

Les obstacles à l'accès aux services de soutien et à leur utilisation chez les immigrantes victimes de mauvais traitements

Sepali Guruge et Janice Humphreys

Le soutien social est un élément essentiel pour les femmes victimes de violence infligée par un partenaire intime. Lorsque le soutien informel qu'elles reçoivent de la part de leurs proches, leurs amis et leurs voisins est limité, les femmes dans cette situation se tournent en général vers les professionnels de la santé, les travailleurs sociaux et les services d'établissement. Dans cette étude qualitative et descriptive, des dirigeantes communautaires qui sont aussi des immigrantes de première génération au Canada décrivent les difficultés qu'éprouvent celles-ci à accéder aux services établis. On constate l'existence d'un certain nombre de facteurs qui influent négativement sur leur expérience : le manque d'information sur les services; des services et des stratégies d'intervention inadéquats; l'absence de services sensibles aux différences culturelles et linguistiques; le manque de transférabilité et de coordination des services; les préoccupations liées au respect de la vie privée; les pratiques discriminatoires et racistes ancrées dans les services et la prestation. Pour améliorer les soins aux femmes victimes de violence infligée par un partenaire intime dans un contexte postmigratoire, les professionnels de la santé devront collaborer avec les travailleurs sociaux et des services d'établissement et trouver des solutions aux obstacles structurels qui limitent l'accès aux mesures de soutien et à leur utilisation.

Mots clés : violence, culture, santé des femmes, soutien social

Barriers Affecting Access to and Use of Formal Social Supports Among Abused Immigrant Women

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Social support is critical for women dealing with intimate partner violence (IPV). When support from their informal sources, such as family, friends, and neighbours, is limited, women tend to access services provided by health professionals, social workers, and settlement workers. In this qualitative descriptive study, community leaders who were also first-generation immigrants describe the complexities of immigrant women's access to and use of formal supports to deal with IPV in Canada. The findings show that a number of factors negatively shape the experiences of these women: lack of familiarity with services, inappropriate services and intervention strategies, lack of culturally and linguistically appropriate services, lack of portability and coordination of services, confidentiality concerns, and discriminatory and racist practices embedded in services and service delivery. In order to improve care for women dealing with IPV in the post-migration context, health professionals must collaborate with social workers and settlement workers to address structural barriers that limit women's access to and use of formal social support.

Keywords: abuse and violence, cultural, cross-cultural and gender, culture, domestic violence and women's health, social support

Introduction

Intimate partner violence (IPV) is the most common form of violence against women worldwide, cutting across ethnocultural and socio-economic backgrounds. Defined as threatened or actual physical, sexual, psychological, or verbal abuse by a current or former spouse or non-marital partner (Health Canada, 1999), IPV is linked to a range of physical and mental health problems that may persist long after the violence has ended. Its rates vary across communities and countries. In a recent World Health Organization (2006) study, the rates of physical or sexual violence (or both) among ever-partnered women ($N = 24,000$) in 10 countries ranged from 15% to 71%. In Canada, the 2000 *General Social Survey* (GSS) of 14,269 women in 10 provinces, 37% of women who had ever been in a marital or common-law relationship experienced at least one IPV incident. In 2006 alone, police across Canada received 38,000 reports of IPV, with women accounting for 83% of all victims (Statistics Canada,

2008). Attempts to assess prevalence rates of IPV in immigrant households in Canada through secondary analysis of GSS data (Hyman, 2002), however, have been hampered by the limitations of the original survey (e.g., exclusion of those who spoke neither English nor French).

Women's responses to IPV are both individually and socially shaped. In particular, they are shaped by the supports and services that are available and accessible within a specific physical and social environment. While there is considerable health sciences literature on IPV and social supports among women born in Canada and the United States, the role of social support in Canadian immigrant women's responses to IPV, and their use of and access to such support, remain under-investigated (Cottrell, 2008; Hyman, Forte, Du Mont, Romans, & Cohen, 2009). This article (which is based on the findings of a doctoral study) reports, from the point of view of a group of first-generation immigrant community leaders who provide services to Sri Lankan (SL) Tamil women, the barriers they face in accessing and using *formal* social supports to deal with IPV.

