoms within the economic arrangements underpinning the health care system result in a management of the health effects of violence that render the patient – in this case the woman who has been abused – as being responsible for her abuse. Post Traumatic Stress Syndrome, the Battered Women's Syndrome and psychiatric classifications become an avenue by which symptoms are managed and controlled. The labeling also serves another purpose – namely to negate the social dimensions of violence against women, and to reformulate them as an “individual problem of self-abuse” (Ahluwalia & MacLean, 1988:190).

Studies by Kurz & Stark (1988), Stark et al. (1979), Varcoe (1997) and Warshaw (1993), identify the specific ways in which women who are abused become labeled and their symptoms used to generate prescriptive interventions in the form of referrals to psychiatric services and antidepressants. In a study of the treatment of abused women in one hospital, Warshaw (1993) found that the very practices of the medical profession have a detrimental impact on the diagnosis of symptoms associated with gender-based violence. As she observes:

... using the standard medical shorthand, which is an important shaper of how physicians learn to organize their thinking, we see how the subject becomes a mere descriptor. What are foregrounded are the symptoms: swelling and pain on the mouth. The physician's note uses the passive voice and focuses on the physical trauma. Even the additional statement, 'hit by a fist,' is structured to give information relevant to the mechanism of the injury and what damage might have been done to the body. It removes the fist from the person attached to it. In doing so, the physician, although perhaps not consciously, makes a choice that obscures both the etiology and meaning of the woman's symptoms. (Warshaw, 1993:141)

Varcoe (1997) points to the ideology of scarcity as expressed in discourses of limited resources and inadequate funding for health care that are used to make sense of and rationalize the rapid processing and turnout of emergency patients. She also notes that patients are assessed on the basis of their appearance and class and that the treatment provided by nurses varies accordingly. In her study, the nurses' perceptions of violence hinged on signs of physical abuse manifested by the women they saw. Thus, their estimates regarding the prevalence of abuse in the women presenting at emergency were much lower than indicated by the statistical evidence.

In the case of battered women, it becomes evident that societal pressures and institutional discourses and practices combine to generate treatment that perpetuates violence against women, but in ways where the agency (will) of these women is harnessed toward their own self and intimate abuse. Hence, rather than acknowledge that the violence women are experiencing is a function of the patriarchal power of the family as embodied in the power of the male partner – a power which is supported and sanctioned by society as a whole – the women are prescribed

antidepressants or diverted to psychiatrists or social workers in order to patch them up so that they can go back to their homes (Ahluwalia & MacLean, 1988; Stark et al., 1979). The outcome of such interventions is “misdiagnosis; repeated, and often inappropriate treatment of symptoms rather than the root problem; lack of empathy leading to greater trauma and poor collection of forensic evidence” (Kinnon & Hanvey, 1996).

Critical analyses of the failure of the medical system to properly address the widespread and systemic issues of violence against women have resulted in a range of interventions spanning from the introduction of screening protocols in hospitals to educational measures aimed at physicians and nurses, and the insertion of violence-related curricula in medical and dental schools (Berman & McLaren, 1997; Coeling & Harman, 1997; Furniss, 1993; Grunfeld et al., 1995; Hamilton, J., 1996; Henderson & Eriksen, 1994; Hotch et al., 1995).⁹

SUMMARY

The health care system is an integral part of society, and as a social institution, it reproduces the larger social forces of sexism, racism and classism that underpin and shape the status of women within the wider society. Violence against women is pervasive and remains a painful reality despite the decades of activism from the women’s movement, reforms in social policy, and educational initiatives. The elimination of violence rests on the eradication of social inequalities. The health care system is predicated on these inequalities as evidenced by the tiered structures that are operative within it, and the differential power and privilege accorded to individuals occupying the different levels of the hierarchy. Patients are accountable to nurses and physicians; nurses are accountable to physicians; and physicians may be accountable to hospital administrators. These categories are permeable to some extent but what they reflect is a presence and entrenchment of a hierarchy. Within this hierarchy, the woman who has experienced violence has virtually no power. If she is presenting in an emergency context, her power and agency are further reduced. As a victim of intimate violence, she embodies the brutality of patriarchal power within the home. Her power is further erased by the discourses and practice of western biomedicine which regard her as a constellation of symptoms to be categorized, managed and processed. Class, gender and race enter the already unequal encounter between the abused woman and the physician/health care worker. Depending on her class, she may be treated better or worse, and depending on her racial features, she may be treated in a worse manner, or have her concerns overlooked and her problems attributed to some innate cultural traits.

INSTITUTIONALIZED RACISM

As with sexism, the formal medical establishment and the health care it offers is not immune to racism. In fact, the traditional power and authority of physicians is maintained by ideological beliefs grounded in the perception of the superiority of western medicine, and the inferiority of other, indigenous forms of health care.

⁹ These interventions have produced valuable tools for medical practitioners by which to ameliorate the treatment of women who have experienced violence and who are presenting at emergency departments, clinics, and doctors offices.

Overt racism in the medical system has been observed in the unequal practices of hiring whites over people of colour, the ghettoization of people of colour in certain jobs, and their lack of advancement and absence in decision-making positions. The reluctance to accredit medical practitioners trained in other parts of the world is another manifestation of the exclusive structure of power and privilege inherent in the medical system. This latter point is an obvious indicator of systemic racism given the Canadian government's concern and preoccupation with the 'brain drain' of qualified health personnel to the US.

In a study focusing on Black nurses in a Toronto hospital, Das Gupta (1996) observed that their work was more heavily scrutinized, the demands and expectations placed on them were greater than those placed on white nurses, and Black nurses were often sidelined for advancement. These findings corroborate an earlier study by Head (1986) of racial minority nurses in Toronto hospitals. Head found that racial minority nurses were significantly underrepresented in decision-making positions in hospitals, and further were not promoted at the same rate as white nurses, despite having the same or superior qualifications (cited in Henry et al., 1995).

In a series of focus groups with patients and physicians, Cave et al., found that physicians tended to stereotype patients according to their cultural groups. They also observed that patients acquiesced to the authority of the doctor and regarded western medicine as superior (1995). Beiser's (1998) overview of the literature indicates that minority status influences the kind of health care one receives. Blacks were more likely to be diagnosed with schizophrenia than whites, and "family doctors are less likely to refer non-English clientele to specialists than their English-speaking counterparts, and surgeons are less likely to perform procedures such as cardiac bypass surgery, or kidney replacement on minority, than on majority group patients" (1996:29). A recent American study found that Black patients were not only less likely to seek emotional assistance from professionals but were also more likely to be under-diagnosed for psychiatric disorders (Kosch et al., 1998). It is not clear whether this finding is equally applicable to physicians of colour.

In an interesting study on patient-physician pairing, Gray & Stoddard (1997) found that after controlling for socio-economic factors, minority patients tended to choose minority physicians. While there are methodological shortcomings to their analysis, the preference for physicians from the same racial or ethnic group is observable among Canadian immigrants and may be predicated on issues concerning language barriers, social networks, and cultural comfort.

ERASURE, TRIVIALIZATION & SILENCING

Studies of immigrant women's access to, and encounters with, medical professionals consistently point to the erasure and trivialization of their health concerns. The MOSAIC (1996) consultation with immigrant women from various ethnocultural communities revealed that women felt they could not communicate with their physicians and further, that the physicians' focus on the physical aspects of their health negated the root causes of their illness and erased the totality of their being (see also Anderson, 1987). In other words, physicians did not employ a socio-ecological analysis that would situate the woman in the context of her experiences and lived reality. Given the stresses and impact of migration combined with the dislocation of traditional roles, the role overload identified by Choi (1997) and Meleis (1991), as well as the streaming of

women into dangerous and unprotected jobs, it is surprising that physicians negate these vital aspects of immigrant women's health.

Anderson notes that the Indo-Canadian women in her study, "continually repeated that health professionals did not understand their concerns, so in other words, there was no point in trying to communicate with them" (1987:426). This lack of response serves to communicate to immigrant women of colour that their concerns are not worthwhile. Consequently, many immigrant women feel silenced. Abraham (1995) found that health professionals' insensitivity and apathy toward immigrant women stems from their racist stereotypes and perceptions about particular ethnic groups. Research conducted by MacLeod & Shin (1990), MacLeod et al., (1994), and Sidhu (1996) with immigrant women in Canada confirms this observation.

Sidhu's (1996) study of 22 immigrant women who had experienced abuse highlights the structural dependency of these women on their spouses. As sponsored immigrants, many of the women relied on the same physician as their abusive partners. The family physician is thus in a position of conflict serving the abuser and victim at the same time, and may be more likely to believe the abuser's account of the violence. As Sidhu argues,

This made it awkward for the women to discuss marital issues. Due to the physician-patient confidentiality, the physicians would not suggest a joint consultation between patients. It was up to the individual to approach the doctor. If the partners were unwilling to cooperate or expressed anger at the women for raising 'their' family problem in the public arena, the women risked more abuse from their partners. (1996:33)

Sexism combined with racist stereotypes contribute to immigrant women's vulnerability and erasure. The long-term health impact of dealing with these forms of oppression is exacerbated by the weight of "enduring racism in silence" (Jackson & Inglehart, 1995, cited in Cameron et al., 1996:201).

'THE UNDESERVING PATIENT'

The prevalence of racist stereotypes about people of colour among health care professionals has been documented extensively by Varcoe (1997) in her participant-observation study of nurses in several emergency departments. Varcoe observed that nurses had definite notions of deserving versus non-deserving patients. Non-white, poor, and intoxicated or overdosed women were usually seen as non-deserving patients. Varcoe maintains that the health care system is organized around discourses of scarcity, deservedness, and violence. She further argues that violence is understood within two frameworks of meaning – that of pauperization and racialization. The two obviously intersect in situations where patients are both poor and of colour. However, in the case of women of colour, violence was more readily associated with their culture. This culturalization of violence or cultural racism (Razack, 1998) prevalent among many nurses is reflective of the dominant Canadian discourse on race and racism that pervades mainstream services (MacLeod & Shin, 1990). As Varcoe notes, nurses' perceptions of women of colour who had been abused was to attribute their abuse to their culture. This leads to a situation of heightened visibility and

scrutiny on the one hand, and on the other hand, a dismissal of the woman's experience in terms of her cultural membership. As one nurse in her study stated:

Culturally, because I have had a lot to do with a [certain group of] people in the last [few] years, I would say overall, that as a group of nurses [at this hospital] people are more suspicious of abuse in a multicultural type of patient situation than they are in an actually Caucasian situation. (Varcoe, 1997:215)¹⁰

The immigrant women of colour interviewed by Anderson noted the prevalence of similar stereotypes which impacted on their ability to access appropriate health care. Anderson suggests that:

One could argue that non-white women's experiences are shaped by the history of imperialism and oppression, and are not only the result of their immigrant status. Instead, these experiences have to be understood in terms of their status as non-white immigrant women from a Third World nation. So, not only must non-white immigrant women contend with ideologies about women's roles, but they must also contend with stereotypes that are entrenched within the mainstream culture, which determine the ways they are perceived. (1987:433)

SUMMARY

For the immigrant woman of colour who has experienced intimate violence, the encounter with the health care system is fraught with risks of being further revictimized. Not only may she be faced with language barriers, isolation, and fears about her legal status, but her whole personhood is reduced to racial stereotypes about the particular cultural group to which she belongs. Her positioning at the juncture of societal racism and sexism, institutional racism and sexism, and her own experiences of patriarchal violence in the home place her in a high risk situation. Her dependency on the State in terms of immigration status, on the medical system in terms of health services, and on her sponsoring spouse serve to drastically limit her choices and her agency. Yet, immigrant women of colour survive.

TOWARD EQUITY & RECOGNITION

In addressing the specific barriers that immigrant women face, the existing literature advances several recommendations which are noted below. Many studies argue for the implementation of culturally sensitive services (e.g., MacLeod et al., 1994; Majumdar & Roberts, 1995; Perilla et al., 1994; Sanchez et al., 1996; Schwager et al., 1991). Rhee (1977) argues for culturally appropriate services, and Williams & Becker (1994) indicate a need for culturally competent or

¹⁰ One can assess from this quote just how far the language of multiculturalism has permeated the thought and talk of members of the dominant society. That a 'multicultural' type of patient exists seems rather illogical and can only be understood as a euphemism for a person of colour or as someone from a different cultural background, but even here, bicultural would be a more accurate term. Nevertheless, the designation presupposes the existence of a monocultural person as the norm.

culturally congruent services. Within these models, cultural issues tend to become foregrounded, and the influence of structural issues tend to be muted. However, as Moussa points out:

The phrase 'cultural sensitivity' is often used in Canada for relating in a positive manner to the cultural background of refugee and immigrant women. I would like to suggest that 'sensitivity' is a very passive, if not a patronizing term. One of the most important approaches for anyone working with refugee and immigrant women is first and foremost to *respect* differences in values and decision-making style. And secondly to recognize that refugee and immigrant women are not in a position of power in Canada because of pervasive racism, the class structure, gender inequality, and because of their uncertain legal status. An assumption behind 'cultural sensitivity' can also be that refugee and immigrant women have nothing to offer Canadian society let alone having ways they can solve their own issues. (1994:66)

In part, the appeal of the 'cultural sensitivity' approach is that it enables service providers and health care personnel to deal with the tangibles – the manifest attributes of the patient – and address these with cultural prescriptions. Structural issues such as racism, lack of employment, deskilling, marginalization and ghettoization, which contribute to vulnerability to violence are expressions of structural inequalities, and require political and social action. Health care, like other institutions in society, is predicated on a capitalist-commodity model despite the rhetoric of universalism and compassion. Thus, as patients are moved through the system, their illnesses are translated into units of time and concomitantly, dollars and cents. While the culturally-specific approach advocated by some studies is untenable in a milieu of immense racial and cultural diversity, it still functions as a remedy and to some small extent, actually facilitates service provision to marginalized groups (Agnew, 1998).¹¹ However, it is impossible for health care providers to know every culture in detail, and similarly impossible to apply culturally specific knowledge in ways that account for diasporic, relational, and generational manifestations of cultural formations. Nevertheless, as existing studies demonstrate, there is a need to take into consideration the various factors impacting on a person's life and find ways to address the ensuing dis-ease stemming from their social, structural and cultural location.

FINDING WAYS OUT

Some of the strategies identified in the existing literature cohere around the following: creating social networks of support (Emmott, 1996); advocating critical analyses of structural issues and self-reflection (Brice-Baker, 1994; Hamilton, J., 1996; Legault, 1996; Lynam, 1999; Varcoe, 1997); empowering women (Varcoe, 1997; Yam, 1995); taking a historical approach to understand the social location of the women (Bohn, 1993), and employing a holistic approach (Sanchez et al., 1996). These strategies are not mutually exclusive but rather overlap in practice. When employed in concert, they work toward empowering the immigrant woman of colour,

¹¹ Agnew (1998) notes that advocating for 'culturally sensitive' services has been one of the few ways in which women of colour from immigrant communities have been able to ensure the provision of services to their communities.

viewing her in context and as a person, and working with her to develop viable strategies. Underpinning all these strategies is the issue of respect and dignity – respecting different social locations, histories and realities without inferiorizing or trivializing their import.

Moving from Risk to Safety

Ramsden (1990, 1993), offers a model of ‘cultural safety’ which neatly encapsulates both the practical strategies that can be employed as well as a conceptual framework by which to understand, appreciate and address the power inequalities and imbalances that structure the medical encounter between indigenous peoples and the white medical professionals who serve them. While Ramsden’s model is grounded in the Maori reality and relationship with the white settler community in New Zealand, her observations and findings echo the lived realities of Aboriginal people and people of colour in Canada. Hence, when she states that “we are not a perspective” (1990:2), she challenges the dominant normative model of multiculturalism which identifies other cultures as perspectives which the dominant culture as the central organizing principle – what Stuart Hall (1990) refers to as the ‘white eye’ – gazes out on.

In referring to cultural safety, Ramsden discusses ‘cultural risk’ and argues from the perspective of the Maori woman who is presenting to a white health professional. She defines cultural risk as “a process whereby people from one culture believe that they are demeaned, diminished and disempowered by the actions and delivery systems of people from another culture” (Wood & Schwass, 1993:2, cited in Ramsden, 1993:7). The Maori woman is thus at risk of being erased or having her concerns trivialized by a white, dominating establishment.

Although speaking in the context of nursing, Ramsden’s recommendations on reducing cultural risk are appropriate to the kinds of changes that health care professionals in Canada can implement in order to ensure access and equitable treatment. Her recommendations pivot on and incorporate many of the strategies identified above, but underscore the recognition of the differential power relations between the dominant and subordinate groups. For instance, she notes that self-reflexivity and value interrogation are necessary steps but that in order to implement structural change, nurses (or other health care professionals) need to be made aware of the impact of poverty, historical and social processes, and to have this understanding inserted in the training of other health professionals so that in the long term, cultural risk is reduced. As Polaschek elaborates, the concept of cultural safety,

... makes clear the structural dimension of health care provision, that care is not simply provided for individuals but for members of groups whose care inevitably reflects the position of their groups as a whole within general society. It shows that such group interrelationships which influence health care provisions are unequal. It highlights the power dimension of ethnic relationships, from social disadvantage to explicit racism, which affect the provision of services such as health. It critiques the assumption of social consensus... (Polaschek, 1998:456)

The notion of power differentials is underscored in Ramsden’s work as well as Polaschek’s elaboration of it. Polaschek notes that ‘culture’ as used in this conceptual framework is not the same as the anthropological definition of culture which when popularized is susceptible to being

static and reified. Rather, the framework is grounded in the wide diversity of Maori culture, reflecting the power relations that have subordinated that indigenous community.

Translating Cultural Safety into Reality

The eradication of racism and sexism within health care constitutes a necessary point of departure for implementing structural change and thereby reducing the power inequalities that contribute to the disadvantage of particular groups, and most especially, to the risks faced by immigrant women of colour. Implicit in this endeavour is the necessity of dismantling stereotypes and negative perceptions through such means as power sharing, and value-based self-interrogation (Hamilton, J., 1996; Lynam, 1992). Recognizing the differential and unequal impact of legislation and other policies on immigrant women of colour is also vital. Immigrant women of colour's dependency on the State in terms of immigration policies (Brice-Baker, 1994; Dosanjh et al., 1994), the medical system, social welfare agencies, and the increased scrutiny of these women must be acknowledged and apprehended. Using a socio-ecological approach that takes into account the structural, social and economic variables impacting on a woman's life is also a necessity.

Additional mechanisms that are identified in the literature that would make health care more equitable include the following:

- Informing women about their rights, services that are available, and the particular procedures that are necessary to ameliorate their health condition (Cave et al., 1995). This can be achieved through outreach (Williams & Becker, 1994), partnerships with the communities, and the inclusion of community members in training and administration of services. It can also be achieved by relaying necessary health information on violence to diverse groups through the use of local, ethnic and mainstream media (MOSAIC, 1996).
- Listening to immigrant women's voices is critical (Shroff, 1996/97; Varcoe, 1997) and can be undertaken by ensuring the representation of these voices in policy and program consultations, partnerships in projects, delivery of services, and inclusion of immigrant women of colour in decision-making bodies within the health care system. Majumdar & Roberts (1995) identify a successful model for the delivery of AIDS education that involved the training of women from different communities who then went back to their communities with the knowledge and information they had received.
- Implementing support groups that are within geographic proximity to women's homes would help reduce isolation, which is a key risk factor, and also allow immigrant women of colour to develop social networks of support that are equally critical for their well-being (Dyck, 1992).
- Implementing a coordinated health care approach that integrates diverse health professionals would not only help to reduce isolation but also reduce risks stemming from other factors such as language barriers, unfamiliarity with the bureaucracy, and a sense of helplessness (MOSAIC, 1996).

