Volume 43 N° 4 CJNR December / décembre 2011

CONTENTS / TABLE DES MATIÈRES

Health and Immigration/ *Santé et immigration*

McGill University School of Nursing

CJNR 2011 Vol. 43 Nº 4, 3–7

EDITORIAL

Dissemination of Knowledge and Information: Rethinking the Model

On a flight to Hawaii this past summer, after attending the 30th annual meeting of the International Academy of Nursing Editors (INANE) in San Francisco, I read John Howkins' book *The Creative Economy,* published a decade ago (Howkins, 2002).

The message of this book is how to rethink an economy when the product is ideas and intellectual property, rather than tangible goods, and how best to safeguard one's ideas from exploitation. It made me think about my role as an editor and how editors treat ideas and then disseminate them. Recall that I had just attended the INANE annual meeting, whose theme this year was the use of social media (i.e., Facebook, blogs, Twitter) to disseminate ideas. (For all intents and purposes, social media are currently being used by publishers and editors to market journals rather than to disseminate content.) The issue, of course, is that people are obtaining information in new and different ways, and, in order to adapt to the times, editors and publishers of scholarly journals will have to change their models for disseminating information and safeguarding ideas. The challenge confronting editors and publishers of nursing journals is how to develop new models for disseminating information that consumers will use. What will these new models look like? Where to begin rethinking models for the dissemination of nursing information?

It has been said that the best decisions are those that use information already at hand to shape the present and carve out the future. A good way to start is to consider what we know about how information is currently being disseminated and how people go about accessing information, in general and as it relates to nursing.

What Do We Know?

We know that our world has been dramatically altered by the advent of information technology. Few of us can imagine a world without the personal computer, the Internet, and the array of software options that have enabled so many to become marketers, publishers, and filmmakers. Facebook, Twitter, Skype, and YouTube have transformed how we interact with and relate to each other. They have forever changed how individuals acquire information, and from whom.

We know that information technology has forced industries that produce creative content — namely the music and film industries and book and magazine publishing — to reconsider all aspects of their respective fields of endeavour. These industries have been hard at work developing new models for producing and financing content. It began with the music industry a decade and a half ago, when illegal downloading from the Internet, counterfeiting, and piracy almost brought the industry to its knees. Meanwhile the television and film industries have had to find new ways of creating and distributing their products. And libraries and bookstores have had to reinvent themselves given the boom in Internet companies such as Amazon and the advent of online publishing, self-publishing, and e-books.

We know that academic publishers and editors are under pressure to rethink their publishing and business models. The sheer volume of information requires that it be made available in pre-digested form and be customized to the reader's needs (see *Zite Personalized Magazine*). The demand for evidence-based research requires that information be published and disseminated in a most timely manner.

We know that consumers expect to have information accessible 24/7. Libraries have gone virtual.

We know that consumers of information are no longer content with traditional ways of publishing. They want enhanced products. They want information presented in multimedia forms. They want to interact with those who produce the information. Some publishers, eager to take full advantage of online capabilities, are experimenting with prototypes for the future journal article. The design team at Elsevier, one of the world's largest publishers of academic journals, has been working in concert with the scientific community to develop several prototypes. The "article of the future" could feature a non-linear structure, integrated multimedia, interactivity, and enhanced graphical navigational capabilities (see www.articleofthefuture.com).

We know that consumers expect information to be available free of charge. The open-access movement took hold and gained momentum when publishers raised their subscription rates to exorbitant levels. Profits were seen by many as verging on the obscene (Monblot, 2011). Few consumers of information believe they should have to pay for content, particularly content that has been developed with public monies, as is the case with knowledge generated by the scientific community. Thus the traditional way of financing journals is no longer economically sustainable or viable and publishers are being forced to rethink not only their publishing model but their business model as well.

We know that we are living in an age when knowledge is not produced or controlled by an elite few. Blogging, Google, the Internet, and self-publishing have democratized the production of information and have made knowledge accessible to all. Everyone is a stakeholder in the knowledge creation-dissemination-uptake enterprise, and therefore everyone must become involved in creating the future. Everyone — to varying degrees — creates, disseminates, and consumes information. We are a world of writers, producers, and directors. Consider how many individuals take part in blogging or in producing YouTube broadcasts; anyone can become an eyewitness with the click of an iPhone or an iPad, and with a press of a Send button can participate in disseminating information that may well "go viral," change attitudes, and even begin uprisings, as happened in Egypt this past year!

We know that books, journals, and face-to-face conferences will become obsolete; people will share information directly through networking, teleconferencing or the use of various electronic devices.

Closer to "home," we know something about nursing and nurses' sources of information.

We know that the public, the nursing profession, and all major stakeholders involved in the delivery of health care, from clinicians to administrators to policy-makers, expect decisions to be based on the best available evidence; best practice guidelines are based on evidence.