Background

Support can be instrumental, informational, emotional, and appraisal (House & Kahn, 1985) and can be provided by members of informal or formal social networks (Stewart, 1989, 1993; Stewart et al., 1997). Informal social networks include members of one's immediate and extended family, friends, and neighbours, whereas formal support may be provided by health professionals, crisis hotline workers, shelter personnel, police officers, social workers, or settlement workers. Social support for women dealing with IPV can include financial assistance, links to resources, information for seeking protection, and/or ways to reduce women's isolation (Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Goodkind, Gillum, Bybee, & Sullivan, 2003; Kaukinen, 2002; Moe, 2007; Rose, Campbell, & Kubb, 2000). Not all women dealing with IPV have family members, friends, and neighbours with the time, information, and means to help them. In some cases informal networks can also be a source of conflict and stress if the network members do not believe the women, blame them for the abuse, minimize the abuse and its impact, maintain silence or secrecy, or discourage the women from seeking "external" help (Goodkind et al., 2003; Moe, 2007). In other cases support from family and friends may be inadequate to prevent abuse from continuing or escalating. As a result, women dealing with IPV may seek *formal* social support.

Immigration to another country results in the loss of informal social networks and supports (Simich, Beiser, Stewart, & Makwarimba, 2005),

the impact of which is compounded by language barriers, un/underemployment, unsafe living conditions, and the racism and sexism in society at large (Guruge & Collins, 2008). Under such circumstances women can become easy targets for abusive husbands (Fong, 2000; McDonald, 2000; Yoshihama, 2008). A number of Canadian and American studies have shown that the moderating role played by informal social supports in reducing the prevalence and/or the impact of IPV pre-migration may be lost post-migration. For example, in some societies wives' relatives play a strong role in imposing authority over husbands and their actions and/or in offering sanctuary to abused women (Bui & Morash, 1999; Hyman, Guruge, & Mason, 2008; Hyman, Mason, et al., 2006; Morrison, Guruge, & Snarr, 1999). The loss of such supports following migration may force women to turn to formal services. The presence of family, friends, and neighbours post-migration does not guarantee support. Therefore, women might turn to formal supports to deal with IPV. Hyman, Forte, et al. (2006) found that recently arrived immigrant women were more likely to report IPV to the police (50.8% vs. 26.0%) but less likely to use social services (30.8%) than their long-term counterparts (52.8%) (the latter group's rates being similar to those of the Canadian-born). Other studies have shown that immigrant women underutilize shelters, hotlines, and health, legal, and social services for IPV (Du Mont, Forte, Cohen, Hyman, & Romans, 2005; Erez, Adelman, & Gregory, 2009; Fong, 2000; Gillum, 2009; Hyman, Forte, et al., 2006; Landrine, Klonoff, Corral, Fernandez, & Roesch, 2006; Lasser, 2006; Lee & Hadeed, 2009; Malley-Morrison & Hines, 2007). The lower use has been attributed to multiple and intersecting barriers faced by immigrant women, including linguistic barriers, financial constraints, social isolation, and discrimination.

Building on the community's interest in addressing post-migration IPV, we conducted a study of IPV in the SL Tamil community. Sri Lanka is an island nation southeast of India. Over the past 25 years the country has suffered the consequences of an ongoing civil war between the Sinhalese government and the Liberation Tigers of Tamil Eelam, a Tamil militant/separatist group that has put forward an agenda for full independence and a separate homeland for Tamils. According to some estimates (e.g., Cheran, 2000), over the years approximately 500,000 Tamils have been internally displaced and more than a million have left Sri Lanka seeking residency in various countries. Canada has been the favourite destination and is home to the largest SL Tamil community outside of Sri Lanka.