- Increasing the availability of alternative models of health care and validating indigenous or cultural models of health care would also help in empowering immigrant women of colour.

For immigrant women of colour who have experienced violence, the most serious needs are interpretation, advocacy, and support. Advocacy and support for victims have been described as essential in the literature dealing with violence (Kurz & Stark, 1988). However, their importance and implications for the safety of immigrant women of colour are accentuated because of issues of legal status, dependency on the sponsor, as well as racism and sexism within the system. Kurz & Stark observed that in the hospital setting where one physician acted as an advocate for battered women, the treatment that the women received was not only more appropriate but actually facilitated their situation. The physician-advocate helped to transform ‘problem patients’ into ‘patients with problems’ (1988:263).

SUMMARY

It is apparent that to meet the needs of racialized immigrant women who have experienced violence, health providers have to take into consideration the totality of a woman’s location, as well as recognize the multiple forms of institutional, societal and individual levels of violence that are impacting on her. Such an approach involves embracing a socio-ecological perspective. It involves assessing the risks that render immigrant women of colour vulnerable to violence, and eliminating these risks in order to enhance their level of safety. To this end, a conceptual reframing is necessary so that, rather than centering the analysis on the needs of health care institutions, immigrant women’s needs become the focal point of analysis and intervention. In-house advocates, social support networks and groups, and other practical measures are necessary in order to balance the current unequal power relations between immigrant women of colour and all health care providers.

CONCLUSION

This review of the literature outlines the major factors impacting on immigrant women of colour who have experienced violence in terms of their access to health care. Key factors that impact on immigrant women and that increase their risk to violence include: the dependency on their spouses as underscored by immigration legislation; isolation; lack of the dominant language skills and knowledge about the dominant cultural norms; ghettoization and exploitation in underpaid, hazardous and unprotected jobs; marginalization and alienation combined with the lack of social support networks; and the combination of sexism from within their communities and the dominant society, as well as the racism of the external society including health care professionals. Inferiorization, trivialization and erasure of the concerns and realities of immigrant women of colour are some of the ways in which immigrant women of colour are treated. The racism they encounter serves to categorize them in terms of their culture and often results in their social construction as ‘undeserving’ patients. Within a health care context where the discourses of scarcity, commodification and racialization operate, immigrant women of colour who have experienced violence are triply jeopardized – by their race, class and gender.

Existing studies identify a number of avenues whereby immigrant women and disadvantaged peoples can be better served by the health care system. Underpinning many of these recommendations is the recognition of the necessity to incorporate a socio-ecological model. The latter incorporates an examination of the structural location of the individual patient, a socio-historical analysis of the group and the stresses it has encountered, and an analysis of the social, economic and political reality of the group. The individual is seen within the context of larger and immediate social forces impacting on her lived reality. Ramsden's model of cultural risk incorporates these variables and offers a conceptual rethinking of the directions that health care workers can pursue. Within this model, health care providers are encouraged to critically reflect on and interrogate their beliefs, and to treat other groups and individuals in more respectful ways. More importantly, the model suggests ways in which to implement structural changes which can work to reduce the risk of disadvantaged groups both immediately and in the long term.

The literature also identifies practical measures that health care providers can implement to better serve the needs of immigrant women of colour who have experienced violence. These include avenues by which to reduce the isolation immigrant women experience, ways to empower them, and vehicles by which to reach out and inform diverse communities about the services that are available and about their rights to adequate and appropriate health care.

In conclusion, the barriers faced by immigrant women of colour in accessing the health care system are substantial. The system's response, as outlined in this review, is one of inferiorization, trivialization, and erasure – *whakam* or the emotional white-out that Ramsden described in the opening quote of this section. These responses are predicated on and in turn, reproduce the dominant discourses of racism and sexism. In order to redress the inequalities, the system requires structural change. However, the point of departure for such change has to be situated in a broader and more complex definition of violence. As Carraway argues,

Our societal definition of violence must include the direct results of poor medical care, economic inferiority, oppressive legislation, and cultural invisibility. By broadening our definition of violence, we combat the minimalization of our experiences as women of colour by the dominant culture. We must name the violence, or we will not be able to address it. (1991:1302)

While the above brief review of the literature provides a portrait of the kinds of issues that impact on immigrant women of colour and their access to health care, the following sections provide a more in-depth examination of the expression of these issues at the level of the daily lived reality of immigrant women of colour and the service providers who advocate for their needs.

PART II: LISTENING TO VOICES: IMMIGRANT WOMEN OF COLOUR & THE HEALTH CARE SYSTEM

INTRODUCTION

In order to access the experiences of immigrant women of colour with the health care system in general – and more specifically, women who had experienced abuse – we conducted: (a) an environmental scan consisting of telephone interviews with twenty-one organizations around the province; and (b) individual interviews with six key informants and service providers working with immigrant women. In addition, we conducted: (c) focus groups with immigrant women who had experienced abuse, as well as with bilingual and bicultural service providers; and (d) individual interviews with immigrant women from diverse communities. Focus groups and individual interviews were collected over the span of a year during 1999. The following sections detail the findings of the interviews and focus groups. As will be seen, many of the emergent themes echo those identified in the literature review.

METHODOLOGY

Questions asked in the interviews and focus groups were developed in concert with frontline anti-violence workers and on the basis of issues identified in the literature review (see Appendices I, II & III). Questions were semi-structured and an informal interview style was used. Triangulation of the data was achieved through the use of different sources of information including the literature review, the environmental scan, key informant interviews, and focus groups with bilingual and bicultural service providers and immigrant women of colour survivors of violence, as well as through individual interviews with ten immigrant women of colour who had experienced violence. Ethics approval was obtained from Simon Fraser University prior to engaging in the collection of data.

Environmental Scan

The purpose of conducting an environmental scan was to obtain a general overview of how women who have experienced violence are treated by the health care system. Within this context, specific questions were then directed to obtaining information on how immigrant women of colour and Aboriginal women are treated by health care providers. Both these groups of women are racialized in particular ways and have low social status. The environmental scan consisted of responses obtained from organizations and key informants.

Organizations that participated in the environmental scan were identified through referral by other organizations and through random selection from a directory of women's organizations and transition houses. Health Canada's directory of transition houses was utilized for making the initial contacts. In addition, a database of women's organizations compiled by the FREDA

Centre allowed for the selection of organizations located in rural areas. Researchers were provided with a background to the project, as well as a telephone interview script. They were asked to speak to the coordinators of the various agencies, and where this was not possible, to speak to a worker directly. In some cases, organizations did not respond. Those who did respond were asked for referrals to other organizations.

A snowball approach was used to contact key informants. Key informants were selected on the basis of referrals by anti-violence workers and advocates located in Vancouver. They were defined in terms of their expertise in this area and/or their familiarity with issues facing immigrant women of colour and the health care system. The key informants consisted of representatives from two immigrant settlement organizations, a hospital-based sexual assault program, a woman's centre, a transition house, and a health program with one of the regional health boards.¹²

In total, twenty-seven informants and service providers working in different organizations were contacted for the environmental scan. Most of the interviews were conducted by telephone; key informants were consulted in person. Twelve of the interviewees were from transition houses and shelters, three worked at rape crisis centres or at women's centres, four worked at immigrant settlement services organizations, four were in hospital-based services or clinics, two worked in social service organizations (i.e., neighbourhood houses), one worked in a program at the Ministry for Children and Families, and one was a regional health board multicultural worker.

Organizations consulted for the environmental scan are categorized below in terms of their rural/urban location and the racial diversity of the populations they mainly serve:

Geographic Location	Number of Organizations	Racial Diversity	Number of Organizations
Urban-based	16	Mixed (includes all groups)	21
Rural	5	Aboriginal	5
Mix of urban & rural	6	White only	1
Total	27	Total	27

Focus Groups

Two focus groups were conducted in order to obtain more direct information about immigrant women of colour and their experiences and encounters with the health care system. The first focus group consisted of five immigrant women of colour who had experienced violence. It was

¹² Key informant interviews were conducted in person by Harjit Kaur.

organized through a local immigrant settlement services organization, and included women who had participated in the English as a Second Language (ESL) program offered by the organization. Participants included women who had immigrated from Mexico, Latin America, India, China, and the Philippines.

The second focus group with bilingual and bicultural service providers was organized through the auspices of a Vancouver-based agency which specializes in providing counselling, accompaniment, interpretation and advocacy services to immigrant women and children who have experienced violence.¹³ The eleven service providers who attended the focus group reflected the following backgrounds: Mainland Chinese, Filipino, Vietnamese, Korean, South Asian, East African, Polish, Latin American and Italian. Many of them had personal experiences of abuse and extensive collective knowledge about other women in their respective communities who had experienced or were still living with violence.

Individual Interviews

In order to supplement the focus group data, 10 individual interviews with immigrant women of colour were conducted obtained using a snowball approach whereby the women who were interviewed would refer the researcher to other women they knew. The interviews were conducted by an immigrant woman of colour researcher familiar with the issues.¹⁴

In total, twenty-six immigrant women of colour were consulted through the focus groups and individual interviews.

Data Analysis

Data obtained from the interviews, focus groups and consultations were collated and analyzed. A thematic analysis based on the responses obtained was completed. The responses were found to cohere around similar themes whether the data were derived from the scan, individual interviews, or focus groups.

ENVIRONMENTAL SCAN

The environmental scan integrates observations from interviews with service providers from twenty-one organizations located around the province, and key informants from another six organizations located in the Vancouver Lower Mainland.¹⁵

¹³ The focus group with bilingual and bicultural service providers, as well as with immigrant women of colour who had experienced violence, were organized by Benita Bunjun.

¹⁴ Individual interviews were conducted by Suki Grewal as part of her course work under the supervision of Dr. Parin Dossa.

¹⁵ Interviews with representatives of organizations located in different parts of the province were conducted by telephone. Kelly D'Aoust coordinated the environmental scan and conducted the majority of the interviews. She was assisted by Tracy Conley and Adriane Billyard. This analysis is based on Kelly D'Aoust's thematic breakdown of the interview data.

The purpose of the scan was to develop a contextual background focusing on how women who have experienced violence are treated by the health care system in rural and urban settings. Within this context, the objective was also to construct a portrait on how racialized women are treated by physicians and nurses in walk-in clinics, private practices, and hospitals, as well as the particular barriers they confront in accessing adequate health care. As both Aboriginal women and immigrant women of colour are racialized, the emphasis was on obtaining information as to how both of these groups are treated.¹⁶ The following analysis begins with a presentation of how women in general are treated by the health care system. Issues specific to Aboriginal and immigrant women of colour are discussed subsequently and separately in order to highlight their distinctiveness. Responses are grouped around themes emerging from the data.

THEMES

(a) Factors Influencing Disclosure

When asked about the likelihood of women survivors of violence disclosing to their family doctors or emergency physicians, only three service providers responded affirmatively. One added that women would only disclose if they were asked the question directly, and another added that disclosure is only likely if the woman's injuries are severe and require medical attention. The remaining interviewees maintained that women are not likely to disclose abuse out of fear of not being believed, fear of being judged harshly, and the shame and stigma associated with being a victim of violence. Another stated that women tend to minimize the violence and assume responsibility for it, or will only disclose if the violence has been perpetrated by a stranger.

The interviewees overwhelmingly reported that disclosure depends on whether the woman has a *trusting relationship* with her physician. Disclosure can occur after years of abuse and depends on how comfortable the woman feels with her physician. Another interviewee added that doctors do not spend the time to sit and listen. One interviewee suggested that women who have been abused are more able to pick up non-verbal cues telling them that doctors are busy and nurses are judgmental. Disclosure is facilitated by the physician asking questions directly, and then pursuing the discussion. Many interviewees reported that while physicians may ask the questions, they do not discuss the matter further. Most women, as one interviewee added, are simply not heard, and most physicians are not trained to ask the pertinent questions or refer patients to other services. It was pointed out that the physician-patient interaction is structured on a power imbalance, where physicians have considerably more power than the patient. The latter has even less power when she is a woman and a woman who has experienced violence. Trust becomes critical if the woman is going to disclose the abuse.

Women who are isolated and transient are not able to develop relationships with their physicians. These women are more likely to access services through walk-in clinics. The clinics included in

¹⁶ Although there are significant differences between Aboriginal women and immigrant women of colour, the scan was designed to include both groups because of their racialization in Canadian society, as well as their low social status.

this scan reported that women do not disclose abuse. Another interviewee at a transition house stated that 25% of the women she had seen have disclosed their experience of abuse to their family physicians. She remarked that this was a significant improvement as compared to the past. One transition house worker noted that women are more afraid to disclose to their doctors for fear of having their children apprehended.

In rural areas, interviewees mentioned the issue of compromising confidentiality, lack of anonymity, and lack of medical services as impeding disclosure. One interviewee noted that in her small community, the emergency unit had four beds separated by curtains. It was difficult for women not to feel as if their privacy was compromised particularly as they were likely to know the physicians and nurses in attendance, as well as the other patients. Moreover, just coming into the hospital with injuries was a tell-tale sign of abuse, and hence many of them either minimized the abuse or pretended that the injuries were 'accidents.' Further, it was noted that in rural areas which face a chronic shortage of physicians, the woman and her abusive partner are often treated by the same physician. This contributed to the woman's lack of security about confidentiality.

(i) Physician Response

Most of the interviewees reported that physicians (general practitioners and emergency staff) did not respond appropriately to women who had experienced violence. Nine interviewees reported that emergency physicians did not ask women about the abuse directly, and were more interested in attending to her physical needs. Further, like general practitioners, emergency physicians were also more interested in processing their patients as quickly as possible, and ignored the links between emotional and physical abuse. As one interviewee noted, women get 'written off' by doctors as suffering from depression, panic disorder or post-traumatic stress. Interviewees noted that women are prescribed drugs such as antidepressants to help them cope with the abuse. Physicians, it was felt, were reluctant to get involved in cases concerning violence.

Interviewees highlighted stereotypes about women that are current among many physicians. Women are told to 'just leave' or are lectured about why they remain in the abusive relationship. One interviewee mentioned that a woman she had seen was "made to feel stupid for tolerating the abuse." Another reported that the physician told a woman that "she must like the abuse since she had tolerated it for so long." Yet another physician reportedly told her patient that her husband was "too cute to be abusive." Six of the interviewees had observed doctors behaving in a rude and condescending manner toward women survivors of violence, and five stated that the physicians had used a woman's past medical history of substance abuse or mental health to blame her for the abuse and dismiss her disclosure. Four of the interviewees mentioned that physicians are not aware of the resources within the community and did not refer women to other services. As one interviewee stated, it is difficult to get 'objective care' and that physicians' responses are influenced by whatever 'baggage' women have in terms of their medical histories and behaviour.

Generally, female physicians were viewed as more supportive and empathetic. One transition house reported that it receives most of its referrals from a female physician working in the area. However, another interviewee noted that while female physicians may be more sympathetic, they often do not respond adequately. In this context, it was also noted that women tended not to

disclose abuse to male physicians, and as one interviewee pointed out, male physicians tended to align with the abuser. Another interviewee noted that abusive men had in the past influenced the perceptions and treatment of their spouses through their interactions with the mental health service provider.

(ii) Nurses' Response

Half of the interviewees stated that nurses are generally more supportive, caring, and sensitive to abused women than doctors in the emergency departments. Nurses, it was noted, tended to spend more time with the women, debriefing them and documenting their stories. In only two cases, were nursing staff reported to be rude, disrespectful or ignorant of issues surrounding violence. One interviewee who is a hospital social worker observed that nurses' behaviour ranges on a continuum from sensitive, supportive and respectful, to demeaning, verbally abusive, dismissive and punitive. Another mentioned that nurses often don't have the time to debrief women who have been abused, and consequently shift the responsibility to other services.

Public health nurses were praised for their outreach efforts, their holistic perspective, and knowledge of services in the community. One transition house worker reported that most of their referrals come from public health nurses, lactation consultants, prenatal consultants, and ambulance workers.

(iii) Protocols

Protocols concerning the screening and treatment of victims of violence were found to be operative in a number of sites that were included in the scan. However, interviewees noted that while protocols in hospitals in Vancouver worked favorably, in other sites, they were implemented inconsistently and not enforced. The training was not mandatory and procedures were not followed consistently. Nonetheless, in those hospitals where protocols had not been implemented, inconsistency in service delivery was more marked and exacerbated by the high turnover of staff.

(iv) Other Health Care Providers

Other health care providers that were identified as being supportive to women who had experienced abuse included physiotherapists, dentists and dental hygienists, chiropractors, and alternative health care personnel. Physiotherapists were specifically mentioned as offering a more holistic view of health care and being able to ask questions that would elicit disclosure.

Mental health workers were perceived to have a lower understanding of woman abuse. It was noted that these workers approach women from a medical model where the emphasis is on pathology. The woman is therefore seen as 'crazy' when in fact the issue is the crazy context in which she lives. Any history of childhood abuse contributes to this pathologization and increases the chances of her experience of abuse being dismissed or trivialized.

(b) Documentation

Interviewees were asked if the issue of documentation was a concern for women who had experienced abuse. The question was based on the findings in the literature which indicated that documentation was a concern for immigrant women because of their legal status. The aim was to assess whether documentation was a concern for all women accessing health care.

Interviewees indicated that most women did not realize the importance of documentation, particularly if they were going to press charges or seek custody of the children. Twelve of the interviewees observed that the process of documentation was intimidating for women. Women were afraid that confidentiality would be compromised, and feared the repercussions that might arise. Interviewees also noted that women were afraid of the loss of respect or the shame they would experience if the documented information was made public. Interviewees noted that health care providers need to explain the importance of documentation. Without adequate documentation that serves to corroborate her story, the onus is on the woman to prove a history of abuse. One interviewee observed that keeping records can also help women reduce their own feelings of denial and make them aware of the ways in which their experiences are being minimized by others. However, interviewees were also quick to point out that documentation can also work against women especially if it leads to the involvement of child protection agencies. As one interviewee stated, documentation reflects the clash between a woman's right to privacy and the system's desire to record details. In too many instances, women have been revictimized by the system which uses their records against them.

Some interviewees mentioned that doctors do not document the case adequately for fear they will later be subpoenaed by the courts. Another interviewee noted that guidelines as to the kinds of information that should be documented are lacking.

(c) Urban/Rural Areas

Interviewees noted that services in rural areas tend to be limited. Further, women are at risk because of the isolation, lack of adequate services, difficulties of obtaining transportation to services, and the tight-knit nature of the community. It was observed that smaller communities tend to censor abuse and silence women. One interviewee articulated the perception that rural areas receive substandard practitioners. Another indicated that the shortage of physicians had resulted in an unofficial 'blackballing' of patients who wanted to switch doctors, and patients were being charged for transferring records. Moreover, because of the shortage of physicians, women had to rely on the same doctors as their abusive spouses. The lack of alternative health centres and counselling services were also noted.¹⁷

One interviewee from an urban northern town reported that it was a "very masculine region where gender specific role playing" occurs creating an environment that fosters abuse and where abuse is normalized. She added that the social structure is very patriarchal and dominated by fundamentalist religious attitudes. The population is male-dominated and transient and relies

¹⁷ These concerns have been noted in a study of violence in two rural communities in British Columbia. See Jiwani et al. (1998).

exclusively on a single industry. Whenever there is an economic downturn, women are at a greater risk of abuse. Yet, this area has been marked by a chronic shortage of health care professionals.