We know that there has been exponential growth in the number of nursing journals available worldwide, from just two at the turn of the 20th century to ten by the late 1960s, along with phenomenal growth in their variety, presentation, and range of target audiences, so that today we have no fewer than 759 nursing titles from which to choose, 650 of which are produced in English. Yet only 4% of nurses read scholarly journals and 95% of nursing materials are published in journals.

We know that frontline nurses, when asked where they get their information, rank both nursing and medical journals at the bottom of their list of sources. The primary sources of information for these nurses are experience, formal training, conferences, and senior colleagues. Frontline nurses do use journals to obtain the latest research evidence, but the literature they consult tends to be secondary sources and pre-digested summaries rather than original studies (Estabrooks, 1999).

We know that the majority of nurses and the public at large want to access the latest information as soon as it is produced, in a form that they can understand, without having to spend too much of their time or having to alter their thinking processes.

Finally, *we know* that information is the latest, hottest, and most important commodity in this age of rapid change, when we all have to be knowledge workers — creating, managing, using, and exchanging knowledge — in order to survive and thrive. We are all stakeholders: clinicians, educators, administrators, researchers, patients, clients, families, communities, and the global world. Thus every stakeholder, each in our own way and in our own familiar universe, needs to participate in the creation of our own personal model of information dissemination, exchange, and uptake, and thereby contribute to the development of different prototypes designed to serve many different purposes.

Where to Begin?

There are many ways to start thinking about how to create new models. Howkins (2002) suggests a process of dreaming and analyzing as a means to develop new ways of thinking. His process, RIDER — **R**eview, **I**ncubate, **D**ream, **E**xcitement, **R**eality check — can be applied to the dissemination of information.

Review entails taking stock of what one knows, as I have just done, albeit in a cursory way. Each stakeholder asks: How are knowledge and information currently being disseminated, exchanged, and used? By whom? How effective are different forms of exchange? What are the challenges to be taken up now and in the foreseeable future?

Incubate entails letting the information sink in, reflecting on what it means, and giving it time to percolate. This could take minutes, hours, days, weeks, or months.

Dream. Once the information has been digested and the challenges understood, the next step is to imagine what the knowledge dissemination-exchange-uptake enterprise will look like. The dream could be developing different forms to disseminate the same information to different stakeholders; or establishing clearinghouses to permit evaluation of quality, checking of facts, and ranking of the information in terms of its validity; or a virtual classroom where only approved information that addresses the specific questions of stakeholders is available.

Excitement is generated when we let our minds and emotions take over, such as by asking "what if" questions about the dream. *What if* the same information were to be disseminated in different forms to suit the needs of different stakeholders — what would that look like? What different forms would be needed for each group (for example, interactive journals for researchers, pocket versions and podcasts for clinicians, Webnar for administrators)? What knowledge, skills, and expertise would be needed to develop each different source?

Reality check. The last phase in Howkins' creative process is determining what is realistic and what is "pie in the sky." What would it take to make the dream reality? How long would it take? Is the technology available now or would a platform have to be developed? How much would this cost? Would the benefits outweigh the costs? Would the information ultimately be used? How does one measure "impact"?

We live in exciting times. Sir Francis Bacon, who lived in the mid-1500s, is credited with the saying "knowledge is power." Throughout history, power rested in the hands of the elite: those who were educated and had access to knowledge — or knew how to create it. The rules have changed and so have the roles. Now, everyone has power, providing that they understand knowledge and the choices that are theirs to make.

Alvin Toffler, the 1970s futurist and author of the bestselling book *Future Shock,* has advised that the most effective way to control the future is to make the right choices today. The choices we make today about fashioning nursing's future knowledge enterprises will be with us for decades to come and will alter the profession. Let us be wise, bold, and creative as we move forward.

Laurie N. Gottlieb
Editor-in-Chief

References

Estabrooks, C. (1999). Will evidence-based nursing practice make practice perfect? *CJNR, 30*(4), 273–294.

Howkins, J. (2002). *The creative economy*. New York: Penguin.

Monblot, G. (2011). Academic publishers make Murdoch look like a socialist. *Guardian,* August 29. http://www.guardian.co.uk/commentisfree/2011/aug/29/academic-publishers-murdoch-socialist.

Toffler, A. (1972). *Future shock*. New York: Bantam.

CJNR 2011 Vol. 43 Nº 4, 9–20

Guest Editorial and Discourse

Health and Immigration

Anita J. Gagnon

In 2010 there were an estimated 214 million migrants worldwide (United Nations Department of Economic and Social Affairs, 2009). Migrants are persons moving to a geographical unit with the intention of settling indefinitely or temporarily in a place other than their place of origin (International Organization for Migration, 2011). Through World Health Assembly Resolution 61.17, *Health of Migrants,* the international community identifies migrant health as a priority and a human right and calls for member states of the World Health Organization (including Canada) to promote migrant-sensitive health policies and programs (World Health Organization [WHO], 2008). Nurse researchers have a key role to play in meeting this challenge, through their clinical knowledge of the needs of this population, their understanding of the social determinants of migrant health, and their expertise in a range of research methods that can be brought to bear to inform responsive policies and programs.