In Sri Lanka, informal social support systems — networks of friends, family, and community members — are “the most sought after method of support” for women dealing with IPV and “are seen as a constant source of help” (Pinnewala, 2009, p. 88). Often, a woman will receive

primary support from her mother and other members of her immediate and extended family, who offer advice, shelter, and food, and even assault the abuser (Wijayatilake, 2003). Post-migration changes in social support among SL Tamils have been reported. For example, in a US study with Sri Lankans (Tamil and Sinhalese) (Meemaduma, 1999), participants expressed a hierarchical preference for support network members; without exception, if family members were available, they were the primary choice of support, followed by other Sri Lankans. Participants indicated that they had moved from a “world within which day-to-day responsibilities were shared, in which the support provided was unconditional, and in which family/kin rights and responsibilities were valued and functional” (p. 205) to a world where they had little or no informal social support. A Canadian study with SL Tamils reports similar findings, and concludes that the loss of social networks and supports post-migration can lead to an increase in both IPV and women’s vulnerability to it (Morrison et al., 1999).

Hyman, Mason, et al. (2006) and Mason et al. (2008) report SL Tamils’ perceptions of and responses to IPV. Both publications (resulting from a study conducted in Toronto) note that, irrespective of their age, participants defined IPV broadly and referred to a range of forms of IPV (consistent with those described by the World Health Organization [2006]). The authors conclude that health professionals need to understand the multiple and complex barriers that women face in dealing with post-migration IPV. However, we found no Canadian studies that explore in depth the complexity of the barriers that SL Tamil immigrant women face in accessing and using services for IPV.

Purpose and Research Question

The purpose of the overall study was to examine the factors that contribute to the post-migration production of IPV in the SL Tamil community and the factors that shape women’s responses to it. The research question addressed here is: *From the perspective of first-generation SL Tamil community leaders who provide services to abused women, what are the barriers that SL Tamil women face in accessing and using formal supports to deal with IPV?*

Methods

Qualitative descriptive methodology (Sandelowski, 2000) was used in this study. Data were generated through individual interviews and focus groups over an 8-month period. This article is based on the results of individual interviews with 16 community leaders, themselves first-generation SL Tamil immigrants, who had facilitated women’s access to

and use of formal social support and had advocated for abused women both within the SL Tamil community and in Canadian society. Because of their (formal) work experience and their (informal) relationships in the community, the participants were well informed about the various barriers faced by SL Tamil women at the micro, meso, and macro level of society in accessing and using formal supports for IPV.

The participants represented the demographics of the Tamil community in Canada in terms of age, birth city, time of leaving Sri Lanka, and duration of stay in Canada (see Table 1 for demographic details). They were recruited from various parts of Greater Toronto using a combination of convenience, snowball, and purposive sampling. They were interviewed at locations of convenience to them, which most often was their office before or after working hours. Overall, the interview questions were open-ended and unstructured, to allow for the emergence of ideas. (Some of the questions posed are listed in Figure 1.) Probes were used to inquire about specific topics, such as the kinds of formal social support abused SL Tamil women accessed and the types of barriers they faced.

The interviews were conducted in English and lasted approximately 2 hours on average. They were audiotaped and transcribed verbatim. Data were analyzed using inductive thematic analysis (Bryman, 2001) by reading and coding transcripts sentence by sentence, examining the codes

| Characteristic | | F (%) |
|----------------------------------|--------|--------------|
| Gender | Female | 10 (62.5) |
| | Male | 6 (37.5) |
| Age Group, Years | 30s | 6 (37.5) |
| | 40s | 5 (31.2) |
| | ≥ 50s | 5 (31.2) |
| Birth City | Jaffna | 9 (56.3) |
| | Other | 7 (43.8) |
| Decade Left Sri Lanka | 1970s | 1 (6.3) |
| | 1980s | 8 (50.0) |
| | 1990s | 4 (25.0) |
| | 2000s | 3 (18.8) |
| Number of Years in Canada | 1–5 | 6 (37.5) |
| | 6–10 | 2 (12.5) |
| | 11–15 | 6 (37.5) |
| | 16–20 | 2 (12.5) |