While urban areas enjoy numerous services and can afford a measure of anonymity to women, they are also riddled with problems. As one interviewee aptly pointed out, in urban areas the bureaucracies tend to be larger and more complex, making it difficult for women to negotiate their way through the systems. As well, the bureaucratic structures fragment services, sometimes forcing women to go through a revolving door to access the appropriate service.

(d) Factors Impacting on Aboriginal & Immigrant Women

As racialized women, Aboriginal and immigrant women of colour not only face similar issues as other women but the particular ways in which these issues are refracted through the prism of cultural difference and racism amplify their effects. Both Aboriginal women and women of colour occupy subordinate positions in the hierarchical structures of society, albeit at different levels. Further, their rights, access to services, and social status are mediated by the definitions imposed by the Canadian state, i.e., as status/non-status Indians/Metis, or as immigrant/refugee/migrant or undocumented women (Thobani, 1998). Racism, sexism and classism are also common experiences that influence and shape the lives of Aboriginal women and women of colour. Experiences of historical colonization and neo-colonization are also common denominators for both groups of women though their manifestation and degree of impact vary.

(i) Sexist Stereotypes & Cultural Racism

In response to questions specifically concerning Aboriginal and immigrant women of colour, interviewees noted that when Aboriginal and immigrant women present to emergency or disclose to their physicians, they are often met with attitudes that suggest to them that violence is culturally based and hence, is an innate part of their cultural heritage. Some interviewees noted that physicians believe that women from these groups should deal with their problems within their own communities. Another noted that some nurses believe that these women only want attention and are not in real medical need.

Interviewees observed that physicians were reluctant to explore the issue in any depth because of their ignorance about particular cultures. Another interviewee pointed out that there were a lot of stereotypes about Aboriginal and immigrant people circulating among health professionals. As a result, Aboriginal and immigrant women are less likely to be believed. One interviewee mentioned that racist attitudes were more prevalent among older medical staff.

Another interviewee stated that racism textures the everyday reality and interactions of medical professionals with Aboriginal women and immigrant women of colour. She gave an example of a situation which involved an Aboriginal woman who was presenting. The woman was ignored by the nurse even though two other white women had come in after her but were served before her. The nurse, when confronted, was oblivious to the preferential treatment she had shown.

(ii) Aboriginal Women

Interviewees were very aware of the systemic discrimination faced by Aboriginal women. Many cited that health care providers were dismissive of Aboriginal women's experiences of violence because they perceived these experiences to be linked to alcohol and drug abuse. Thus, the Aboriginal woman is treated unsympathetically and treated as an 'undeserving victim.' Physicians assume that violence is a part of their lifestyle. One interviewee noted that she had observed that when Aboriginal women present, the attitude of the health care providers is one of "oh, here she comes again." Another added that Aboriginal women are given Tylenol 3 and immediately questioned whether they are on drugs. Comments such as "we're not seeing you," and "you probably don't have a health care card," are often used to dismiss women. Aboriginal women's experiences are erased. The intersections between historical violence and intimate forms of violence are neither explored nor integrated in the treatment of Aboriginal women.

Interviewees also noted that Aboriginal women have few places to turn to. In one community, an interviewee mentioned that relations between the Aboriginal community and the white community were strained. The lack of Aboriginal doctors exacerbates the situation of Aboriginal women. On the one hand, they are forced to leave their communities to access health care services, but on the other hand, they are met with racist attitudes and erasure from the non-Aboriginal communities. Trust levels between the Aboriginal communities and white service providers are extremely low. Aboriginal women are more likely to utilize walk-in clinics than have a single family physician. One interviewee noted that Aboriginal women report receiving the "look of recognition" from physicians. That look reinforces and communicates to them their demeaned status and worthlessness in the eyes of physicians. Attitudes of inferiorization combined with differential and discriminatory institutional practices ensure the perpetuation of institutionalized forms of racism.

Several factors exacerbate the situation of Aboriginal women. Aboriginal women are wary of written documentation. Not only are they under constant surveillance by the various systems, but within the health care system, documentation also works against them. Historically, documentation has been used to categorize and deny them their rights. Low levels of literacy combined with this historical experience contributes to their suspicions about documentation. In many cases, documentation has led to the apprehension of their children.¹⁸

(iii) Immigrant Women of Colour

In the case of immigrant women of colour, service providers noted that language barriers compound disclosure. Where language is not an issue, immigrant women of colour are more likely to disclose abuse to their physicians after a period of time has elapsed and they have developed comfort with the physician. However, disclosure also depends on the severity of the abuse, the geographic (rural/urban) area in which the woman resides, and on whether health care professionals ask about it directly. In rural areas, the lack of confidentiality and anonymity circumscribe disclosure. Many interviewees also mentioned the issue of public shame as

¹⁸ See for instance, Duffy & Momirov (1997), and Koshan (1997) for more background on Aboriginal women, violence and the law.

detering immigrant women of colour from disclosing. Another discussed the tight-knit nature of some of the communities of colour and indicated that women were not allowed to access services in situations involving violence for fear it would stigmatize the whole community. When women accessed services, they were harassed by members of their community. Women were made to feel ashamed and responsible for breaking up the marriage. Disclosure was also impeded by women's fear that their abusive spouses would obtain full custody of the children.

Several interviewees mentioned the particular vulnerabilities of 'mail order brides' who were involved in interracial marriages.¹⁹ They highlighted the isolation of these women and the power imbalance of the interracial marriage indicating that the white spouse would ensure that the woman's concerns were trivialized and her experiences of violence disbelieved. Many immigrant women could not drive and were doubly isolated in rural areas. Interviewees indicated that immigrant women of colour tended to be prescribed medications, usually antidepressants, for their symptoms of violence.

Language and cultural barriers were mentioned frequently by interviewees. These were identified as contributing to miscommunication and misdiagnosis. Some interviewees underlined the necessity for cultural interpreters to accompany and advocate on behalf of women. Another interviewee noted that too often the men in the community accompany their wives to the doctor and translate on their behalf. Often, children are put in the position of interpreting for their mothers. This creates a power imbalance within the family with children being the cultural brokers, mediating between the different and unequal cultural worlds.

Interviewees also noted the impact of immigration status and women's lack of knowledge regarding their rights. Women are afraid of jeopardizing their immigration status or having themselves or their husbands deported should they disclose the abuse. One hospital-based social worker indicated that the hospital required a demand for disclosure of abuse by sponsors. Documentation was perceived negatively by immigrant women of colour as they often saw it in conjunction with issues concerning their legal status. As is the case with other women, the purpose or implications of documentation are not explained to immigrant women.

(iv) Culture, Race & Gender of Physician

Interviewees were asked whether having a physician from the same cultural or racial background would make any difference in ameliorating the situation of immigrant women of colour who had experienced violence. Interviewees pointed out that while having a physician from the same cultural background would enhance communication and eliminate language barriers, the likelihood of the physician being supportive and facilitating disclosure depended on her/his beliefs about violence, and the kind of relationship that s/he had established with the woman. One worker stated that the women in the community she dealt with would not feel comfortable disclosing to a male physician from the same community for fear that he would make the knowledge public. It was pointed out that women who had disclosed to male physicians from their own community had been told that "this is a family matter." Another interviewee

¹⁹ For more information on "mail order brides," see Chin (1994), Narayan (1995), and the report of the Philippine Women Centre & the Global Alliance Against Traffic in Women Canada (1999).

mentioned that the women in the ethno-racial group that she was familiar with, visited a female physician from their community. Female physicians from the same community were reported to be more supportive of women who had experienced violence.

(e) Communication of Information

Interviewees were asked how best to communicate health-related information about violence to immigrant women. Their recommendations included the following:

- Communicate information through multicultural societies and their offshoot grassroots organizations.
- Ensure that information is available in multilingual formats.
- Include a pamphlet inside every tax form.
- Provide welcome packages to new immigrants and refugees at the airport. These packages should be available in a multilingual format and should identify all the relevant services that are available.
- Set up a 1-800 number which can provide assistance in multiple languages.
- Communicate information through ethnic media and community newspapers.
- Focus on daytime cultural programming at which time the abuser is less likely to be home.
- Communicate information to children at school so they can take it home.
- Introduce violence information in ESL classes, places of worship, settlement agencies, ethnic grocery stores, community centres, neighbourhood houses and local libraries.
- Disseminate information at immunization clinics, daycare centres or any public health centres.
- Distribute information through public services and events that are family oriented.
- Train health care providers to be aware of racism and to work toward the elimination of everyday racism and institutional racism.
- Train and empower individuals within different communities to take information to their communities.
- Deliver violence-related information in settings that are neutral and safe for women.
- Create centres or spaces where women can come together, network and support each other.
- Increase the number of interpreters and accessibility to interpreters so women do not have to rely on family members.
- Communicate information in ways that women can remember, i.e. an easy telephone number so that they don't have to take pamphlets home.
- Distribute information and posters in women-only spaces, such as bathrooms and women's centres.
- Offer free community activities where the entire family is invited and where the focus or theme is not controversial.

In addition to the above, interviewees were asked to make recommendations regarding the health care system and its services for immigrant women of colour. These recommendations are integrated with those emerging from the focus group and interview data and presented at the end of this report.

CONSULTATIONS WITH KEY INFORMANTS

Many of the issues raised by key informants echoed those identified by interviewees in the environmental scan. However, in addition to these, key informants also discussed the following issues as impacting on immigrant women of colour who have experienced violence, and their encounters with the health care system.

THEMES

(a) Police-Hospital Reporting

One of the key issues identified by key informants working in the hospital setting dealt with the requirements of reporting the incident of violence to the police. Key informants indicated that this compromised women's confidentiality, and further endangered them to retaliation by their abusive spouses. The informants also indicated that documentation and reporting to police invoked fear among immigrant women of colour who were concerned about how this might jeopardize their immigration status and sponsorship agreement.

(b) Lack of Information

Several key informants who work in the area of multicultural health and immigrant settlement services indicated that while multilingual information (brochures, fact sheets, etc.) are available in abundance, they are not reaching immigrant women of colour. As one informant stated, these women "are not plugged in" and unaware of the preventive health care system. They further noted that existing outreach and distribution measures do not result in the provision of information about health care, the effects of violence, or even rudimentary information on how to find a physician. Such material exists but again, its strategic dissemination is absent. Proactive strategies by which to disseminate information are lacking. This is especially relevant when considering that most immigrant women are dependents of their spouses, and hence, in an abusive situation, their contact and exposure is limited. Language barriers enhance the isolation, thus making it difficult for women to know where to turn to for help.

(c) Poverty & Financial Issues

Several key informants stated that immigrant women of colour, like other women fleeing violent relationships, have no money to buy prescriptions, obtain transportation or pay for medicare. This is particularly true for women who have left abusive relationships. While BC Benefits Hardship Assistance provides some money, this is deducted from subsequent cheques, and further, BC Benefits recuperates the cost from the abusive partner. This contributes to the already fearful situation of women. Uncertainty about their immigration status combined with the constant threat of deportation contributes to immigrant women being economically unable to

cover the costs associated with treatment, or even obtain medical assistance. As one key informant underlined, the costs of medicare insurance are covered by the sponsor.

(d) Physician's Authority

Key informants noted that immigrant women of colour tend to regard physicians as authority figures. They reported that women's complaints are not treated seriously by physicians. Complaints are minimized. Mental health issues are not dealt with or are undiagnosed, and physicians do not make the effort to link the mental health effects of violence to women's somatic complaints. Moreover, physicians fail to make the necessary referrals and do not seem to be aware of community-based services that could help the women. Women reported having difficulty in convincing their physicians of the illnesses they were experiencing. They also reported that physicians do not spend enough time going over their complaints and explaining treatment. Thus, illnesses such as low-grade depression and anxiety disorders are not given enough time. Further, key informants observed that spouses often act as interpreters for women, thereby compromising confidentiality and potentially misinterpreting requests or information provided by the physician. Women are also unaware of the health care bureaucracy and how it works. The lack of a medical interpreter was identified as a major issue by one of the key informants. Another noted that women's homeopathic and cultural remedies are not considered legitimate by physicians.

(e) Lack of Multi-Racial Representation

Key informants reported a lack of trained staff to deal with the needs of immigrant women of colour in the health care system. One informant pointed out that equity in employment practices is still lagging and hence, there is a chronic lack of adequate representation of immigrant women of colour at various levels of the health care system. Several key informants noted the prevalence of stereotypes about different cultural groups within the system. This was especially true of hospitals.

(f) Broadening the Definition of Violence

Several of the key informants working with immigrant women who have experienced violence indicated the need for broadening the definition of violence to include systemic racism and discrimination. Informants also outlined the need for sensitive health care, education about women's rights in relation to immigration and welfare benefits, and the need for advocacy within the system for immigrant women of colour who have experienced violence.

FOCUS GROUP WITH SERVICE PROVIDERS

A focus group conducted with eleven bicultural and bilingual service providers through the auspices of a local, specialized agency providing services and support to immigrant women from diverse cultural backgrounds yielded the following information. Many of these responses echo those obtained from the environmental scan and consultations with key informants. Direct quotes from the focus group participants are italicized.

THEMES

(a) Help-Seeking Patterns

Service providers were asked to identify the help-seeking patterns of immigrant women of colour who have experienced violence. Most indicated that women seek assistance from other family members, friends, their faith community leaders, community outreach workers, and ESL teachers. Service providers indicated that women rarely approach doctors for assistance. In extreme situations of abuse where the injuries are severe, women will seek medical assistance but will minimize the injuries and attribute them to 'accidents.'

(b) Barriers

Barriers identified by these service providers included the following:

(i) Lack of Knowledge Regarding the Health Effects of Violence

Service providers added that women do not seek to disclose to physicians because they do not necessarily understand their symptoms as arising from the violent context in which they live. One service provider drew the parallel between financial abuse and the partner's control of finances. The woman did not necessarily realize that his control was tantamount to a form of abuse. She had normalized the behaviour.

On the other hand, service providers noted that physicians themselves are unaware of the links between mental health and physical abuse, and do not spend the time to decipher women's concerns in the context of the violence they are experiencing. Thus, it is apparent that the lack of knowledge about the health effects of violence among both immigrant women and the physicians they turn to, reinforce each other, resulting in a no-win situation for immigrant women who are experiencing these health effects and trying to deal with them.

(ii) Legal Status

Issues concerning immigration status were a common thread in the focus group discussion. Service providers indicated that for women who were sponsored dependents, and even women who sponsored their husbands, disclosing violence was problematic because of the legal consequences. Service providers also mentioned the case of undocumented women who could not obtain medical assistance except from free clinics. In terms of sponsorship regulations, one service provider recounted the case of a woman who had sponsored her husband:

But the problem is that the sponsorship obligation is for 10 years. She's tied to the man because he would threaten her and say, 'Well, I'm going to go and get social assistance so you'll be in trouble. You're going to have to pay for my apartment, my food, my clothing.'

Hence, even though the legislation has been changed in order to deal with issues of domestic violence, the reality is that for this woman, BC Benefits will pursue her for restitution of the costs incurred from providing social assistance to her spouse.

Fear of deportation is a constant reality for many immigrant and refugee women. Women are unaware of their rights. As these two examples illustrate, health care professionals are not always sensitive to the issue of legal status or women's rights.

It is very important in a situation where a woman ends up in a hospital for the hospital staff or the personnel to assure the immigrant women, because a lot of time the women are feeling very scared that 'If I do talk about the abuse then maybe eventually I might be deported back to my country.' Because I find that even though the transition staff are so sensitive to this issue, when it comes to sponsorship issues, even they don't talk about it.

Women are unaware of the differences between landed immigrants, permanent status, and convention refugees. They do not know what rights and privileges are associated with each status and live in constant fear that they might reveal something that will lead to their deportation.

Access to medical services is also mediated by legal status. Women who are undocumented 'aliens' or visitors do not have the same access. One service provider noted that:

I had a client who was a visitor and she has two children. Of course she did not qualify for any medical services. She was just getting some herbal remedies for colds or she was praying that the kids would not get sick. But finally, they had some issues that required a dentist. So we found out there was a guy who wanted to donate his services. But other than that, there's nothing.

Women who are undocumented or do not have legal status have to seek out health care services through free clinics. However, knowledge about where these clinics are located is often inaccessible except through a community worker or advocate.

(iii) Fear of Documentation

Fear of deportation and uncertainty about their rights also contribute to the reluctance to disclose abuse. Additionally, women are fearful that information about their abuse will be made public or become common knowledge in the community. However, the lack of documentation also works against women who want to press charges or seek custody of their children. As one service provider noted:

I find that when it comes to a point where the woman is planning to leave and when I say, 'Okay, can we get some medical records because that can help your case,' then usually the women turn around and say to me, 'But I never told my doctor.' Or, on the contrary, at times I have heard from the women that, 'I told my doctor ... I don't want this to go into the record.'

(iv) Cultural Racism

Service providers indicate that stereotypical notions about different ethno-racial and cultural groups are prevalent in the health care system, particularly in hospitals. These influence the ways in which women are perceived and subsequently treated. As this service provider indicated:

You are judged in the sense that the minute a South Asian woman walks into the emergency department, she's already judged. Okay, maybe this is what it is, maybe she has an arranged marriage, she's not going to talk about the abuse. Maybe even if she talks about it, she's not going to seek any services. Even if she goes to the transition house, she's going to go back. If the police are called in, the police will take the statement halfheartedly, thinking, 'anyway, she's not going to go through the whole process so what's the use of doing all this work?'

Another service provider mentioned:

... the principal problem is stereotyping. Like categorizing people. Let's say southern Europeans are emotional people therefore you tend to downplay what the woman or the patient is saying because you assume that because they are emotional, their verbal expressions, their body language is so much more expressive than North Americans. So the doctor tends to say, 'well okay, perhaps I should cut it in half.' Well the general perception that we have as immigrants is that North Americans think that their culture and their mode of culture is superior to any other, therefore they have to educate us and make us meet their standards. I think it's very serious if you look at the whole context and the implications that brings up. And for immigrants, it's a very serious situation because we are never looked at as equals, we are never looked at as being people who can actively contribute to this country. And when it comes to the health care system, we actually run into a set of problems.

These implications were pointed out by a particular service provider in relation to the issue of female genital mutilation (FGM). She mentioned that women who have had FGM are treated differently and negatively by the health care providers.