A migrant is referred to as "immigrant" when the speaker positions himself or herself in the place where the migrant is settling; the term "immigrant" thus describes the move relative to the destination (Urquia & Gagnon, 2011), and it is from this perspective that the majority of health-care providers in the Western world view the migrants with whom they are in contact — as the "other," moving in the direction of the Western world. However, the notion of unidirectional immigration is becoming obsolete. Movement trends now include secondary migration (i.e., to another place after the initial migration), serial migration (to more than two destination countries), and return migration (to the country of last residence) (Urquia & Gagnon, 2011).

On the other hand, the notion of "immigration" is still relevant. Nation-states have the legal right to decide who may cross their borders, the conditions under which they may cross, and the benefits and responsibilities entailed in so doing. Immigrants are categorized by official immigration-regulating agencies of receiving countries based on criteria defined by these countries. Although there is no universally accepted classification system, the immigration classes applied in a number of countries include the following: economic class (working-age migrants to be integrated into the labour force — these may include business persons, entrepreneurs, and skilled workers); family class (dependants of the main applicant, such as spouse and children, who are allowed to migrate for the sake of family reunification); and refugees (any persons who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, are outside the country of their nationality and are unable or, owing to such fear, unwilling to avail themselves of the protection of that country; UN High Commissioner for Refugees, 2005) (Urquia & Gagnon, 2011). Other labels might include "receiving-country citizen," "foreign-born citizen," "documented resident," "undocumented resident," "asylum-seeker" (i.e., a person who has applied to the immigration authorities of the receiving country for protection and is awaiting determination of status), "student," and "visitor." An understanding of where a migrant sits with regard to these immigration classes is relevant to research on immigration and health, since these classes provide information about both health and exposure risk profiles as well as eligibility for services (with asylum-seekers and undocumented residents at greatest risk for inadequate access).

Within receiving countries, assignment of migrants to immigration classes serves to operationalize population interventions (i.e., policies and programs) that apply to them. For example, in Canada asylum-seekers (also known as "refugee claimants") who have inadequate financial resources have access to federal health insurance through the Interim Federal Health Program, although insurance is restricted to emergency care. Economic class immigrants do not have access to this federal scheme but do have access to provincial schemes offering coverage beyond emergency care, regardless of financial means, after a certain amount of time in the province. Access to employment, social benefits, and other resources also differs by immigration class. Hence, the legally defined immigration class of an individual directly determines several key social determinants of health as outlined in the *Ottawa Charter* (Health Canada, 2010). Other determinants of health that are not legally proscribed but that may be more common among or more applicable to international migrants than non-migrants include language or cultural mismatch with health professionals, lack of familiarity with the health and social service systems, and limited social support networks.

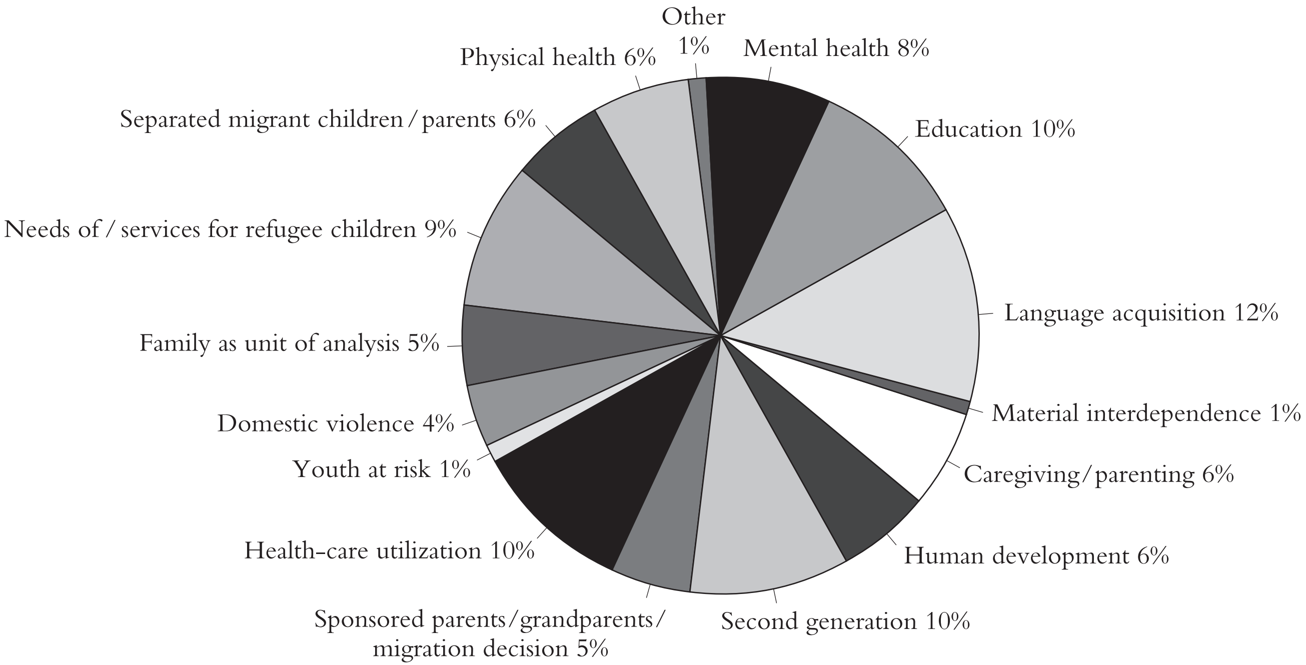
The range of population interventions that affect migrants, including the right to provincially supported health services, the right to work, and the right to seek formal education, suggests the need for researchers to work closely with policy-makers responsible for these areas, to ensure that timely research questions are being asked and that results emanating from research will be ultimately useful in developing or revising responsive policies and programs that affect the social determinants of migrant health.