Figure 1 *Examples of Individual Interview Questions*

Who do Tamils turn to for help and support in Sri Lanka/Canada?
What kind of support do Tamils expect/receive from such people?
Who do Tamil women in Sri Lanka turn to for support to deal/cope with wife abuse, in particular? What kind of support do women experiencing abuse get from them?
Who do they go to for such help and support after coming to Canada?
How do you think Tamil women's responses to wife abuse are influenced by their friends, family, and neighbours, the Tamil community, and the Canadian society?
What kinds of support do Tamil women experiencing wife abuse need/seek/get from health, social, and/or settlement workers in Canada?
What are the barriers Tamil women face in accessing/using formal supports and services in Canada?

for the ways in which they converged or departed within and across interviews, and grouping significant codes as subthemes and themes. Strategies used to enhance trustworthiness (Lincoln & Guba, 1985) included prolonged engagement, member checking, peer review, audit trail, reflexive journaling, and thick description.

Findings

The findings reveal that women experienced a number of changes in their informal social networks and associated sources of support. We will briefly describe these changes to set the context for why women are forced to seek formal social supports, before presenting our findings on the barriers they faced in accessing and using such supports.

Not surprisingly, women's social networks were smaller post-migration than pre-migration. Because of the smaller social networks and resultant social support limitations, women and their husbands often relied solely on each other for instrumental, financial, emotional, and informational support, which resulted in increased family stress and conflict. In addition, the structure/composition of the networks was changed. Prior to migration both men and women had access to their natal families. Although a woman can be the first family member to arrive in Canada, more often it is the man who immigrates first due to a number of challenges related to leaving the war-torn country of Sri Lanka and the restrictions with respect to refugee admissibility criteria.

Typically the man, once settled, sponsors his natal family along with his wife and children. This sequence of events results in a situation wherein the couple live with or near the husband's family while the wife's family might not yet have even immigrated to Canada.

In Sri Lanka, a woman's family and friends often act as a buffer against stress, conflict, and abuse and provide her with support, advice, and resources to deal with IPV. One participant described the structure of the pre-migration informal social network that serves to impose some limits on a husband's power and authority:

If you understand our [marriage] system back home, it allows women to stay in their own house and men have to come into [wives'] house [and] into wives' network. Then he can't just do things on his own right yet. He has his power, but that doesn't mean he can do as much as he likes.

Another participant described the kind of support an abused woman can expect from her informal social network:

In Sri Lanka, she can leave . . . maybe to live with her parents . . . even if the parents live somewhere else . . . she can go live in neighbour's house, and the men in that house will protect her, together with the women.

Such a system is not available post-migration, the consequence of which is reduced support for women who are the victims of IPV.

Even when their own family members were present in the Toronto area, women did not always receive adequate support to deal with IPV. The participants gave the following reasons for this: the pace of life in a large city; long work hours; travel distance and transportation challenges; and the value placed on individual rights, freedom, privacy, and family privacy in Canada:

[In Canada] everyone is sort of cut off . . . there's very little contact within families. Even if your neighbour [from Sri Lanka] is here in Toronto, you may have to take three buses to go [and then sometimes s/he] doesn't have time to talk to you.

Even if they have the extended family here, we shouldn't be interfering in other persons' affairs or matters, right? That is the Canadian system. The people don't interfere in other people's matters, because it can backfire. So they just keep their distance from them.

In Canada, as is sometimes the case in Sri Lanka as well, the presence of family placed pressure on women to remain married, even when family members were aware of the abuse, in order to preserve the family's status in the community. The conflict that is driving Tamils out of Sri Lanka has made family harmony ever more important. Participants told

of the spoken and unspoken pressure that women felt from the general community in this regard:

This community that can be supportive is not at all supportive. Now, for example, if she leaves the husband and she attends a function, she is put aside and she's not even allowed to [take part in] the event.