Another service provider indicated that health care professionals perceived certain cultural groups as having cultures of violence. As she put it: *the attitude that the mainstream society has about women of colour – they seem to think domestic violence is part of our culture somehow.*

(v) The 'Preferred Patient'

One of the implications of the differential treatment stemming from cultural racism is the construction of the 'preferred patient'. The literature has demonstrated that preferred patients or 'deserving patients' (Varcoe, 1997) are those who are white, middle class, and who are not presenting for substance abuse. In the situation of immigrant women, the preferred or deserving patient is the woman who will leave the abusive relationship. The difference here is that within the ranking of deservedness, a woman of colour may qualify for deserving treatment, if she exhibits active agency and decides to leave the relationship with the help of the staff. In other

words, making the staff feel that they are contributing to something 'valuable' as in rescuing the woman elevates her status to that of a preferred patient.²⁰ This standard seems to be applied to immigrant women even though their dependencies on their partners are complicated and underscored by legislation, as well as financial, economic and social dependency. Nevertheless, as one service provider indicated:

I find that if a social worker or the doctor gets the feeling that the woman is ambivalent, that the woman is not sure about separation, they don't even want to talk about it. Only the woman who will say that 'I want to separate' is the woman they'll refer, not acknowledging that even if the woman is not separating at this time, how important it is for her to connect with a support service for her future.

The language of benevolence underpinning the social construction of the deserving or preferred patient is an inherent aspect of the Canadian discourse of racism.

(vi) Financial Issues

Costs incurred from accessing health care services were also cited as deterrents by some of the service providers. This was particularly mentioned in the case of obtaining ambulance services. As this service provider stated:

I hear that from so many of my clients where they end up with the ambulance bill and at times, these women have to go on income assistance and they don't even have a dollar to spare and here they have to pay \$44 for the ambulance bills. And then you speak to the financial aid worker if they will cover the cost, that's again a struggle. Some workers will take care of it, some workers will say 'sorry, it's from the past. We don't want to cover it.'

This observation corroborates the perspective of the key informants who also mentioned financial costs in terms of prescriptions, health care insurance, and transportation as deterrents.

(vii) Language Barriers – Lack of Female Cultural Interpreters

Language barriers were cited as some of the key factors impeding women from seeking health services for effects resulting from violence. Cultural interpreters are not readily available, and women are unaware of these services. As a result, many women seek health care from physicians in their communities who share the same cultural frame of reference and are fluent in the language.

The power and control dynamics of the abusive relationship are amplified in the immigrant woman's situation where she is completely dependent on her abusive spouse to select a physician for her, drive her to the doctor, interpret for her, and get her the prescribed medication. Women's

²⁰ Elsewhere, I have made the argument that the only time women of colour are deemed to be acceptable by dominant, normative standards is when they show signs of assimilation or when the dominant society can perceive itself to be in a benevolent situation, as in rescuing Third World women from their oppressive conditions (Jiwani, 1992).

ability to seek assistance independently – their autonomy – is compromised by language barriers as well as lack of knowledge about the conceptual frameworks and norms of the dominant society. In the case of medical services, having an abusive partner interpret for the woman can result in a violation of her rights. One service provider gave the following example:

[One client] was living with him and he didn't get her a medical card so she was going through all these problems and then because of his negligence, she was diagnosed with a [reproductive] problem ... and then he was translating for her as well. ... He had children in his country [of origin] and he told the doctor that this woman doesn't need children, and because her [organs] were already damaged, they took out her ovaries. Now she cries everyday, and he was her interpreter and it was his doctor that he took her to.

This service provider added that there are not enough women interpreters available and that women who have been abused or who have reproductive health issues are reluctant to communicate these concerns through male interpreters. Another service provider added that men often accompany their wives to the physicians' offices and consequently, the women cannot confide in their physicians. It was suggested that physicians be discouraged from having the spouses present when they are conducting their examinations with women, and that instead nurses or other health care workers be present.

(viii) Conceptual Frameworks of Meaning

While language is one obvious barrier, another more subtle and pervasive barrier emerges in the differences in conceptual frameworks of meaning that are employed by health care providers and the immigrant women whom they treat. As service providers in this focus group noted, the meanings of certain words carry different connotations to the immigrant women they serve. Thus, terms such as confidentiality and counselling have different meanings and physicians do not provide adequate explanations. As one service provider mentioned, when women are asked to go to a support group or a counselling session:

They get so discouraged by that. 'The only help they could offer me is support groups and counselling.' I think some time needs to be spent going through and explaining what is the role of a support group. It doesn't mean that you just sit with a bunch of women and whine about your husband. But that's the common perspective a woman has about a support group. And counselling. Sometimes counselling brings a very negative connotation. That needs to be explained to them.

Service providers also indicated the need for physicians to be accountable to the code of confidentiality and to explain the meaning of confidentiality to the women they see.

(ix) Pathologizing Abuse

Several service providers mentioned that the medical professionals' response to immigrant women who are abused is to prescribe them antidepressants. Another strategy, particularly if they are unable to understand the woman because of a language barrier, is to admit her into a

psychiatric facility. One service provider mentioned that she is often at a psychiatric unit where she is asked to interpret for the patients. She observed that many of the patients there, both male and female, were there not because of any mental issues but because nobody could understand them. It was assumed that there was something wrong with them. The service provider mentioned that the mental institution's reluctance to obtain the services of an interpreter was based on economic costs. She indicated that having patients remain within an institution results in additional funds for the institution.

(x) Dismissive Responses – Minimizing the Violence

Service providers noted that most physicians tend to be dismissive of immigrant women's health care concerns. The brevity of time and the rapid processing of patients were cited as factors influencing the lack of sensitivity. In addition, women's concerns were dismissed because they were women and hence the implicit stereotype of women as 'complainers' underpinned the physicians' attitudes. As this service provider recounted:

... sometimes doctors tend to either dismiss it or to say, 'Oh, keep busy. This will pass.' And they don't really see that the woman is trying to say something. She doesn't want to disclose the whole situation but is trying to give some clues. In the community, they just go to the family doctor. They try to find family doctors who are from the community and they try to sort of unload their situation with the family doctor who doesn't have the time to listen to the whole story, of course.

Another service provider recounted a situation involving a woman who was injured, but whose husband told the police that she had mental health problems. As she stated:

And I asked her, 'did you ever end up calling the police?' She said, 'yeah, I did call the police but my husband told the police that I have a mental health problem. So the police didn't pay attention. But, the police did take me to the hospital because I was badly bruised and I was hurt.' And she says at the hospital again, 'the doctor did not spend time with me to ask me what was the issue, like how did I get hurt?'

This service provider could not understand how two systems – the police and the health care system – ignored this woman's plight and basically appeared to believe the abusive husband despite the abuse being manifested in the form of visible injuries.

The dismissal of women's concerns was also mentioned in the context of physicians' reluctance to spend time with them and efforts to process them as quickly as possible.

(xi) Passing the Buck – Shifting the Responsibility

As indicated in the literature review, physicians and other health care providers who come into contact with immigrant women also shift the responsibility once their work of addressing the physical injuries is completed. Statements such as 'we're going to close the file' are used a lot. One service provider stated:

They don't want to walk the extra step, even though they do acknowledge that immigrant women have very different needs than the women who are born and brought up in Canada. They do say it, but when it comes to actually putting that in practice, it's not being practiced.

Another added:

I think it's the attitude of passing the buck onto other professionals instead of that collaborative effort where they call you and we work together. It's okay, 'We're done with her. Now it's your problem.' And if something goes wrong, we've done our part.

The immigrant woman has already been constructed in this discourse as a “problem patient” rather than a “patient with a problem” (Kurz & Stark, 1988:263). Add to this the fact that when community workers are contacted, it is often at the last minute when the woman is about to be discharged. For workers who have heavy case loads, it means dropping everything in order to ensure that the woman has some kind of support before she is returned home.

(xii) Lack of Awareness of Other Services

Service providers noted that in those instances where physicians were responsive to women's experience of abuse, they would recommend that women seek out services. However, the situation for immigrant women is compounded by the lack of awareness about services, a lack that is echoed by physicians themselves. One service provider stated:

[Physicians] wouldn't mention the resources and we know, working with immigrant women, how difficult it is for them to take the first step on their own. Like if only the physician would put in an effort to call an agency like ours or another agency and say that, 'there is this woman. Can you please connect with this woman?' or 'Can you come and meet with this woman in my office?' I think that we could get a lot of women to come out, but that doesn't happen. Even in hospitals, I find that there are hospitals where there are social workers who are aware of resources – I get a lot of referrals – but the hospitals where the social workers are not aware of our services, I don't hear from them completely. It's not that women are not going to these hospitals, it's just that they are not aware of the resources. So to educate not only the physician but also the other staff or the other people that work along in the same field about the resources is necessary.

Another service provider mentioned that when referrals are made, they are communicated inappropriately. She referred to a case where the physician's office had called her and given her the telephone number of the woman to be contacted. When she called the woman, the woman was agitated and angry because her abusive spouse was in the home at the time. The woman did not feel free to talk, and was scared that her spouse would find out and retaliate against her. In this case, as in others that were mentioned, physicians do not seem to be aware that their actions can endanger a woman's life.

(xiii) Family Physicians Who Share the Same Cultural Background

Language was identified as a significant barrier impeding women from seeking assistance from health care personnel. When asked if women sought assistance from physicians who shared the same cultural/linguistic background, service providers affirmed that they did. However, they immediately raised concerns about the potential breaches of confidentiality and privacy as deterrents. These concerns were qualified when comments were made about female physicians from the same cultural background. In contrast to male physicians, female physicians were spoken of very favourably, and the same fears of breaching confidentiality were not raised in their case.

The issue of confidentiality has to be understood in the context of the family physician who serves not only the immigrant woman's immediate family but also her extended family. In many cases, physicians who come from the same cultural community are well known, and they share the same high social status as their white counterparts. So one family physician may have as his clients the immigrant woman, her spouse, children, parents-in-law, sisters and brothers-in-law, their children, and so forth. This pattern is very much based on the networking and sharing of information and resources that occur in the immediate context after migration. In such a context, the issue of confidentiality not only emerges with respect to the physician but also his/her staff who may be members of the same cultural community. The issue of changing physicians is hampered by considerations such as the fact that often the male head of the family has the care card in his possession, and within the context of the power and control dynamics of an abusive relationship, will monitor who his spouse sees and in the case of a physician, not only drive her there but insist on being in the examination room.²¹

(xiv) Fear of Breach of Confidentiality

In speaking to the issue of male physicians from the same community, one service provider noted:

... quite often clients say that I would not tell anything to my physician who speaks the same language, who is from the same community. It carries some kind of feeling of embarrassment.

Another added:

[Women] always say to me that, 'I used to go to my doctor but I never opened up to my doctor because I thought he would tell everything to my husband or to my mother-in-law or to anyone in the in-law family.'

²¹ It is the sponsor's responsibility to pay for the medical care of his dependents.

(xv) Reluctance of Physicians to Get Involved

Not wanting to get involved and fear of jeopardizing their own reputations within the community were cited as factors to explain the lack of response from physicians who shared the same cultural background. As one service provider stated:

... the doctors who speak the same language seem to be less sympathetic and less understanding as compared to English-speaking doctors. I always find it such a struggle to get any information from [name of linguistic group]-speaking doctors because they don't want to be part of it, because they want to keep their image with the extended family, or with the husband rather than with the woman.

The economic consequences of getting involved in issues concerning violence was raised by one service provider who noted that providing medical care is a business. As she put it:

... we have to take into consideration that the medical field is not just to help people, it's a business. And so for a lot of [mentions nationality] doctors, we sort of compare what they have to lose if they start getting involved in domestic violence issues. First of all, they lose business from the community which is their main bread and butter. Some people will say, 'Oh, here he is, breaking families apart.' Number two, there are people in the community who will say, 'It's a family matter. Why is he calling other workers, talking about this woman and this issue of domestic violence.' And we have to take that into consideration. It's a business and so he doesn't want to lose business and therefore, if you start touching issues like family violence, it ruins your rapport with the community and therefore you lose business.

Not only are women forced to seek health care services from physicians from their own communities because of language barriers, but when they do so, their needs are compromised by the physician's concern about maintaining his reputation in the community. Another service provider added that physicians in her community simply did not want to recognize the reality of violence. They could not accept that violence against women was prevalent in their community.

Female physicians from the same cultural communities as the immigrant women themselves were perceived to be more sympathetic, less judgmental, and more aware of services in the community. As one service provider noted:

I find that in the [name of community] some of the female doctors, they're very pro-active and they're doing such an excellent job. And when the women go to them, they talk about the abuse, they give out the agency's name and phone numbers and they encourage the women. [One doctor] calls me personally and says to me that 'this woman needs your help. Can you get in touch with her,' or she'll facilitate the meeting, our first meeting. And I think if more doctors can do that, it will really help the women.

However, while these female physicians are more helpful, they are also vulnerable to harassment from within the community. Patriarchal forces that are strengthened by retreatism into

communities as a result of the racist milieu, assert and express themselves in ways that are detrimental to female physicians. Thus, the same reasons for which some male physicians maintain a safe distance from taking a position against violence in their practices, make female physicians more vulnerable. This situation very much echoes the kinds of dynamics that occur in small towns and enclaves with respect to physicians who take an active stance on domestic violence and abortion rights. In these situations, physicians are targeted for taking a stand and supporting women's choices.

(xvi) Protocols in Hospitals

Service providers were overwhelmingly in support of protocols for screening domestic violence. They mentioned that when doing accompaniments with immigrant women who had been abused, hospitals with protocols in place provided better service and health professionals were more empathetic with women. However, they also noted that sending women home with pamphlets was not appropriate given that their spouses would see the information. One service provider reported that:

I have heard from some of my clients that they do do follow-up calls like a month later. Like some women, they haven't made up their minds as to whether they want to leave or not. And so they go home and then about a month or two later, she does call some of them under the guise that she's trying to see about ... because this woman came to the hospital about a feminine matter so the husband doesn't know. But then the client would know who she is and she just checks to see if the woman is okay.

(xvii) Public Health Nurses

As with the findings of the environmental scan, the service providers in this focus group were very supportive of the role of the public or community health nurse. They noted that the nurses were critical in ensuring that mothers were not isolated after the birth of their child. They suggested that that public health nurse could be mandated to conduct periodic visits to immigrant households, particularly those of recent immigrants. This would help break down the sense of isolation that immigrant women experience and also enable those who are being abused to make links with women outside the home and through them, links with other services.

(c) Suggestions

The service providers made several concrete suggestions, some of which are integrated in the recommendations presented at the end of the report. However, they emphasized the need for a coordinated approach to health care for immigrant women who have experienced violence. Further, they noted the need to conduct outreach activities that provide information and facilitate networks with the different racial and cultural communities in the area. They especially emphasized the need for physicians to become educated about the signs of violence, and to become aware of services that are extant in the communities they serve. They underlined the necessity of physicians to take the time to communicate with the immigrant women who consult them, ask them directly about the violence, explain the various options available in terms of

treatment, and refer them to the appropriate services. They urged that physicians not ask husbands to interpret for the women, or to have the husbands present at the time of the examination.

FOCUS GROUP AND INTERVIEWS WITH IMMIGRANT WOMEN OF COLOUR SURVIVORS

A focus group with immigrant women of colour who had experienced violence was organized through the auspices of a local immigrant settlement services organization. The women who participated in the focus group came from a variety of backgrounds which included Mexico, Latin America, India, China, and the Philippines. All of these women had been students in the ESL program and had a basic level of fluency in English. However, attendance at the focus group was problematic for some of the reasons identified in the literature that are inherent to the situation of immigrant women. Transportation was a problem for some women. Other women had to return to their places of work so the focus group had to be terminated after a duration of two hours. Although women had a basic understanding of English, the need for interpretation was apparent. Questions that were asked in the focus group had to be communicated in simple English and were vetted by an immigrant settlement worker prior to the focus group (see Appendix III for a sample of the questions). As well, some of the women were visibly fearful of the ways in which the information might be used, and while we attempted to assuage their fears, it undoubtedly influenced their response. All of them had experienced violence.

In order to supplement the information obtained from the focus group, ten individual interviews with immigrant women of colour were conducted by a research assistant.²² The majority of these interviews were with South Asian women, and two with East Asian women. The interviews were informal and lasted for approximately one hour. A snowballing method was used to locate women who were interested in being interviewed.

The following sections present an integrated thematic analysis of the data obtained from the focus group and individual interviews. Many of the themes identified below echo those articulated in the previous sections of this report and resonate with the findings of the literature review.

Length of Time in Canada

Within the focus group, participants had lived in Canada for a period ranging from 3.5 to 13 years. Most of the women were older – in their 30s and 40s. Women who were individually interviewed exhibited an age range that spanned from the early 20s to the late 50s. Four of the women were in their 20s and had lived most of their lives in Canada. The average length of residence in Canada was 14.9 years, and the range spanned from 5 to 24 years.

²² These interviews were conducted by Suki Grewal.

THEMES

(a) Barriers

(i) Finding a Physician

When asked how the women (both focus group participants and interviewees) selected their physicians, the majority indicated that either their husbands or families had chosen the physician. Only one woman reported that she had found a physician by consulting a list that was available from the immigration office. Her selection was based on the name of the physician that reflected the same nationality/culture. In a majority of the cases, the physician treated the entire family and in some cases, the extended family. Other participants emphasized their lack of knowledge about the health care system. They noted that upon arrival, immigrants are faced with taking care of the basics of life and thus choosing a doctor is a matter of expediency rather than careful scrutiny.

(ii) Disclosure Issues – Shame and Confidentiality

Although most of the physicians were chosen by family members and/or husbands, the majority of the participants in the focus group and interviews did not emphasize the nationality or cultural background of their physician as contributing to their ability to disclose. Rather, this was seen as immaterial and much depended on the kind of trust they had established. Most women had not disclosed to their family physicians or the staff they encountered at emergency departments. However, the issue of public shame and humiliation within the community was noted by several of the interviewees as impeding disclosure. As this interviewee stated:

For me, I was so afraid and embarrassed I didn't go to anyone I knew. How could I? I was this strong ambitious woman. How did I let this happen to me? I knew my family would tell me to try and work it out, that is what my sister and cousins had done. So I did not tell anyone until I was strong enough to leave my husband...

(iii) Legal Status

Legal status was mentioned by both focus group participants and interviewees. Focus group participants indicated that legal status determined how much information was provided to immigrants and refugees. Convention refugees were given more information in contrast to landed immigrants who had to depend on their sponsors or relatives for assistance in negotiating the various normative and bureaucratic structures of Canadian society.

As in the focus group with service providers, interviewees also mentioned the lack of information they have about their rights and how this impedes their leaving abusive relationships. One woman noted that:

I didn't even realize I was in an abusive relationship until it was really bad. I didn't see any alternatives for myself. I guess if I knew I could get financial help or my immigration would not be taken away maybe I would have left before it

became really bad. Now it is too late for me. Maybe if women knew it can happen to anyone.

(iv) Economic Constraints

Economic constraints also impeded women from leaving abusive relationships. The fear of not being able to have custody of the children because they were unemployed as well as the lack of knowledge about systems that might offer assistance were cited as two of the most common barriers. Added to this, women could not afford to seek medical attention as it often resulted in them taking unpaid time off work. As this woman stated:

Yes, it might have helped [to have a doctor or nurse who spoke the same language]. But the money was more important, and who would have watched the children if I had to work? A Punjabi-speaking doctor could not change that for me.

Economic constraints also influence access to transportation, and ability to pay for medication.