The community perception of self and being part of the community are important considerations for Tamil women (as for most women from racialized communities) because of the various forms of subtle and overt racism and “othering” based on skin colour, dress, accent, and behaviour that they experience in Canadian society.

Within this context, women dealing with IPV sought *formal* social supports. Often, however, their access to and use of such supports were negatively shaped by a number of interrelated barriers. These are discussed next.

Lack of Familiarity With Available Services

Participants remarked that formal social supports are not common in Sri Lanka. Therefore, most women, especially those who had arrived recently, who were isolated, or who were not fluent in English, were unfamiliar with the kind of supports and services available to them, such as shelters, welfare benefits, subsidized housing, legal aid, and counselling:

Maybe the woman has language issues. If she is a woman who has contacts outside, who's going outside, and being able to talk to someone, she will know about services. Other women have no way to know who does what and what helps.

As the excerpt suggests, a number of factors led to women's lack of familiarity with available services, which in turn shaped their responses to IPV.

Inappropriate Services and Intervention Strategies

Another limitation identified by the participants was the lack of services and interventions directed at immigrant women. One participant highlighted the lack of fit between the kind of services often offered to abused women and the kind of services often expected by an abused Tamil woman:

We don't need to think like Westerners, that we have to go to a psychologist or a consultant and sit and talk about this experience, but maybe find some creative approaches to come together to help people, some practical ways [of dealing with] a lot of basic things like getting jobs, keeping occupied, and having some room to [have] fresh air in your mind.

The models and frameworks for the services focusing on immigrant women were said to create barriers for women and to be a source of frustration for service providers because the models/frameworks did not necessarily capture the complexity of the women's lives or the multiple oppressions they experienced. For example, the women and their husbands faced many issues together, such as underemployment and difficulty securing safe housing owing to racism. Participants saw these common issues as meriting as much attention as the women's individual need for services.

Lack of Linguistically and Culturally Appropriate Services

Participants also highlighted the problems that women encountered in accessing and using services that were not culturally and linguistically appropriate. One participant commented on a situation that she had faced on numerous occasions:

Even in the middle of the night the shelter workers call me to interpret. Sometimes Tamil clients couldn't express their problems or wishes to the workers, so they — in a desperate way — give my number to the worker and ask them to call me. Imagine if I say no — then the clients have to wait till the next day. So I feel obliged. But for me it's hard. I also have to cook, put my children to bed, and go to work the next day.

Some participants worried about calls going out to the community for interpreters, since a woman's safety could be jeopardized if a message about her whereabouts were to be shared with someone connected to her family. Some women were forced to return to their abusive husbands because their family members found out which shelter they were staying at. Participants also spoke of women returning to their abusive husbands because of difficulties they encountered due to the lack of linguistically and culturally appropriate services in shelters, hospitals, and clinics.

Lack of Portability of Services

Participants noted that abusive husbands often purposefully and systematically isolated their wives by restricting their access to the telephone and/or denying them bus fare. Such women had no means of reaching providers of formal social support:

We provide services to women. But the women have to get out of their houses and come. It's a time factor, it's a geography factor, and it's commuting.

It is difficult for a woman to go by bus. Even if she knows about the place and how to get there, can she go and come back before her husband comes? He will be calling to check whether she is home.

You know, even reaching out for help . . . where to call? Can you call [organization's name]? Can you call [organization's name]? Are they going to go to these women? No! Nobody in the world is there to go and help this woman when she is alone and she needs help. There is no such system.

Participants said that there should be a way for health professionals, social workers, and settlement workers to meet women in their homes or nearby, in order to improve women's access to service providers without jeopardizing their safety. However, home visiting was seen as having legal implications for the service providers and their agencies — neither individual workers nor their institutions were willing to take the next step. This illustrates how policies and regulations serve to shape women's access to services and their responses to IPV.

Lack of Coordinated Services

Participants identified the lack of interconnected services and of coordination between the various health, social, and settlement organizations:

One of the settlement workers sent this woman to the inappropriate person. She went there, then the person sent her to another person. At that place she didn't get the proper help, and she came to me. Oh my god! I felt so sorry for her. She has language problems, she is not young, she is scared, too, and her only child is not happy with her decision, and she is feeling guilty about disclosing abuse.

A number of participants noted women's frustration with not being able to have most of their concerns addressed in one place, especially for the women who knew little about services and locations, faced language barriers, were constrained financially, and had limited access to transportation. Most of the women thus affected were those most marginalized by unequal access to socio-economic resources.

Confidentiality Concerns

Like most women dealing with IPV, abused Tamil women preferred to keep their experience confidential. This was viewed as particularly important in the case of Tamil women because of pressures from and conflicts within the community pertaining to the impact of divorce and separation on children and other family members. However, for those not fluent in English, keeping one's situation confidential within the community appeared to present a dilemma and a challenge for a number of reasons, some of which are captured in the following comments:

I think they face a difficult dilemma during crises. They need someone who can speak the language. But still they don't want to talk to Tamil consultants, because the word may get out. So it's really difficult.

Whenever they talk about the woman, other clients are also there. Sometimes the volunteers move around. So, imagine, how would the women see this?

These excerpts highlight the serious concerns about lack of respect for confidentiality. The latter comment also alludes to a lack of closed, private space in which to interview women or discuss cases — the result of insufficient government funding for agencies that serve immigrants.

Discriminatory and Racist Practices

Another concern was the various discriminatory and racist practices encountered by women seeking formal support. Failure to provide culturally and linguistically appropriate services was interpreted by participants as discriminatory and racist in that it conveys the message that the services will be provided only if one speaks English and adheres to “mainstream” cultural values and beliefs. Participants cited a number of other discriminatory practices:

I've heard many stereotypical ideas about visible minority people. The service providers' way is to tell the women, “Do as I say.” If you don't, the services are withheld or they don't provide the services in the way the woman wants. Visible minorities are being treated differently. A lot of Tamil people functioning as interpreters have seen women go through very difficult crisis situations without an interpreter at all. Things are understood in various manners, and this creates [for] the woman even more problems, like child custody stuff.

Participants also highlighted the challenges faced by service providers because of their heavy workload and lack of sufficient resources to help the number of clients sent to them. They indicated that services addressing the needs of immigrant women remain in the margins of government funding agendas, and that many agencies that provide services to immigrants have to reapply for funding annually. Other concerns raised by participants were related to eligibility criteria for services (such as women having to show their immigration documents), systemic intrusions into their lives (such as the need to justify their income or expenses), and the threat of deportation for breaking sponsorship as barriers to the use of such services.

Discussion

Limitations of Formal Social Supports and Services

The lack of information about available services and the lack of culturally and linguistically appropriate services were highlighted in this study.

Various studies conducted in Canada and the United States (e.g., Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; Kulwick & Miller, 1999; MacLeod & Shin, 1990, 1993; Murdaugh, Hunt, Sowell, & Santana, 2004) have noted that women often have little knowledge about services available for dealing with IPV. According to Huisman (1996), “domestic violence agencies” in the United States often have little or no ties to immigrant communities and tend to engage in few outreach efforts. Other authors report that even when women are aware of services they may not view them as culturally or linguistically relevant (Perilla, 1999; Rodriguez, Bauer, McLaughlin, & Grumbach, 1999). Many of the women interviewed for MacLeod and Shin’s (1993) Canadian study across a number of immigrant communities expressed the view that “existing services with their emphasis on individualism and centred on North American culture and values do not validate nor recognize their cultures and value systems” (p. iii). Bui (2003), Tran and Des Jardins (2000), and Runner, Yoshihama, and Novick (2009) also highlight language barriers that immigrant women face in attempting to access and use services such as hotlines, shelters, and counselling and legal services.