(v) Naming the Abuse – Vague Symptoms

For many of the women who were interviewed, the abuse began as emotional harassment and then escalated to physical violence. However, women stated they did not recognize the early warnings as signs of abuse. The health effects of violence that they experienced stemmed from the emotional abuse but in seeking health care for these symptoms, the physicians they encountered also did not recognize them as signs of abuse. Thus, the inability of the women to identify these symptoms as signs of emotional abuse was reinforced by the physician's ignorance of the health effects of violence. As one woman stated:

I had a very pessimistic view of life and often contemplated suicide. Because of the stress, I turned to smoking as a conditioning solution although I knew it was ineffective. Under stress, I often suffered from fatigue. I over ate but sometime ate to a point where I had to puke. I was also prone to colds and headaches, tension in my back and neck muscles. My immune system was weakened from the emotional tension and stress, and over the last two years I have developed allergies on my face, usually involving dry red patches or rashes.

Another woman stated:

I did not have any physical injuries as far as bruises and broken bones. This is always how I defined abuse until it happened to me. I didn't even realize what was happening. I am an educated woman with a career but that didn't matter.

The manifestation of emotional abuse in 'vague' symptoms and somatic complaints was also echoed by focus group participants. As one participant expressed it:

I think it would be easier that way for them to realize what is going on with that person because sometimes, like for me, I was having so many things, I really

thought I was going to die. I didn't know what was going on with me. So I think for the doctor, it would be easier to detect what was happening to me if she knew my situation.

(b) Encounters with the Health Care System

Women's encounters with the health care system varied as a function of the level of care they accessed and the conditions under which they sought care. Thus, some women obtained assistance from staff at walk-in clinics, while others sought care from their family physicians. Where injuries were severe as a result of physical violence, women turned to emergency departments. Again, the response varied. Nurses and specialists were cited as being more helpful and supportive. Public health nurses were frequently cited as being the most supportive in helping women to break the isolation. In contrast, family physicians were often identified as not providing the necessary level of care and as 'watching the clock.'

(i) Watching the Clock

For many immigrant women of colour, language barriers already impede the flow and pace of communication between physician and patient. Add to this the complexities involved in disclosing violence, and women often leave feeling frustrated that their concerns haven't been heard nor has there been an attempt to explain the possible causes of their symptoms. As this focus group participant reported:

When I go to the doctor, I don't expect the doctor to give me an hour because I know it cannot be. But at least to listen. Not my whole life story but to at least have enough time for me to say, 'Okay, this is what I'm feeling,' and maybe for them to ask, 'Do you think this could be related to something else, with a problem that you might have?' Or something like that. But lately, when I go to the doctor, she just asks, 'What are you feeling?' and then she starts writing and that's it. So I don't have time to express myself, that this is my difficulty or my consequence of whatever it was that I'm feeling. I think it would help just to have a little more time.

The reliance on doctors who share the same cultural background (because of language barriers) often makes it impossible for immigrant women to change physicians or find ones that will actually listen to them. One woman in the focus group reported that she now makes up a list of all her concerns so that she has this in hand when she goes to her appointment.

(ii) Not Asking about Violence

Inadequate time and lack of listening often results in physicians not asking about violence. When physicians do not ask about violence, women do not reveal the abuse they are experiencing. As these women reported:

I went to see my doctor because I started getting nosebleeds and fainting spells. He never asked what was wrong. He did some tests but never really said you are

anorexic. I didn't find out until I got pregnant. That's when he said, 'well you should eat more.'

Another mentioned that:

... language is very important. But it only matters if the doctor or nurse is going to listen to their patient. If they are too busy to listen or do something, it doesn't matter what language you speak. I see that all the time in my job.

From the interview and focus group data, it was apparent that in those hospitals which had screening protocols in place, women were more apt to be asked about violence. However, much depended on how the asking was done. In some cases, individual interviewees reported highly negative experiences with emergency departments where questions about violence were asked in a perfunctory manner, or in some cases asked when the abuser was in the immediate vicinity thereby impeding women from disclosing the violence. One interviewee recounted a particularly traumatic case of physical violence which resulted in her presenting at the emergency room. She stated that while she received medical care, she was never once asked about the violence nor provided with any compassion or support. Another mentioned presenting at an emergency department on a regular basis and again, not being asked about the violence. As she put it:

I went to the emergency room. But never for the real reason. Once my husband got angry with me because his cousins were visiting and I was in our room studying. He pushed me and I fell back and banged my head against the wall and fainted. He carried me downstairs and told everyone I had fainted and then banged my head. We repeated the same story at the hospital. So I was treated like any other patient. I was going to the hospital on a regular basis but no one ever asked any detailed questions about why I kept fainting or banging into things. My only complaint is that no one stopped to say, 'why have you been here almost every month for a year and a half? That can't be normal?' But I try and not to be angry anymore. What is the use?

(iii) Children as Interpreters

Women in the focus group noted how children are used as interpreters. They were very opposed to this and argued for health care providers to obtain the services of professional cultural interpreters. As this woman stated:

... to take a child and to put him in a position like that, it's like putting my child in my situation and instead of helping my kids, I am also hurting them.

(iv) Conceptual Frameworks of Meaning

As with the service provider focus group, women indicated that terms that are taken for granted have different meanings for them. Hence, referring women for counselling indicates to them that they are mentally unstable. The discordance in conceptual frameworks of meaning also arises in women's preference for and use of alternative therapies, and in particular, indigenous practices. These are often viewed by allopathic practitioners as harmful or irrelevant.

(c) Suggestions

Women in the focus group and individual interviews articulated the following suggestions for improving the distribution of information about violence to immigrant women of colour, as well as recommendations regarding the training and conduct of physicians:

- Distribute information about violence through colleges and universities, community centres, fitness facilities, schools, ethnic and mainstream media, grocery stores that serve different communities, places of worship, and beauty parlors.
- Create and distribute posters and brochures which state, “Talk to your doctor if you have been abused or are experiencing domestic violence.”
- Train and educate doctors to be aware of the health effects of violence, detect violence and to make the links between physical and emotional forms of violence.
- Create cultural programming that reflects an anti-violence message but also provides information about the health impacts of violence.
- Create advertising with the same message and ensure that it is relayed in magazines, cultural programs, popular sitcoms and the news media.
- Encourage doctors and nurses to talk to patients and to actively listen to their concerns. Doctors need to ask more questions and to be aware of services in the community that women can connect with.
- The health care system needs to be organized differently so that there is one place to turn to for women and children who are abused.
- Health care providers need to know the linkages between emotional and physical abuse. They need to be aware of the mental health issues that are involved.
- Health care services need to be provided in multiple languages. However, aside from transliterations, services have to recognize the conceptual differences that may exist and to take measures to ensure that patients are aware of the meanings of various terms as used in referrals, prescriptions and treatments.
- Implement effective outreach strategies which involve the use of public health nurses and community health workers from within different groups.
- Provide additional funding to health care so that the ‘hidden’ effects of violence can be better detected and treated more immediately.

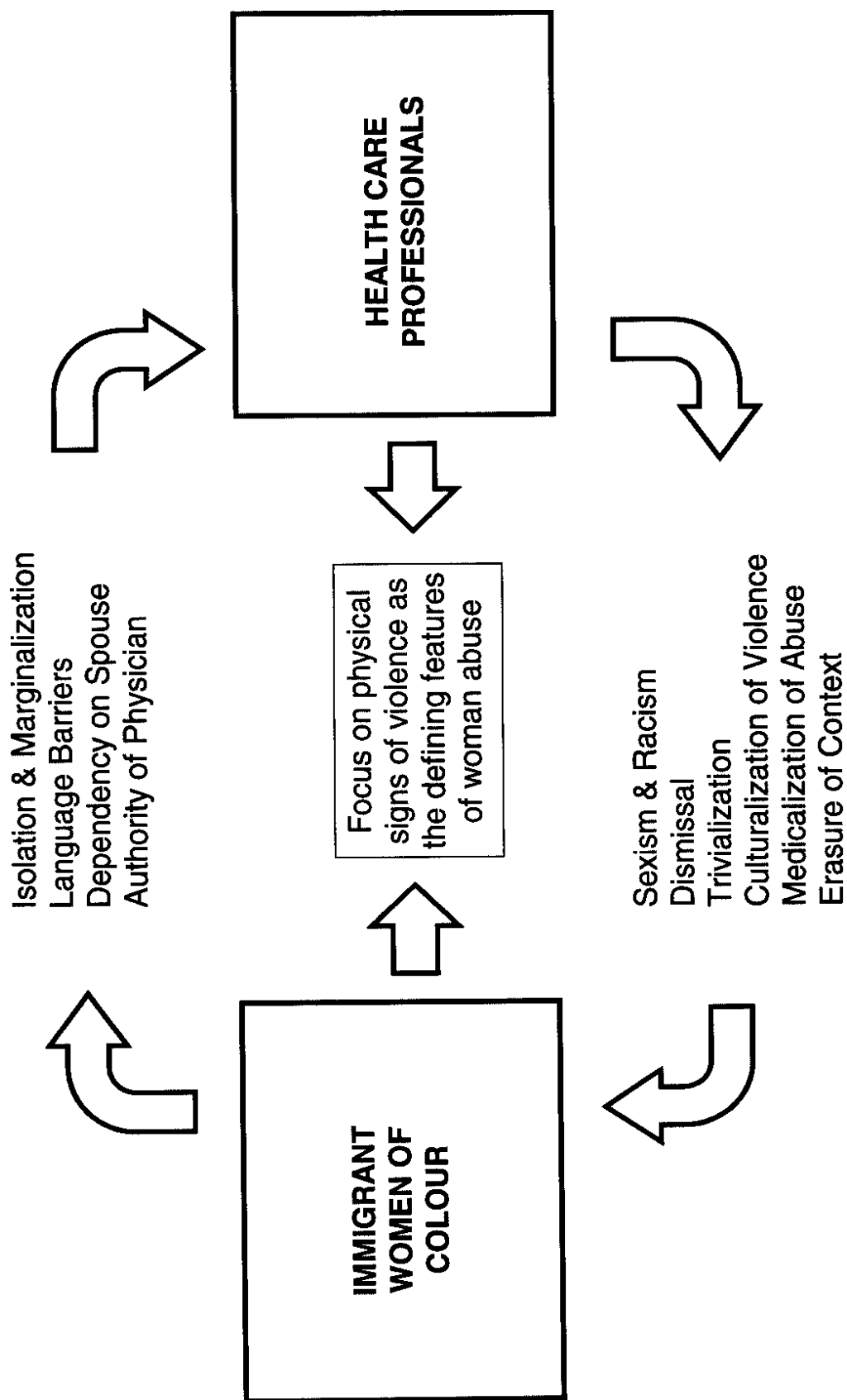


FIGURE 1: REPRODUCING DOMINANT DEFINITIONS OF ABUSE

PART III:

CAUGHT BETWEEN 'A ROCK & A HARD PLACE': A DISCUSSION & ANALYSIS

This report began with two poignant quotes by Christine Rasche (1988) and Irihapeti Ramsden (1993), respectively. These two quotes eloquently summarize the situation of racialized immigrant women who have experienced violence and their encounters with the health care system. They describe on the one hand, the physical experience of violence that knows no cultural or racial boundaries; and on the other hand, the response of health care providers that results in an 'emotional white-out' for abused women whose histories, needs and lived experiences are erased, inferiorized and trivialized.

Violence against women is grounded in the unequal and subordinate status of women. Thus, violence is about the abuse of power in a context of inequality. The formal medical system is stratified along the lines of power and privilege. Different groups have more power and privilege relative to other groups. The woman who has experienced violence encounters this system at different points. However, in contrast to the physician, nurse or even the ambulance driver, she has relatively little power. Further, the system is raced, classed and gendered in that the dominant power resides with white, heterosexual males who belong to the upper- or middle-class income bracket. The racialized woman, whether she is an immigrant woman of colour or an Aboriginal woman, has considerably less power and privilege in such an encounter.

As the environmental scan suggests, immigrant women of colour share with their white sisters, some of the same barriers that the latter experience when accessing health care. These barriers are predicated on systemic and institutionalized sexism within the health care system. Women who have experienced violence and who present to emergency staff and/or family physicians are often responded to with disbelief, minimization of their experiences, and medicalization of the abuse. Their concerns are often trivialized or erased, and they are subjected to blame. They are in fact constructed as 'problem patients' as indicated in the literature, and revictimized by the very system they turn to for assistance.

Aboriginal and immigrant women of colour have to deal with multiple and intersecting forms of violence. The gender-based violence they experience in their communities intersects with and is compounded by the everyday and institutionalized racism and sexism they encounter within the health care system. Institutionalized racism expresses itself in the streaming of women into dangerous occupations which are downwardly mobile. It is also manifested in the diversion of women away from language and employment programs that would alleviate their situation. Everyday racism underscores women's subordinate status by constantly inferiorizing them, erasing their contributions, and minimalizing the violence they encounter. Cultural racism within the various bureaucratic systems underscores their inferiorization and 'otherness,' and amplifies the risk they face when turning to these institutions for support and assistance.

In many cases, physicians' lack of knowledge about the health effects of violence combined with their orientation toward the efficient processing of patients contributes to the inadequacy and

inappropriateness of their response and treatment of women who have experienced violence. Further, some physicians are reluctant to engage in any discussion about violence, or to refer women to other services in the community. This may reflect a lack of training that would equip physicians to recognize the health effects of violence and ask the right questions. However, in many of the situations identified by service providers and immigrant women of colour, physicians do not invest in the time required to develop a trusting relationship with their patients. Rather, they are constantly 'watching the clock,' thereby contributing to the lack of ease and the discomfort of immigrant women of colour, as with other women who seek their services.

Clearly, if physicians do not spend the time with patients, are not cognizant of the health effects of violence, and are not aware of community services that can help women, women who are experiencing violence will not be in a position to disclose that abuse. Similarly, if the physician is treating both the woman and her abusive partner, and/or her entire family, she may not feel comfortable in disclosing the violence for fear of a breach of confidentiality and retaliation from the spouse. This situation is particularly relevant for immigrant women of colour and women in rural areas. In the former case, racism, lack of dominant language skills and lack of knowledge regarding their legal rights, contributes to their vulnerability in seeking services and fears about having their concerns documented.

The review of the literature as well as the data from interviews and focus groups demonstrate that stereotypes about women and specific ethno-racial groups structure the common-sense understandings of violence among health care providers. This results in attitudes toward racialized women that hold them and their cultural communities responsible for the violence. Cultural racism defines this discourse and underpins many physicians' reluctance to discuss violence with racialized women, and to attribute the violence to 'innate' cultural traits. Thus, rather than perceiving the risk factors that make immigrant women vulnerable to violence, physicians tend to localize the abuse and attribute it to the immediate cultural context in which the woman lives. This reinforces the stereotype that some cultures are more violent than others. It also deflects attention away from the structural forces and inequalities that contribute to immigrant women of colour's vulnerabilities to violence. Most immediately, it deflects attention away from the physicians' shortcomings and failure to provide adequate care.

Language barriers combined with structural dependency on the sponsoring spouse forces many immigrant women of colour to seek medical care from physicians selected by their abusive partners. These physicians are often reluctant to identify the abuse and to provide referrals and assistance. Further, many of these physicians rely on the abusive partner or children to interpret for the women, thus compromising women's ability to disclose the abuse. In other cases, potential breaches of confidentiality contribute to the silencing of women. The silencing is reinforced by patriarchal forces within the community which threaten to stigmatize or exclude the women should they disclose. The situation parallels the experiences of women who have been abused in rural communities and demonstrates the salience of structural forces in rendering some women more vulnerable than others. Again, as the literature demonstrates, the strength of patriarchal forces within communities of colour is not an innate or essentialist element of these communities, but rather is rendered more potent by the dislocation and displacement of these communities through migration, economic exploitation and their exclusion from participation

and integration into the dominant society. Racism and sexism thus work hand-in-hand in silencing the voices of immigrant women of colour.

Women of colour do want to tell their stories of abuse. This study shows that where screening mechanisms and protocols were in place, women at least had the opportunity to disclose. However, the ways in which they are asked questions about violence is equally important. Further, having information that helps them to define the abuse is even more important.

Fears of involving the police inform issues around documentation for immigrant women of colour. As with women who have experienced abuse, the import and strategic use of documentation is rarely explained by health care service providers. Racism not only feeds popular stereotypes about communities of colour as being more violent, but it also informs social policy and police practices so that these communities are under constant surveillance and men within these communities are criminalized. For communities to be labeled as violent leads to a situation where on the one hand, the women are dismissed as the violence they experience is normalized or culturalized, and the men on the other hand, are subjected to intense scrutiny and more likely to be subjected to punitive measures. For women in racialized communities, being aware of the differential and racially inscribed relations of power often means being silent about the violence. Not only are they threatened with deportation by their abusive partners, but the State also threatens to deport both themselves and their partners. These dynamics also make communities of colour more cautious about disclosures of violence, and contribute to the stigmatization and exclusion of women who 'tell.'

The reluctance to get involved on the part of many male physicians who share the same cultural frame of reference as the immigrant women of colour they serve, is again rooted in a similar dynamic, albeit one grounded in the economic success and the social status ascribed to health care professionals. On the one hand, there is the need to maintain a credible reputation and social status among clientele. On the other hand, taking a stance by actively advocating and supporting immigrant women of colour who have experienced violence can result in being stigmatized in the community and losing clientele. For female physicians, the risks are greater as they are also targeted by patriarchal forces within the community and harassed for taking a stand against the violence. As with every society, women who challenge the normative order are subjected to punitive measures. Similarly, those who advocate for unpopular causes are subject to backlash and violence, as is evident in the cases of physicians who have continued to provide abortion services. In this case, however, the potency of backlash is experienced to a greater extent given the small size of the community, its minority status, its geographic concentration, and the turning inward that has occurred as a result of the racism of the wider society.

Without a socio-ecological analysis that takes all of these variables into account, it is easy for health care professionals to continue to revictimize immigrant women of colour who seek their services. A socio-ecological model would not only help to contextualize women's lives, but would locate these experiences within a wider conceptual framework which recognizes their high-risk status as emanating from their structural location at the juncture of multiple and intersecting forces of domination. These forces of domination translate into the kinds of violence to which immigrant women of colour are subjected. These include social, economic and intimate forms of violence.

Reducing the risk to and enhancing the safety of immigrant women of colour entails a recognition of the societal, systemic and individual forms of violence they encounter. It involves a dismantling of cultural stereotypes, sexist stereotypes, as well as racist and sexist attitudes and behaviours that inform and structure social institutions. It also entails an awareness of the dynamics of abuse within intimate relationships, social institutions and societal attitudes and norms. It necessitates a dismantling of the hierarchies within the medical system which favour some patients over others on the basis of their race, class, and gender, and where the 'preferred patient' is identified as one who is willing to be rescued by the system despite endangering her life and legal status.

Within the formal health care system, 'culturally sensitive' approaches can easily succumb to a piecemeal approach to social change. In part, this is a result of the very nature of the system, predicated as it is on a western biomedical model which defines illness in discrete terms and categories and relies on prescriptive antidotes that can help eradicate the illness or at least manage the symptoms. The conceptual framework that organizes such an approach favours tangible solutions. Cultural prescriptions in the form of services and treatments which are organized, concrete and discrete have an affinity to the medical model. In contrast, solutions that argue for structural change involve mobilization, changing attitudes, practices and conceptual frameworks. They involve advocacy and are predicated on a social justice model of substantive equality (as opposed to formal equality). The difficulty of translating this approach within the dominant framework of western biomedicine is apparent in the continued inadequacy of the medical professions' response to violence against women. Rather than dealing with the systemic roots of gender-based violence, as grounded in the inequality and subordination of women, the system tends to focus on the physical signs of violence and treat them as if they are isolated from the larger social context.