In the present study as well, women experienced geographic and transportation barriers when trying to reach various agencies in order to obtain formal supports. Similar findings are reported from a Canadian study with Chinese immigrants (Fong, 2000), an American study with Hispanics (Murdaugh et al., 2004), and a recent study with African-American women dealing with IPV (Gillum, 2009). Concern about getting to services and returning home before the abusive partner returns or calls is not unique to Tamil women or to immigrant women in general. However, coupled with language barriers and not knowing where to obtain services, this concern makes accessing and using formal social supports even more difficult for immigrant women. The challenge is even greater if the woman and her children require a number of services offered at different locations, requiring multiple visits to different agencies. One of the reasons for the piecemeal approach to services for women dealing with IPV is the low priority given by decision-makers to needs that are created at the intersection of racism, classism, and sexism.

Service eligibility requirements such as proof of citizenship or knowledge of English were seen by participants as deterring SL Tamil women from accessing formal services. Similar findings are reported for immigrant women in other studies conducted in Canada (Bernhard, Goldring, Young, Berinstein, & Wilson, 2007; Fong, 2000; McLeod & Shin, 1990, 1993) and the United States (Erez et al., 2009; Gillum, 2009; Sorenson, 1996). Also consistent with other findings (Arat-Koç, 1999; MacLeod & Shin, 1990, 1993), in the present study women’s use of formal services

was hindered by immigration policies that impose financial obligations on the sponsor/sponsored dyad and threaten deportation of both parties if expectations are not met. These policies are based more on economic interests than on human rights concerns.

The present findings also suggest the need to re-examine both the kind of interventions being prescribed by health professionals and the appropriateness of the models and theories favoured by agencies serving abused women and their families. MacLeod and Shin (1993) explain that “counselling approaches which do not emphasize practical approaches are seen by many women as all talk and no substance, as inappropriate personal intrusion by outsiders, and as patronizing” (p. ii). Fong (2000) also questions the appropriateness of implementing Western models and theories in counselling and social work, especially in the context of violence against women.

Implications for Programs and Policies

It is paramount that community-based outreach programs for health promotion and violence prevention be developed and situated in apartment buildings, schools, and other central locations in the community. Information about IPV services for women should be distributed through multiple channels, such as television programs, community newspapers, daycare centres, schools, groceries, workplaces, libraries, places of worship, and community organizations. As proposed by Hanby (2000) and Trickett (1996), health professionals should identify and build on those aspects of religious beliefs and cultural values that support non-violence and rely on community strengths. Community-based health promotion can also focus on building supportive relationships within the community and on breaking the silence around IPV and minimizing stigma. Concerns have been successfully addressed through community theatre, dance, and drama (P. Kanthasamy, personal communication, August 15, 2008; Shirwadkar, 2004). Such work, however, must be undertaken within and with communities.

In the present study, women who were able to access formal services expected to have all their concerns addressed in one place, expected services to be coordinated and interconnected, and expected to have their wishes regarding confidentiality respected. Latta and Goodman (2005) observe that “once women overcome many hurdles on the path to seeking services, these services must be able to provide adequate responses to their needs and places where they can feel safe” (p. 1458). Since not all programs will have the expertise or the capacity to provide services in one place, better coordination between agencies is needed. According to Whitaker et al. (2007), a network-based approach to integrated services facilitates referral and follow-up among agencies, ensur-

ing that women “are not forced to weave their way through a complex web of social systems” (p. 205). Furthermore, agencies that provide a range of health, social, and settlement services in one place may be able to reach women who might not seek help specifically for IPV because of the stigma attached to it.

Our study participants identified the need for culturally and linguistically appropriate services. Similarly, based on their US studies, Gillum (2009) and Ingram (2007) cite the need for culturally and linguistically appropriate interventions that address the many factors confronting women who are grappling with the multifaceted issue of IPV. Latta and Goodman (2005) note that the “one size fits all” approach to services does not address “the many different cultural and contextual factors that uniquely affect the experiences of different ethnic groups” (p. 1458). A culturally and linguistically appropriate approach must also take into account the diversity of women in each ethnocultural community and allow for the tailoring of strategies so that each woman can respond to IPV in her own way. Agencies and institutions “need activities to promote cultural competence and collaboration, specific education and outreach activities and agency-level changes in procedures and policies to facilitate more culturally competent services” (Whitaker et al., 2007, p. 191). As part of their mandate to address cultural competence and cultural appropriateness, agencies must address the racism that is inherent in the ways in which they provide services, their eligibility criteria, and their attitude with respect to which clients are “deserving” of support. In the process, IPV service providers and their agencies must address those concerns that are particularly critical for women, such as intrusion, control, trauma, and violence resulting from the threat of deportation, welfare surveillance, and systemic racism.

Community partnerships and participatory research are ideal means of developing healthy public policies that are relevant for immigrant communities. The insights gained from such approaches may also help to change policies that negatively affect women’s health and that address or even break down structural barriers. Structural barriers include lack of interpreters, confidentiality breaches, lack of safe, private space in clinics and agencies providing services to women dealing with IPV, and ethnocentrism and racism. In addition, health researchers must sharpen their focus on health promotion and violence prevention among all subgroups of the Canadian population, in order to address IPV more proactively and in the broader context of violence against women in society.

The findings of this study indicate the need for a paradigm shift in the planning, funding, and delivery of services to Canadian immigrant women dealing with IPV and suggest a number of recommendations:

- Develop programs that can be delivered at various locations and that incorporate portable modes of delivery (such as mobile health units).
- Develop programs in collaboration with the community and relevant stakeholders.
- Build and maintain complementary partnerships between mainstream and ethno-specific agencies.
- Recruit and train women who are fluent in the target language and ensure that they are aware of the nuances that can affect different communities that speak the same language.
- Institute mandatory annual training of all service agency staff in the areas of domestic violence and racism.
- Foster an environment that is conducive to the confidential sharing of information.
- Use diverse media and channels to distribute information about available services to the intended audience. Employ culturally appropriate pictures, symbols, and language.
- Develop community-appropriate health interventions that incorporate cultural values, beliefs, norms, and attitudes in the pre- and post-migration contexts. Know that these change over time.
- Deliver a range of services under one roof.
- Develop strategies and interventions that are practical and problem/solution-oriented and that address the needs of both the woman and her family. For each situation, develop solutions in collaboration with the woman herself.
- Address social determinants of health so that women can deal with IPV in a way that is appropriate for them and their families. In addressing social determinants of health, health professionals should work in partnership with social, settlement, and legal workers.
- Address various practices and rules and regulations that are based on systemic racism in the planning, funding, and delivery of IPV services to immigrant women. Conduct gender, race, and class analyses at all levels of service delivery in order to address the limitations of current policies and to develop new policies in the health, social, and immigration and settlement sectors.
- In partnership with women, men, and their communities, develop interventions that address the needs of immigrant women dealing with IPV and its aftermath and that could serve to prevent violence.

Limitations of the Study

The main limitation of this study relates to the source of the data, which is not the women themselves. However, each of the participating community leaders had worked in different capacities, with many SL Tamil

women, in order to better deal with the issue of IPV. Thus, these individuals — themselves Tamil immigrants — acted in a sense as translators and cultural interpreters for the researchers, to help us more fully understand the struggles of abused SL Tamil women.

Conclusion

Health professionals are responsible for delivering research-based care and support to persons of all backgrounds. However, the paucity of health research on IPV in the post-migration context has constrained the practice of health professionals. This qualitative study represents a step in revealing the complexities of women's access to and use of formal social supports post-migration. The limitations of formal support systems need to be addressed so that every woman can access the support she needs to deal with IPV in a way that is most suited to her unique situation. Truly appropriate and effective care for women coping with IPV post-migration is delivered in the context of the social determinants of health and is based on each woman's life priorities and lived realities. Health professionals should take into account the needs identified by women experiencing IPV and build on the women's strengths in order to advocate for the women and their families as they interface with a new environment and a new country.

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