For the immigrant woman of colour, the system's focus on physical manifestations of violence feed into and reinforce her own notions of what constitutes abuse. Racism, sexism and classism combined with the lack of dominant language skills, unfamiliarity with the conceptual frameworks of meaning and the bureaucratic nature of the medical system, work in concert to create barriers impeding her access to services. This situation amplifies the risk that women face – risks that are institutionally and societally grounded. In such a situation, it is not surprising that women fail to disclose abuse to medical practitioners, nor is it surprising that women first disclose to their friends and family. The few social networks of support available to immigrant women of colour need to be reinforced, and one of the avenues by which this can be done is to create spaces for women to network with each other. It is only in such safe spaces that information about abuse can be rendered meaningful enabling women to be able to use it in ways that are most appropriate for them. A more critical avenue through which to redress the unequal position of immigrant women is to support advocates who can work with them to navigate the complex and often fragmented bureaucracy of health care services. Additionally, the work of the public nurse and the community outreach worker need to be recognized because of their instrumental role in helping to reduce the isolation, and hence the vulnerability, of immigrant women of colour.

However, without structural changes, social support networks and outreach by public nurses can only function as band-aid solutions addressing the most immediate needs. Band-aid solutions are

temporary in nature. Dismantling inequalities within the health care system requires a more serious and committed approach. It requires recognition of alternative ways of healing, and recognition of the resources, skills and expertise that immigrant women of colour have to offer. The harnessing of these skills and expertise would not only address the issue of the 'brain drain' but would also facilitate the introduction and integration of different approaches to health care. Further, it would address the current ghettoization of people of colour in the lower echelons of the health care system and redress the power imbalances within the system. However, these changes necessitate a rethinking of the current model of the provision of health care services where access to the system is mediated by the 'care card,' and services are commodified in terms of dollars and cents. For immigrant women of colour who often have neither the money nor the unpaid time it takes to access services, the current system exacts social and economic costs which they can ill afford.

In conclusion, structural change remains the only viable solution if we are to meet the needs of immigrant women of colour and truly achieve the expectations of a health care system that is universal, humanitarian and compassionate. Until then, we will continue to have a system that perpetuates inequalities.

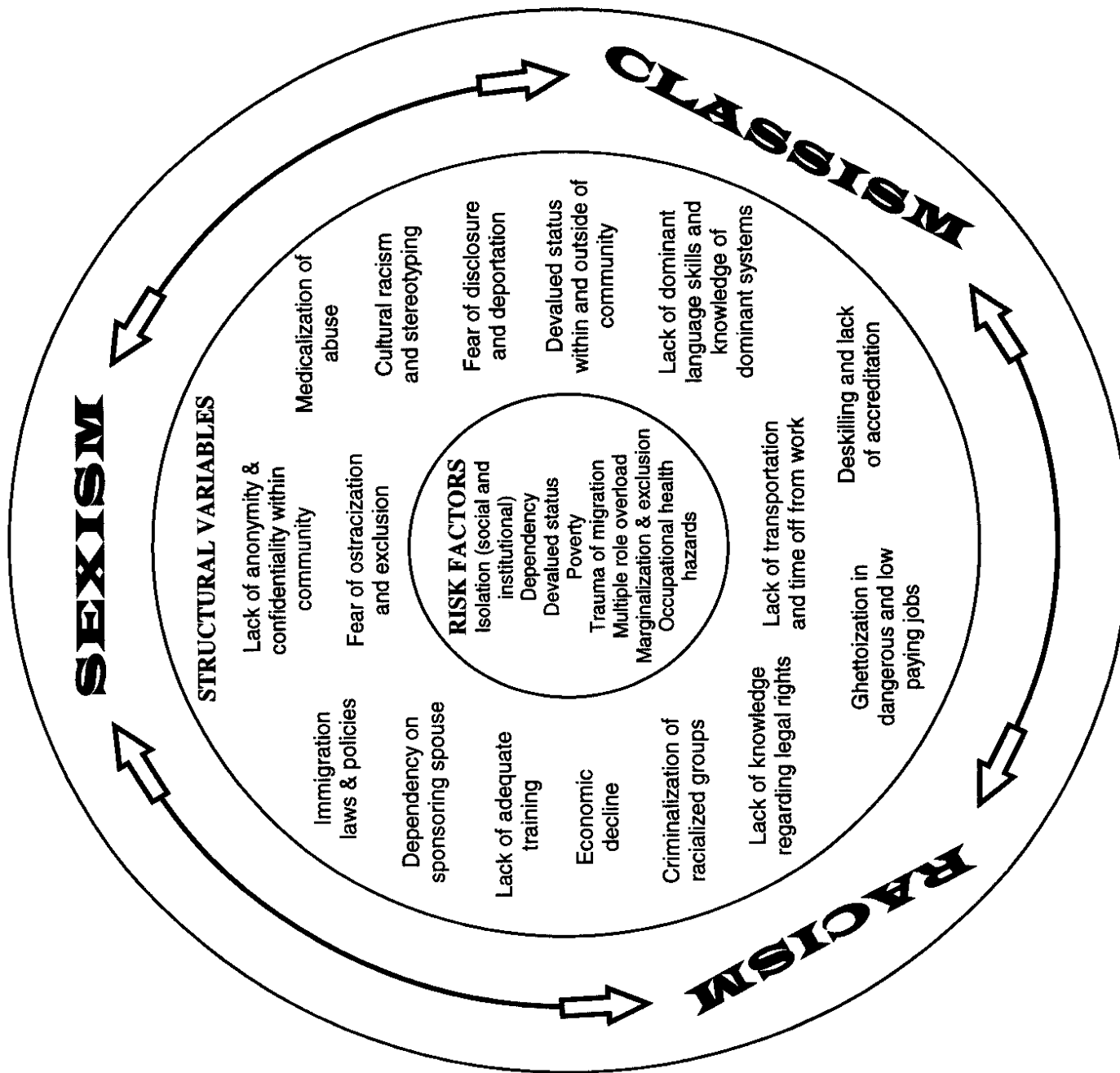


FIGURE 2: STRUCTURED OPPRESSION

RECOMMENDATIONS

RECOMMENDATIONS TO PHYSICIANS, REGIONAL HEALTH BOARDS, PROFESSIONAL BODIES AND VARIOUS LEVELS OF GOVERNMENT

- That, as per its mandate to promote “the highest quality of health care delivery to the people of British Columbia,” the British Columbia Medical Association create a committee that focuses on gender-based violence, and encourage physicians to become aware of the health effects of violence.
- That such a committee focus on the impact of multiple and interlocking forms of oppression and how these interact with intimate forms of violence.
- That the British Columbia Medical Association Committee issue guidelines concerning the care and treatment of women who are abused, and encourage the employment of an integrated socio-ecological model in physician practice.
- That the British Columbia Medical Association compile and disseminate a list of physicians who are conversant in different languages, who come from different cultural backgrounds and who are knowledgeable about the health impacts of violence. The list should be made available to immigrant settlement societies, posted at the airport, and distributed to community centres and other physicians.
- That all professional bodies and medical schools be mandated to undertake and implement education and awareness regarding the impact of systemic racism, sexism and classism. Hence, educational initiatives and provision of services should take into consideration the multiple and intersecting forms of violence that render particular populations at risk.
- That regional health boards commit resources toward the employment of public health nurses and community health care workers to conduct community outreach. Outreach should not be limited to the period immediately after the birth of the child but should include outreach to new immigrants and to women who are isolated.
- That the government and the various professional bodies involved with the provision of health care, support and encourage research on the effects of intimate violence and the interlocking effects of multiple forms of violence.
- That community outreach workers and public health nurses be drawn from the communities they are to serve and be provided with the tools by which to deal with situations of intimate violence.
- That regional health boards ensure the provision of specialized interpreters who can be called upon to interpret for immigrant women who have experienced violence. Information about credible interpretation services should also be made available to all practicing physicians and clinics. Interpreters should also be trained in dealing with violence and in recognizing the dynamics of violence that are operative in intimate relationships.

- That governments and regional health boards work together to create opportunities of networking which would reduce the risk of isolation that immigrant women and women of colour face.
- That settlement services and advocacy organizations be provided with additional funding in order to support their work with and advocacy on behalf of immigrant women of colour.
- That physicians refrain from using children or husbands as interpreters when examining a woman at any time, no matter how convenient this may seem at the time.
- That ongoing education be provided to physicians and other health care workers about the links between mental health and violence, as well as ways in which to detect and screen for violence, and further, to understand the root causes of gender-based violence. Physicians need to be aware of violence as a health issue, and to be attuned to the symptomatic manifestations of violence.
- That the BC Medical Association take a lead role in encouraging physicians to acquire knowledge about the health impacts of migration, racism, sexism and other forms of oppression.
- That documentation about violence should be at the discretion of the patient rather than being imposed by the physician or other health care workers.
- That reporting violence to the police be done at the discretion of women who are abused and in consultation with health care service providers.
- That measures be taken to support female physicians from diverse communities to practice within these communities and to encourage them to serve the women in their communities.
- That alternative systems of healing be recognized and supported.
- That medical coverage for the utilization of alternative systems be implemented and that costs be covered to a greater degree than at present.
- That screening mechanisms and protocols for violence be implemented in private practices, walk-in clinics and hospitals throughout the province. However, the development of these protocols should involve members of the communities that are impacted as well as health care professionals at these various sites.
- That physicians and other health care professionals be made aware of, and encouraged to utilize existing community-based support services that deal with women in abusive relationships. More particularly, they need to be aware of where women from racial minority backgrounds can access these services. This information should be available in their offices so that patients can perceive it and access it in unobtrusive ways.
- That physicians and nurses be encouraged to make referrals to other community services directly, and where possible facilitate the first meeting between the patient and community service provider.

- That family physicians be discouraged from serving an entire extended family at any time as this makes confidentiality problematic, and it also hinders women from disclosing abuse especially if they are being served by the same physician as their abusive partner and/or family.
- That male physicians be required to examine the woman in the presence of a female nurse. Physicians should be strongly discouraged from examining women in the presence of their partners.
- That physicians and nurses be required to explain to patients what they mean by maintaining confidentiality and the conditions under which confidentiality will not be maintained, for example in criminal justice proceedings.
- That physicians take the time to explain and listen to their patients in a respectful way that also maintains the dignity of the patient, and that they be made aware of the differing conceptual frameworks of meaning that are being used by their patients.
- That a more coordinated approach be taken in the delivery of health care services to women who have experienced violence, and particularly to women who are at risk because of the multiple forms of violence directed against them. This includes women who are poor, homeless, in transition, and women who do not speak the dominant language.
- That all health care service providers be made aware of the various categories of immigration legislation which govern the lives of immigrant women, and to use this information to assuage the concerns of immigrant women who seek assistance from them.
- That health care professionals be made to realize the often dangerous conditions in which all women who are experiencing violence live, and the escalation of that danger upon leaving the relationship. This information should be understood in the context of providing referrals, and hence referrals should be made in the most sensitive and appropriate manner.
- That health care services be provided in an equitable manner regardless of the woman's decision to remain in or leave the abusive relationship.
- That stereotypes about racialized groups as being violent communities be eradicated. Educational initiatives that deal with this issue should be encouraged and implemented at all levels of the health care system.
- That the provision of adequate and appropriate health care not depend on the presentation of a 'care card.' Women's access to a 'care card' can be limited by the abusive partner.

RECOMMENDATIONS REGARDING THE PRODUCTION AND DISTRIBUTION OF INFORMATION

- That health related information about violence be made available in different languages and distributed at religious and cultural centres, as well as at schools, libraries, walk-in clinics, specialized grocery stores serving different communities, neighbourhood houses, community centres and other frequented sites.
- That information about violence and its health effects be communicated and distributed to multicultural societies and immigrant settlement agencies, as well as to advocacy groups who are involved with immigrant women and women of colour.
- That settlement services and advocacy organizations be provided funding in order to support their work with immigrant women of colour.
- That information be distributed through the mainstream and ethnic media, and through cultural programming that is broadcast during the day.
- That the federal and provincial governments produce posters, cards, and other media incorporating information about violence and its health effects, and that such information be distributed in women-only spaces, and made publicly visible and accessible in private spaces such as bathrooms. This information should be available in a multilingual format.
- That education initiatives be implemented through outreach, and through family-oriented events.
- That the current 1-800 number used for disseminating information about violence also include information about the health-related effects of violence. Health Canada's National Clearinghouse on Family Violence can be encouraged to take the lead in this area.
- That a multilingual telephone line be set up which can be accessed by immigrant women and women of colour to obtain information about health services and knowledge relating to migration, the impact of racism, sexism and other forms of violence.
- That immigrant women of colour from diverse communities be trained to deliver information about the health effects of intimate and systemic forms of violence in their communities.
- That community advocates be recognized and supported for their work in empowering immigrant women and communicating information about health care.

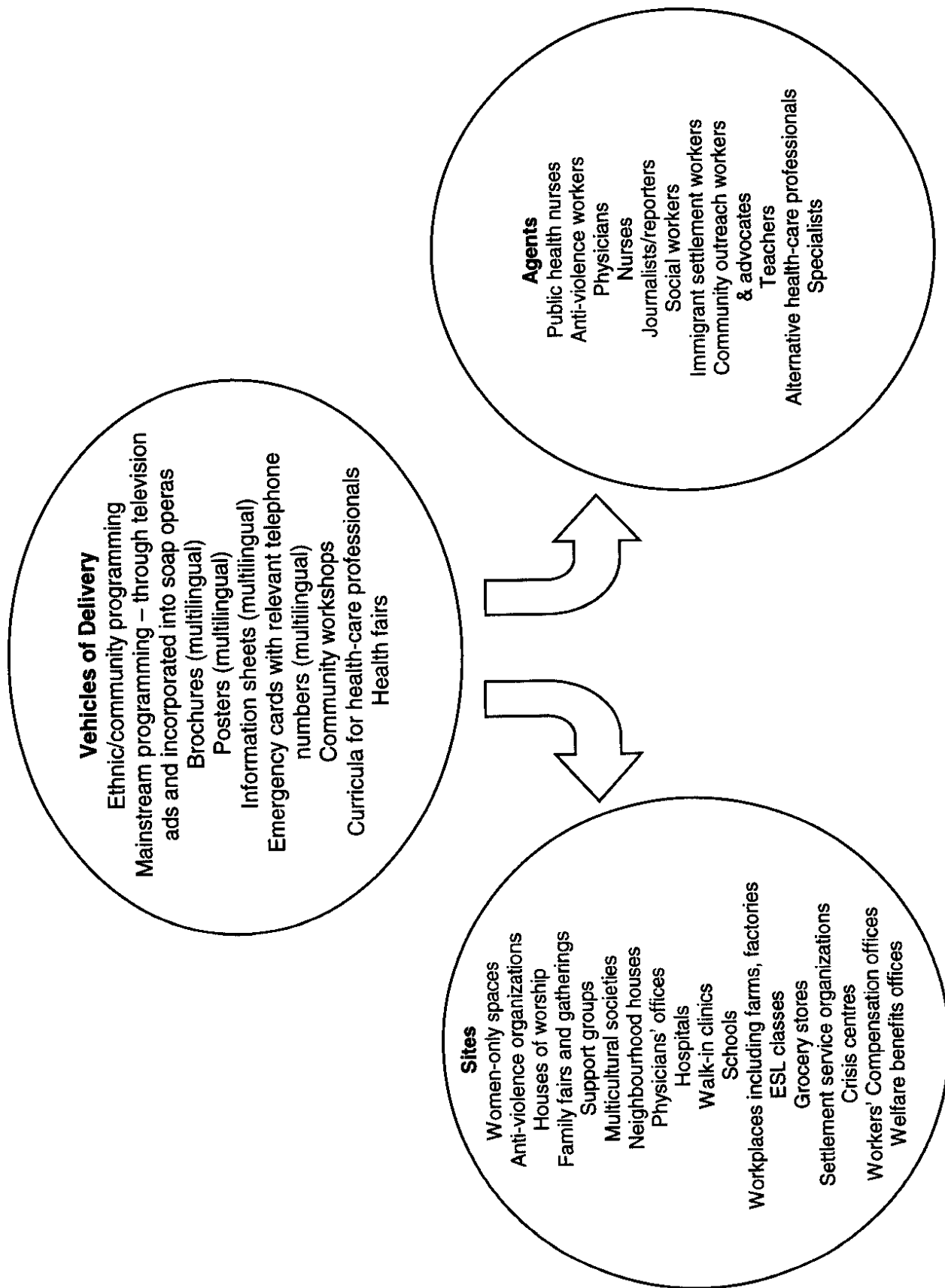


FIGURE 3: DELIVERY OF INFORMATION CONCERNING THE HEALTH IMPACTS OF VIOLENCE

BIBLIOGRAPHY

- Abbott, Jean, Robin Johnson, Koziol Mc-Lain & Steven R. Lowenstein. "Domestic Violence Against Women: Incidence and Prevalence in an Emergency Department." *Population Journal of the American Medical Association*, 273, 22 (1995): 1763-1767.
- Abraham, Margaret. "Ethnicity, Gender, and Marital Violence: South Asian Women's Organizations in the United States." *Gender & Society*, 9, 4 (August 1995): 450-468.
- Abu-Laban, Yasmeen. "Keeping 'Em Out: Gender, Race, and Class Biases in Canadian Immigration Policy." In *Painting the Maple: Essays on Race, Gender, and the Construction of Canada*, ed. Veronica Strong-Boag, Sherrill Grace, Avigail Eisenberg & Joan Anderson, 69-82. Vancouver, BC: UBC Press, 1998.
- Agger, Inger. "In the Blue Room." *Nordisk Sexologi*, 12 (1994): 29-50.
- Agnew, Vijay. *In Search of a Safer Place: Abused Women and Culturally Sensitive Services*. Toronto, ON: University of Toronto Press, 1998.
- Ahluwalia, Seema and Brian D. MacLean. "The Medicalization of Domestic Violence." In *Sociology of Health Care in Canada*, ed. B. Singh Bolaria and Harley D. Dickinson, 183-197. Toronto, ON: Harcourt Brace Jovanovich, 1988.
- Ahmed, Wagar I. U. & Reg. Walker. "Asian Older People: Housing, Health & Access to Services." *Ageing & Society*, 17 (1997): 141-165.
- Alcalay, Rina and Robert A. Bell. "Ethnicity and Health Knowledge Gaps: Impact of the California Wellness Guide on Poor African American, Hispanic, and Non-Hispanic White Women." *Health Communication*, 8, 4 (1996): 303-329.
- Alicea, Marixsa. "'A Chambered Nautilus': The Contradictory Nature of Puerto Rican Women's Role in the Social Construction of a Transnational Community." *Gender & Society*, 11, 5 (October 1997): 597-626.
- Anderson, Joan. "Empowering Patients: Issues and Strategies." *Social Science and Medicine* 43, 5 (1996): 697-705.
- _____. "Migration and Health: Perspectives on Immigrant Women." *Sociology of Health and Illness*, 9, 4 (1987): 410-438.
- _____. "Perspectives on the Health of Immigrant Women: A Feminist Analysis." *Advances in Nursing Science*, 8, 1 (1985): 61-76.
- Anderson, Joan, Connie Blue, Angela Hollbrook & Mirian Ng. "On Chronic Illness: Immigrant Women in Canada's Work Force – A Feminist Perspective." *Canadian Journal of Nursing Research*, 25, 2 (1993): 7-22.
- Anderson Joan & Sheryl Reimer Kirkham. "Constructing Nation: The Gendering and Racializing of the Canadian Health Care System." In *Painting the Maple: Essays on Race, Gender, and the Construction of Canada*, ed. Veronica Strong-Boag, Sherrill Grace, Avigail Eisenberg & Joan Anderson, 242-261. Vancouver, BC: UBC Press, 1998.

- Anthias, Floya & Nira Yuval-Davis. *Racialized Boundaries, Race, Nation, Gender, Colour and Class and the Anti-Racist Struggle*. London, UK: Routledge, 1992.
- Archer, Lynda A. "Empowering Women in a Violent Society, Role of the Family Physician." *Canadian Family Physician*, 40 (May 1994): 974-985
- Argüelles, Lourdes & Anne M. Rivero. "Gender/ Sexual Orientation Violence and Transnational Migration: Conversations with some Latinas We Think We Know." *Urban Anthropology and Studies*, 22, 3-4 (1993): 259-275.
- Bald, S.R. Coping with Marginality: South Asian Women Migrants in Britain. In *Feminism/Postmodernism/Development*, ed. M.H. Marchand and J.L. Parpart, 119-126. London, UK: Routledge, 1995.
- Bannerji, Himani. "Returning the Gaze: An Introduction." In *Returning the Gaze: Essays on Racism, Feminism and Politics*, ed. H. Bannerji, ix-xxix. Toronto, ON: Sister Vision Press, 1993.
- _____. "Introducing Racism: Towards an Anti-Racist Feminism." *Resources for Feminist Research*, 16, 1 (May 1987): 10-12.
- Beiser, Morton. "Towards a Research Framework for Immigrant Health," presented at the Metropolis Health Domain Seminar, December 12-13, 1996. In the *Metropolis Health Domain Seminar, Final Report*, pp.23-32. Ottawa, ON: Minister of Public Works and Government Services Canada, 1998.
- Berman, Sandra and Norma-Jean McLaren. *Multicultural Change in Health Service Delivery*. Resource Manual, 1 & 2 (March 1997). Vancouver, BC: Chara Health Care Society and Multiculturalism BC, 1997.
- Billingsley, Brenda and Leon Muszynski. *No Discrimination Here? Toronto Employers and the Multi-Racial Workforce*. Toronto, ON: Social Planning Council of Metropolitan Toronto and the Urban Alliance on Race Relations, May 1985.
- Bohn, Dianne K. "Nursing Care of Native American Battered Women." *AWHONNS Clinical Issues Perinatal Women's Health Nursing*, 4, 3 (1993): 424-436.
- Bolaria, B. Singh and Rosemary Bolaria. "Immigrant Status and Health Status: Women and Racial Minority Immigrant Workers." In *Racial Minorities, Medicine and Health*, ed. B. Singh Bolaria and Rosemary Bolaria, 149-168. Halifax, NS: Fernwood, 1994.
- Bolaria, B. Singh and Peter S. Li. *Racial Oppression in Canada*. Toronto, ON: Garamond Press, 1988.
- Bond, Charles F., Clarisse G. DiCandia & John R. MacKinnon. "Responses to Violence in a Psychiatric Setting: The Role of Patient's Race." *Personality and Social Psychology Bulletin*, 14, 3 (September 1988): 448-458.
- Boychuk Duchscher, Judy E. "Acting on Violence Against Women." *The Canadian Nurse*, 90, 6 (June 1994): 21-25.

- Boyd, Monica. "Family and Personal Networks in International Migration: Recent Developments and New Agendas." *International Migration Review*, 23, 3 (1989): 638-670.
- Brice-Baker, Janet R. "Domestic Violence in African-American and African-Caribbean Families." *Journal of Social Distress and the Homeless*, 3, 1 (1994): 23-38.
- British Columbia Ministry of Health Advisory Council on Women's Health. *Report on Women's Health, 1996-1998*. Victoria, BC: BC Ministry of Health & Ministry Responsible for Seniors, 1999.
- Bulhan, Hussein Abdilahi. *Frantz Fanon and the Psychology of Oppression*. New York: Plenum Press, 1985.
- Bullock, Linda, Judith McFarlane, Louise H. Bateman & Virginia Miller. "The Prevalence and Characteristics of Battered Women in a Primary Care Setting." *Nurse Practitioner*, 14 (June 1989): 47-56.
- Burns, Maryviolet C., ed. *The Speaking Profits Us: Violence in the Lives of Women of Color*. Seattle, WA: Centre for the Prevention of Sexual and Domestic Violence, 1986.
- Calvo, Janet M. "Health Care Access for Immigrant Women." In *Man-Made Medicine: Women's Health, Public Policy, and Reform*, ed. Kary L. Moss, 161-181. Durham, NC: Drake University Press, 1996.
- Cameron, Rebecca P., Jennifer D. Wells & Stevan E. Hobfoll. "Stress, Social Support and Coping in Pregnancy." *Journal of Health Psychology*, 1, 2 (1996): 195-208.
- Canadian Public Health Association. *Violence in Society: A Public Health Perspective*. Ottawa, ON: Canadian Public Health Association, 1994.
- Carlisle, David M., Barbara D. Leake, Robert H. Brook & Martin E. Shapiro. "The Effect of Race and Ethnicity on the Use of Selected Health Care Procedures: A Comparison of South Central Los Angeles and the Remainder of Los Angeles County." *Journal of Health Care for the Poor and Underserved*, 7, 4 (1996): 308-322.
- Carraway, Chezia G. "Violence Against Women of Colour." *Stanford Law Review*, 43 (July 1991): 1301-1309.
- Cave, Andrew, Usha Maharaj, Nancy Gibson & Eileen Jackson. "Physicians and Immigrant Patients." *Canadian Family Physician*, 41 (October 1995): 1685-1690.
- Chambers, Susan D. *An Analysis of Trends Concerning Violence against Women: A Preliminary Case Study of Vancouver*. Vancouver, BC: FREDA Centre, 1998.
- Champion, Jane Dimmitt. "Woman Abuse, Assimilation, and Self-Concept in a Rural Mexican American Community." *Hispanic Journal of Behavioural Science*, 18, 4 (November, 1996): 508-521.
- Chavez, Leo R., F. Allan Hubbell, Shiraz I. Mishra & R. Burciaga Valdez. "Undocumented Latina Immigrants in Orange County, California: A Comparative Analysis." *International Migration Review*, 31, 1 (Spring 1997): 88-107.

- Christensen, Carol. Presentation at – Ending Violence Against Women: Setting the Agenda for the Next Millennium – 10th International Nursing Conference, June 1-3, 2000, Vancouver, BC.
- Chen, Jianjian, Edward Ng & Russell Wilkins. “The Health of Canada’s Immigrants in 1994-5.” *Health Reports*, 7, 4 (Spring, 1996): 33-45.
- Chin, Ko-Lin. “Out of Town Brides: International Marriage and Wife Abuse Among Chinese Immigrants.” *Journal of Comparative Family Studies*, XXV, 1 (Spring 1994): 53-69.
- Choi, Gil. “Acculturative Stress, Social Support, and Depression in Korean American Families.” *Journal of Family Social Work*, 2, 1 (1997): 81-97.
- Choudry, Salma. “Pakistani Women’s Experiences of Domestic Violence in Great Britain.” *Research Findings*, 43. London, UK: Home Office Research and Statistics Directorate, n.d.
- Chuly, Phyllis. “Women’s Health Notes, For Remarks to Women and the Law Conference.” In *Ten Years Later: The Charter and Equality for Women, A Publication from a Symposium Assessing the Impact of the Equality Provisions on Women in Canada*, ed. Margaret A. Jackson and N. Kathleen Sam Banks, with the assistance of Krista Robson, 160-168. Vancouver, BC: Simon Fraser University, 1996.
- Coeling, Harriet V. & Gloria Harman. “Learning to Ask about Domestic Violence.” *Women’s Health Issues*, 1997, 263-268.
- Collins, Patricia Hill. “Toward a New Vision: Race, Class and Gender as Categories of Analysis and Connection.” *Race, Sex & Class*, 1, 1 (Fall 1993): 25-45.
- Das Gupta, Tania. *Racism and Paid Work*. Chapter 4, Racism in Nursing, pp. 69-91. Toronto, ON: Garamond Press, 1996.
- Dasgupta, Das Shamita. “In the Footsteps of ‘Arundhati’: Asian Indian Women’s Experience of Domestic Violence in the United States.” *Violence Against Women*, 2, 3 (September, 1996): 238-259.
- Davis, Angela. “The Colour of Violence Against Women.” *ColorLines*, 3, 3 (Fall, 2000). Available at: http://www.arc.org/C_Lines/CLArchive/story3_3_02.html
- _____. *Women, Culture & Politics*. New York, NY: Vintage Books, 1990.
- Dosanjh, Raminder, S. Deo & Surjeet Sidhu. *Spousal Abuse in the South Asian Community*. Vancouver, BC: FREDA Centre, 1994.
- Dossa, Parin. “The Narrative Representation of Mental Health: Iranian Women in Canada.” *Working Paper Series*, #99-18. Vancouver, BC: Vancouver Centre of Excellence for Research on Immigration and Integration in the Metropolis (RIIM), June 1999.
- Duffy, Ann & Julianne Momirov. *Family Violence in Canada: A Canadian Introduction*. Toronto, ON: James Lorimer & Co., 1997.

- Dunn, James & Isabel Dyck. "Social Determinants of Health in Canada's Immigrant Population: Results from the National Population Health Survey." *Working Paper Series*, #98-20. Vancouver, BC: Vancouver Centre of Excellence for Research on Immigration and Integration in the Metropolis (RIIM), October, 1998.
- Dyck, Isabel. "Managing Chronic Illness: An Immigrant Woman's Acquisition and Use of Health Care Knowledge." *American Journal of Occupational Therapy*, 46, 8 (1992): 696-705.
- Easteal, Patricia. "Double Jeopardy, Violence Against Immigrant Women in the Home." *Family Matters*, Newsletter of the Australian Institute of Family Studies, 45 (Spring/Summer, 1996).
- Emmott, Sue. "'Dislocation,' Shelter and Crisis: Afghanistan's Refugees and Notions of Home." *Gender & Development*, 4, 1 (1996): 31-38.
- Ervin, Alexander M. "Service Providers' Perceptions of Immigrant Well-Being and Implications for Health Promotion and Delivery." In *Racial Minorities, Medicine and Health*, ed. B. Singh Bolaria and Rosemary Bolaria, 225-243. Halifax, NS: Fernwood, 1994.
- Essed, Philomena. *Everyday Racism, Reports from Women of Two Cultures*. Translated by Cynthia Jaffe. Claremont, CA: Hunter House, 1990.
- Fanon, Frantz. *Black Skin, White Masks*. Translated by Charles Lam Markmann. New York, NY: Grove Press, 1967.
- Ferraro, Katherine. "The Dance of Dependency: A Genealogy of Domestic Violence." *Hypatia*, 11, 4 (1996): 77-91.
- Fleras, Augie & Jean Leonard Elliot. *Unequal Relations: An Introduction to Race, Ethnic and Aboriginal Dynamics in Canada*. Second Edition. Scarborough, ON: Prentice Hall, 1996.
- Flynn, Karen & Charmaine Crawford. "Committing 'Race Treason': Battered Women and Mandatory Arrest in Toronto's Caribbean Community." In *Unsettling Truths: Battered Women, Policy, Politics, and Contemporary Research in Canada*, ed. K.D. Bonnycastle & G.S. Rigakos, 91-102. Vancouver, BC: Collective Press, 1998.
- Gany, Francesca & Heike Thiel de Bocanegra. "Overcoming Barriers to Improving the Health of Immigrant Women." *Journal of the American Medical Women's Association*, 51 (1996): 155-160.
- Geertz, Clifford. *The Interpretation of Cultures*. New York, NY: Basic Books, 1973.
- Gray, Bradley & Jeffrey J. Stoddard. "Patient-Physician Pairing: Does Racial and Ethnic Congruity influence Selection of a Regular Physician?" *Journal of Community Health*, 22, 4 (August 1997): 247-259.
- Greaves, L., O. Hankivsky & J. Kingston-Riechers. *Selected Estimates of the Costs of Violence Against Women*. London, ON: Centre for Research on Violence Against Women and Children, University of Western Ontario, 1995.

- Grunfeld, Anton, Deborah Hotch & Kathleen MacKay. *Identification, Assessment, Care Referral and Follow-up of Women Experiencing Domestic Violence Who Come to the Emergency Department for Treatment*. Final Report. Vancouver, BC: Vancouver Hospital and Health Sciences Centre, 1995.
- Hall, Stuart. "The Whites of Their Eyes." In *The Media Reader*, ed. Manuel Alvarado and John O. Thompson. London, UK: British Film Institute, 1990.
- Hamilton, Janice. "Multicultural Health Care Requires Adjustments by Doctors and Patients," *Canadian Medical Association Journal*, 155, 5 (September 1, 1996): 585-587.
- Hamilton, Roberta. *Gendering the Vertical Mosaic: Feminist Perspectives on Canadian Society*. Toronto, ON: Copp Clark, 1996.
- Hanvey, Louise & Dianne Kinnon. *The Health Care Sector's Response to Woman Abuse*. Ottawa, ON: National Clearinghouse on Family Violence, 1994.
- Health Canada. *Report on an Information Session with Ethnocultural Communities on Family Violence*. Ottawa, ON: Health Canada, March 19-20, 1994.
- Heber, Lou. "Arranged Marriages and Mental Health Among Immigrant Women." In *Racial Minorities, Medicine and Health*, ed. B. Singh Bolaria and Rosemary Bolaria, 363-369. Halifax, NS: Fernwood, 1994.
- Henderson, Angela D. & Janet R. Ericksen. "Enhancing Nurses' Effectiveness with Abused Women: Awareness, Reframing, Support, Education." *Journal of Psychosocial Nursing*, 32, 6 (1994): 11-15.
- Henry, Frances & Effie Ginzberg. "Who Gets the Work?" *A Test of Racial Discrimination in Employment*. Toronto, ON: Social Planning Council of Metropolitan Toronto and the Urban Alliance on Race Relations, January 1985.
- Henry, Frances, Carol Tator, Winston Mattis & Tim Rees. *The Colour of Democracy: Racism in Canadian Society*. Chapter 6, "Racism and Human Service Delivery," pp. 153-170. Toronto, ON: Harcourt Brace Canada, 1995.
- Hills, Marcia and Jennifer Mullett. *Women-Centred Care: Working Collaboratively to Develop Gender Inclusive Health Policy*. Final Report. Victoria, BC: Community Health Promotion Centre, Faculty of Human & Social Development, University of Victoria, August 1998.
- hooks, bell. *Killing Rage, Ending Racism*. New York, NY: Henry Holt & Co., 1995.
- Hotch, Deborah, Anton Grunfeld, Kathleen MacKay & Leigh Cowan. *Domestic Violence Intervention by Emergency Department Staff*. Vancouver, BC: Vancouver Hospital and Health Sciences Centre, 1995.
- Huisman, Kimberly. "Wife Battering in Asian American Communities." *Violence Against Women*, 2, 3 (September 1996): 260-283.

- Iyer, Nitya. "Some Mothers are Better than Others: A Re-examination of Maternity Benefits." In *Challenging the Public/Private Divide, Feminism, Law & Public Policy*, ed. S.B. Boyd, 168-194. Toronto, ON: University of Toronto Press, 1997.
- Janovicek, Nancy. *On the Margins of a Fraying Safety Net: Aboriginal and Immigrant Women's Access to Welfare*. Vancouver, BC: FREDA Centre, 2000.
- Jiwani, Yasmin. "The Criminalization of Race/The Racialization of Crime." In *Erasing Connections*, ed. W. Chan & K. Mirchandana. Toronto, ON: Broadview Press, 2000.
- _____. *Violence Against Marginalized Girls: A Review of the Current Literature*. Vancouver, BC: FREDA, 1998.
- _____. "Women of Colour and Poverty." *Occasional Working Papers in Women's Studies and Gender Relations*, 3, 1 (1994): 1-15.
- _____. "By Omission and Commission: Race and Representation in Canadian Television News." Unpublished Doctoral Dissertation, School of Communication, Simon Fraser University, Burnaby, BC, 1993.
- _____. "To Be or Not to Be: South Asians as Victims and Oppressors in the *Vancouver Sun*." *Sanvad*, 5, 45 (1992).
- Jiwani, Yasmin & Lawrence Buhagiar. *Policing Violence against Women in Relationships: An Examination of Police Response to Violence against Women in British Columbia*. Vancouver, BC: FREDA, 1997.
- Jiwani, Yasmin with Patricia Kachuk & Shelley Moore. *Rural Women and Violence: A Study of Two Communities in British Columbia*. Vancouver, BC: FREDA, 1998.
- Johnson, Holly. *Dangerous Domains: Violence Against Women in Canada*. Scarborough, ON: Nelson Canada, 1996.
- Kinnon, Dianne. *Canadian Research on Immigration and Health: An Overview*. Ottawa, ON: Health Canada, 1999.
- Kinnon, Dianne & Louise Hanvey. "Health Aspects of Violence Against Women: A Canadian Perspective." 1996. Available at: <http://www.hc-sc.gc.ca/canusa/papers/violence.htm>
- Kosch, Shae Graham, Mary Ann Burg & Shifa Podikiju. "Patient Ethnicity and Diagnosis of Emotional Disorders in Women." *Family Medicine*, 30, 3 (1998): 215-219.
- Koshan, Jennifer. "Sounds of Silence: The Public/Private Dichotomy, Violence, and Aboriginal Women." In *Challenging the Public/Private Divide, Feminism, Law & Public Policy*, ed. S.B. Boyd, 87-109. Toronto, ON: University of Toronto Press, 1997.
- Kurz, Demie and Evan Stark. "No-So-Benign Neglect, The Medical Response to Battering." In *Feminist Perspectives on Wife Abuse*, ed. K. Yllö and M. Bograd, 249-266. New York, NY: Sage Publications, 1988.
- Lai, Tracy A. "Asian Women: Resisting the Violence." In *The Speaking Profits Us: Violence in the Lives of Women of Colour*, ed. M.C. Burns, 8-11. Seattle, WA: Center for the Prevention of Sexual and Domestic Violence, 1986.

- Laroche, Mireille. "Health Status and Health Services Utilization of Canada's Immigrant and Non-Immigrant Populations." *Canadian Public Policy*, XXVI, 1 (2000): 51-73.
- Lee, Jo-Anne, with the assistance of Cheryl Harrison. *Immigrant Settlement and Multiculturalism Programs for Immigrant, Refugee and Visible Minority Women: A Study of Outcomes, Best Practices and Issues*. Victoria, BC: Ministry Responsible for Multiculturalism & Immigration, June 1999.
- Legault, Gisèle. "Social Work Practice in Situations of Intercultural Misunderstandings." *Journal of Multicultural Social Work*, 4, 4 (1996): 49-66.
- Lewin, Ellen. "The Nobility of Suffering: Illness and Misfortune Among Latin American Immigrant Women," *Anthropological Quarterly*, 52, 3 (1979): 152-158.
- Li, Nancy and Patrick May. "A Tale of Two Communities – HIV/AIDS Education in Asian Women." Unpublished report prepared for the Asian Society for the Intervention of AIDS. Vancouver, BC: March 1997.
- Lutz, Helma. "The Legacy of Migration: Immigrant Mothers and Daughters and the Process of Intergenerational Transmission." *Comenius*, 15, 3 (Fall 1995): 304-317.
- Lynam, Judith. "Towards the Goal of Providing Culturally Sensitive Care: Principles upon which to Build Nursing Curricula." *Journal of Advanced Nursing*, 17 (1992): 149-157.
- MacKinnon, Marion with Laura Lee Howard. *Affirming Immigrant Women's Health: Building Inclusive Health Policy*. Final Report. Halifax, NS: The Maritime Centre of Excellence for Women's Health, May 2000.
- MacLeod, Linda and Maria Y. Shin. *Isolated, Afraid and Forgotten: The Service Delivery Needs and Realities of Immigrant and Refugee Women Who Are Battered*. Prepared for the National Clearinghouse on Family Violence. Ottawa, ON: Health and Welfare Canada, December 1990.
- MacLeod, Linda and Maria Y. Shin in collaboration with Queenie Hum, Jagrup Samra-Jawanda, Shalen Rai, Maria Minna and Eva Wasilewska. *Like a Wingless Bird: A Tribute to the Survival and Courage of Women Who Are Abused and Who Speak Neither English Nor French*. Ottawa, ON: National Clearinghouse on Family Violence, 1994.
- Majumdar, B. & J. Roberts. "Culturally Sensitive AIDS Education for Hamilton-Wentworth Immigrant Women." System-Linked Research Unit, Working Paper Series, April 1995.
- Meleis, Afaf, I. "Between Two Cultures: Identity, Roles and Health," *Health Care for Women International*, 12 (1991): 365-377.
- Memmi, Albert. *The Colonizer and the Colonized*. Boston, MA: Beacon Press, 1965.
- Miles, Robert. *Racism*. London and New York: Routledge, Key Idea Series, 1989.
- Mohanty, Chandra. "Under Western Eyes: Feminist Scholarship and Colonial Discourses." In *Third World Women and the Politics of Feminism*, ed. C. T. Mohanty, A. Russo and L. Torres, 51-80. Bloomington and Indianapolis, IN: Indiana University Press, 1991.
- MOSAIC. Immigrant Women's Health: A Community Consultation Project. Vancouver, BC: MOSAIC, January 1996.

- Moussa, Helene. "Violence Against Refugee Women: Gender Oppression, Canadian Policy, and the International Struggle for Human Rights." *Resources for Feminist Research*, 26, 3/4 (1998): 79-111.
- Moussa, Helene. *Challenging Myths and Claiming Power Together: A Handbook to Set Up and Assess Support Groups for and with Immigrant and Refugee Women*. Toronto, ON: Education Wife Assault, 1994.
- Narayan, Uma. "Male-Order Brides: Immigrant Women, Domestic Violence and Immigration Law." *Hypatia*, 10, 1 (1995): 104-119.
- NAWL (National Association of Women and the Law). "Gender Analysis of Immigration and Refugee Protection Legislation and Policy." NAWL Ad Hoc Committee on Gender Analysis of the Immigration Act, Submission to Citizenship and Immigration Canada, March 1999.
- Ng, Roxana. "Racism, Sexism, and Immigrant Women." In *Changing Patterns: Women in Canada*, ed. S. Burt, L. Code & L. Dorney, 279-301. Toronto, ON: McClelland & Stewart, 1993.
- Nicholas, Lee. *Amor Sin Violencia (Love Without Violence)*. A Manual for Spanish Speaking Lay Counsellors and Group Leaders. Translated by Iona Whishaw. Vancouver, BC: Family Services of Greater Vancouver, n.d.
- Ocran, Amanda Araba. "Across the Home/Work Divide: Homework in Garment Manufacture and the Failure of Employment Regulation." In *Challenging the Public/Private Divide, Feminism, Law & Public Policy*, ed. S.B. Boyd, 144-167. Toronto, ON: University of Toronto Press, 1997.
- O'Keefe, Maura. "Racial/Ethnic Differences Among Battered Women and Their Children." *Journal of Child and Family Studies*, 3, 3 (1994): 283-305.
- Perilla, Julia L., Roger Bakeman & Fran H. Norris. "Culture and Domestic Violence: The Ecology of Abused Latinas." *Violence and Victims*, 9, 4 (1994): 325-339.
- Philippine Women Centre. *Trapped: Holding on to the Knife's Edge – Economic Violence against Filipino Migrant/Immigrant Women*. Vancouver, BC: FREDA Centre, 1997.
- Philippine Women Centre & the Global Alliance Against Traffic in Women Canada. *Echoes: Cries for Freedom, Justice and Equality, Filipino Women Speak*. Vancouver, BC: GAATW Canada and the Philippine Women Centre, 1999.
- Pinn, Vivian W. & Mary T. Chunko. "The Diverse Faces of Violence: Minority Women and Domestic Abuse." *Academic Medicine*, 72, 1, Supplement (January 1997): S65-S71.
- Polaschek, N. R. "Cultural Safety: A New Concept in Nursing People of Different Ethnicities." *Journal of Advanced Nursing*, 27 (1998): 452-457.
- Porter, John. *The Vertical Mosaic: An Analysis of Social Class and Power in Canada*. Toronto, ON: University of Toronto Press, 1965.
- Ramsden, Irihapeti. "Kawa Whakaruruhau: Cultural Safety in Nursing Education in Aotearoa (New Zealand)." *Nursing Praxis in New Zealand*, 8, 3 (1993): 4-10.

- Ramsden, Irihapeti. "Cultural Safety." *The New Zealand Nursing Journal, Kai tiaki* 83, 110 (1990): 18-19.
- Radomsky, Nellie A. *Lost Voices: Women, Chronic Pain, and Abuse*. Binghamton, NY: Haworth Press, 1995.
- Rasche, Christine E. "Minority Women and Domestic Violence: The Unique Dilemmas of Battered Women of Color." *Journal of Contemporary Criminal Justice*, 4/3 (1988): 150-171.
- Razack, Sherene. *Looking White People in the Eye, Gender, Race, and Culture in Courtrooms and Classrooms*. Toronto, ON: University of Toronto Press, 1998.
- _____. "What is to be Gained by Looking White People in the Eye? Culture, Race, and Gender in Cases of Sexual Violence." *Signs*, 19, 4 (1994): 894-923.
- Reitz, Jeffrey G. & Sherrilyn M. Sklar. "Culture, Race, and the Economic Assimilation of Immigrants." *Sociological Forum*, 12, 2 (1997): 233-277.
- Rhee, Siyon. "Domestic Violence in the Korean Immigrant Family." *Journal of Sociology and Social Welfare*, XXIV, 1 (March 1977): 63-77.
- Ristock, Janice L. & The Mental Health Division, Health Promotion and Programs Branch, Health Canada. "The Impact of Violence on Mental Health – A Guide to the Literature." *Discussion Papers on Health/Family Violence Issues*, 3. Ottawa, ON: Minister of Supplies & Services, 1995.
- Roberts, Barbara. *Immigrant Women: Triple Oppression, Triple Jeopardy*. Presentation given at the opening meeting of the Simone de Beauvoir Institute Research Seminar (1987-1988): Immigrant Women/La femme immigrante. Collection 'Working Papers/Inédits' 3. Montreal, QC: Publication of the Simone De Beauvoir Institute, 1990.
- Said, Edward. *Orientalism*. New York, NY: Vintage Books, Random House, 1979.
- Sanchez, Tony R., Judith A. Plawecki, and Henry M. Plawecki. "The Delivery of Culturally Sensitive Health Care to Native Americans." *Journal of Holistic Nursing*, 14, 4 (1996): 295-307.
- Sasso, Angela. *Interpreter Services in Health Care: A Call for Provincial Standards and Services*. Report prepared for the Multicultural Health Committee, Affiliation of Multicultural Societies and Service Agencies of BC. Vancouver, BC: January 2000.
- Savary, Rosalind. *What Does Gender Have to Do with It? An Environmental Scan on Women's Health Issues*. Prepared for the Adult Health team, Health Promotions and Programs Branch, Health Canada, BC/Yukon Regional Office, 1998.
- Schneller, Debora Podolsky. "The Immigrant's Challenge: Mourning the Loss of Homeland and Adapting to the New World." *Studies in Social Work*, LI, 2 (March 1981): 95-125.
- Schwager, K. Walter, Anne-Marie Mawhiney & John Lewko. "Cultural Aspects of Prevention Programs." *Canadian Social Work Review* 8, 2 (Summer 1991): 246-254.
- Shroff, Farah M. "Walking the Diversity Talk: Curriculum within First Year Midwifery Education." *Health and Canadian Society*, 4, 2 (1996/97): 389-440.

- Sidhu, Surjeet. *Perspectives of Women Who have Experienced Violence in Relationships and Their Children*. Research initiated and conducted by the Richmond Coordinating Response Committee to End Violence Against Women. Richmond, BC: November 13, 1996.
- Shepherd, Judith. "Coping in America: Contextual Variables in the Adaptation of Female Refugees and Immigrants." *Social Development Issues*, 11, 2 (Fall 1987): 72-86.
- Spelman, Elizabeth V. *Inessential Woman: Problems of Exclusion in Feminist Thought*. Boston, MA: Beacon, 1988.
- Stark, Evan, Anne Flitcraft & William Frasier. "Medicine and Patriarchal Violence: The Social Construction of a 'Private' Event." *International Journal of Health Services*, 9, 3 (1979): 461-493.
- Statistics Canada. (1996). Canadian Statistics: The People – Population. Available at: <http://www.statcan.ca/english/Pgdb/popula.htm>
- Strobel, Margaret. "Gender, Sex, and Empire." *Essays on Global and Comparative History*. Washington, DC: American Historical Association, 1993.
- Thobani, Sunera. "Sponsoring Immigrant Women's Inequalities." *Canadian Woman Studies*, 19, 3 (1999): 11-16.
- _____. "Nationalizing Citizens, Bordering Immigrant Women: Globalization and the Racialization of Women's Citizenship in Late 20th Century Canada." Doctoral Dissertation, Department of Sociology & Anthropology, Simon Fraser University, 1998.
- Trute, Barry, Peter Sarsfield & Dale A. MacKenzie. "Medical Response to Wife Abuse: A Survey of Physicians' Attitudes and Practice." *Canadian Journal of Community Mental Health*, 7, 2 (1988): (no page numbers).
- Van Dijk, Teun A. *Elite Discourse and Racism*. London and New York: Routledge, 1993.
- Varcoe, Colleen Marie. "Untying Our Hands: The Social Context of Nursing in Relation to Violence against Women." Doctoral Dissertation, School of Nursing, University of British Columbia, 1997.
- Vega, W.A., B. Kolody, J.R. Valle. "Migration and Mental Health: An Empirical Test of Depression Risk Factors among Immigrant Mexican Women." *International Migration Review* 21, 3 (1987): 512-529.
- Warshaw, Carole. "Limitations of the Medical Model in the Care of Battered Women." In *Violence Against Women: The Bloody Footprints*, ed. Pauline B. Bart & Eileen Geil Moran, 134-146. Newbury Park, CA: Sage, 1993.
- Waxler-Morrison, Nancy, Joan Anderson and Elizabeth Richardson, eds. *Cross-Cultural Caring: A Handbook for Health Professionals in Western Canada*. Vancouver, BC: UBC Press, 1990.
- Wiik, Maija-Liisa. "Immigrant Women and Wife Abuse: A Phenomenological Exploration." Masters Thesis, Department of Counselling Psychology, University of British Columbia, 1995.

- Williams, Oliver J. & R. Lance Becker. "Domestic Partner Abuse Treatment Programs and Cultural Competence: The Results of a National Survey." *Violence and Victims*, 9, 3 (1994): 287-296.
- Williams, Patricia J. *The Alchemy of Race and Rights*. Cambridge, MA: Harvard University Press, 1991.
- Wilson, Laurene J. Patient Satisfaction and Quality of Life: A Study of Women with Abusive Male Partners Treated in an Emergency Department. Doctoral Dissertation, School of Criminology, Simon Fraser University, 1998.
- Windsor Occupational Health Information Service. *Protecting Our Health: Immigrant Women, Work and Awareness*. Windsor, ON: Windsor Occupational Health Services, June 1995.
- Wyshak, G. & G.A. Modest. "Violence, Mental Health, and Substance Abuse in Patients who are seen in Primary Care Settings." *Archives of Family Medicine*. Chicago, IL: American Medical Association, 1996: 441-447.
- Yam, Marylou. "Wife Abuse: Strategies for a Therapeutic Response." *Scholarly Inquiry for Nursing Practice: An International Journal*, 9, 2 (1995): (no page numbers).
- Zulman, Arthur. "The Hidden Trauma of Immigration." *Australian Family Physician*, 25, 11 (November 1996): 1707-1710.

APPENDIX I: ENVIRONMENTAL SCAN QUESTIONS

1. On the basis of your experience, are women likely to tell their doctors (GPs) about the abuse they are experiencing?
2. What kinds of responses have they encountered? Is there any difference whether it's a male or female doctor?
3. Is the situation any different for immigrant women or Aboriginal women? Is it better when the doctor is from their own ethnic or language group?
4. Have you done any hospital accompaniments?
5. What kinds of responses did you see in terms of how the women were treated by nurses? By emergency physicians?
6. On the basis of your experience, how do specialists, alternative health care personnel, public nurses, physiotherapists, or chiropractors respond to woman abuse? Are some more responsive than others? Can you give us any examples?
7. Was the response any different for immigrant women or Aboriginal women?
8. Are you aware of any policies governing how the health sector should respond to women survivors of abuse?
9. Are you aware of how any laws might impact on the delivery of health care services to immigrant & refugee women, and to Aboriginal women?
10. Is documentation / record keeping by doctors or nurses an issue for women survivors seeking these services?
11. Does the presence of children influence women's decision to disclose abuse to health care personnel? Can you tell us how?
12. What would you suggest is an effective way of communicating information to immigrant and refugee women about health care issues related to violence? [e.g. putting pamphlets or material in temples, grocery stores, schools, ethnic media, local media, etc.; have public nurses conduct outreach in these communities?]
13. Do you have any views on how the health care system **should** respond to women – from doctors, nurses to emergency department staff?
14. Would you describe your area as rural or urban? Do you think there are any differences in rural versus urban areas regarding how the health care system responds to women survivors of violence? To immigrant & refugee women? To Aboriginal women?

APPENDIX II: FOCUS GROUP QUESTIONS – SERVICE PROVIDERS

1. Based on your experience, where do immigrant women who are abused most often seek help and support?
2. Are you aware of existing supports and services that may be available to these women?
3. What are the most frequent problems / barriers that immigrant women who are abused encounter when seeking help and support?
4. Are immigrant women who are abused likely to seek the help of health care professionals, e.g. doctors, nurses, emergency departments?
5. Do you provide accompaniment to immigrant women who are abused when they are seeking health care? If so, can you give us examples of how health care personnel treat these women? (e.g. how do nurses, doctors, emergency personnel, clinic staff respond to these women?)
6. From your experience, do immigrant women tend to visit the same physicians as their husbands / partners and family?
7. Are you aware of any issues or problems that have resulted because of this?
8. How do immigrant women access information about health-related information and care regarding abuse / violence / 'family violence'?
9. Can you suggest ways in which immigrant women who are experiencing abuse / 'family violence' can better access health care?
10. Can you suggest ways in which the health care system can better respond to the needs of immigrant women experiencing violence?
11. Would it help immigrant women in specific communities if they were provided with a list of physicians who spoke their same language?
12. Would it help immigrant women experiencing abuse to be knowledgeable about the health care system, and in particular information related to violence?
13. Would it be better if all immigrant women were issued their medical cards under their own name? See a separate physician? Be aware of confidentiality criteria that is required of physicians and nurses?
14. Would immigrant women experiencing abuse be better served by public nurses rather than physicians?
15. Can you offer any other suggestions for improving the delivery of violence related health care information and services to immigrant women who are abused?

Refugee Women

While we have generally discussed immigrant women, the issue of refugee women also merits consideration. Do you have any thoughts about the barriers and difficulties that refugee women who are experiencing violence may encounter?

Can you suggest ways in which the health care system can be improved to better serve the needs of refugee women who are experiencing violence?

APPENDIX III: QUESTIONS FOR FOCUS GROUP PARTICIPANTS (IMMIGRANT WOMEN)

Preamble concerning confidentiality, consent forms and objectives of the project.

Demographic Information

1. How long have you been in Canada?
2. When you arrived in Canada, did you pick a doctor for yourself / family?
3. How did you find your doctor (through referral from a relative, friend, agency?)
4. Did the doctor treat your whole family?
5. How long were you in an abusive relationship?
6. What kinds of health-related problems did you experience as a result of the abuse?

Encounter with the Health Care System

1. Did you ever tell your doctor about the abuse / violence?
What was her / his response?
2. Did you ever tell a nurse?
What was her / his response?
3. Did you ever go to an emergency department of a hospital?
How did the person there treat you?
4. Did you go to a walk-in clinic?
How did the person there treat you?
5. Did you experience any problems with how you were treated by the health care professionals?
6. Do you feel that you received adequate treatment and health care?

Supports & Needs

1. What health care services – information, support, advocacy, services – were helpful for you when you left the abusive relationship?
2. Based on your experience, what kind of health related (medical, psychological) information would a woman need when she is in or leaving an abusive relationship?
3. Would it have been beneficial to have a nurse or doctor who spoke your own language or was from your own community / cultural background?

4. Was it easy for you to get information about violence related health care issues in your language?
5. Who or where did you get this information from?

Recommendations

1. Should there be more information made available in your language about violence related health care issues?
2. How could information be given to you and other women, in a safe and easy to understand way? Or, what is the best way to get this information about violence related health care to you and other women?
3. In what ways can the health care system be made more accessible in terms of providing adequate treatment to women who have experienced abuse?

Is there anything else that you would like to add?

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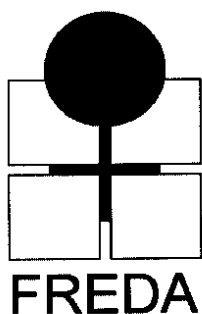
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Feminist Research, Education, Development & Action Centre

The Feminist Research, Education, Development and Action (FREDA) Centre is one of five violence research centres funded by Health Canada, and the Social Sciences and Humanities Research Council of Canada.

Since its inception in 1992, the FREDA Centre has worked with numerous groups in British Columbia on various aspects of violence against women and children. The Centre has also published a report dealing with violence against women in the Yukon.

FREDA is a collaboration of community groups, and feminist academics from Simon Fraser University and the University of British Columbia. The Centre's mandate is to undertake and promote action-based research on violence against women and children. As well, the FREDA Centre works with community groups to forward recommendations for action to relevant policy makers and mandated agencies.

For more information, or to order other publications, please contact the FREDA Centre at the following address:

The Feminist Research, Education, Development and Action Centre
515 West Hastings Street, SFU Harbour Centre
Vancouver, BC, V6B 5K3

Telephone: 604-291-5197

Fax: 604-291-5189

E-mail: freda@sfu.ca

Web Site: www.harbour.sfu.ca/freda/