Canadian policy-makers have identified "family, children, and youth" migrants to Canada as a priority *group* for policy-relevant research (through a memorandum of understanding with the Social Sciences and Humanities Research Council within the Metropolis Project). As an initial step, and to help further refine their research goals with regard to this group, the policy-makers sought to learn about current Canadian research with migrant families. Hence, a review of studies published in 2009 on families, children, and youth migrants to Canada was conducted. This review offers nurse researchers a single-year snapshot of the state of knowledge of immigration and health in Canada, specifically through the lens of the social determinants of health that can be affected by population interventions.

More than 1.2 million migrants were included in the reports reviewed. At least one report was located for each of the following *themes* identified a priori as priority by federal policy-makers with regard to migrant families, children, and youth: mental health; language acquisition; material interdependence; caregiving; human development; second generation; sponsored parents/grandparents; health-care utilization; cultural competence; youth at risk; education; family as the unit of analysis; separated migrant children/youth; family violence; needs of/services for immigrant and refugee children and youth; and physical health. The distribution of research within these themes and others not identified by federal policy-makers is shown in Figure 1.

Nurse researchers may also be interested to know the specific policies or programs addressed in this literature. These include the Immigration Medical Examination (McElroy, Laskin, Jiang, Shah, & Ray, 2009); the Interim Federal Health Plan (Wahoush, 2009); Canada's Multiculturalism Policy (Chuang & Su, 2009b; Costigan, Su, & Hua, 2009; Stroink & Lalonde, 2009); the Live-In Caregiver Program (Pratt, 2009; Rousseau et al., 2009); the Canadian *Immigration Act* (Alaggia, Regehr, & Rishchynski, 2009; Aydemir, Chen, & Corak, 2009; Collicelli, 2009; Lu, Zong, & Schissel, 2009; Roessingh & Elgie, 2009; Vatz Laaroussi, 2009); the Family Class Migration Program (VanderPlaat, Ramos, & Yoshida, 2009); the *Immigration and Refugee Protection Act* (Grenon, Kerisit, & Magunira, 2009); the Ontario Health Insurance Plan (Wahoush, 2009); the Reasonable Accommodation crisis in Quebec (Vatz Laaroussi, 2009); Prior Learning and Experience Assessment for Midwives in Manitoba (Kreiner, 2009); the Multicultural Health Brokers Co-operative in Edmonton (Chiu, Ortiz, & Wolfe, 2009); and francophone minority schools in New Brunswick (Bouchamma, 2009).

Figure 1 *Themes Reported in the 2009 Literature on Family, Children, and Youth Migrants to Canada*



Methodological elements of interest to policy-makers included the extent to which comparative studies, longitudinal designs, and population data sets were employed. Comparisons of Canada to the United States (Collicelli, 2009; Rothon, Heath, & Lessard-Phillips, 2009), to China (Chuang & Su, 2009a: Chuang & Tamis-LeMonda, 2009), and to Great Britain (Rothon et al., 2009) were identified in this body of literature. Longitudinal designs included studies addressing physical health (Newbold, 2009); language acquisition (Roessingh & Elgie, 2009); and sponsored parents/grandparents/migration decisions (Vatz Laroussi, 2009). Population-based data sets included, at the federal level, the Longitudinal Survey of Immigrants to Canada (Newbold & Willinsky, 2009; VanderPlaat et al., 2009); the Landed Immigrant Data System (Urquia et al., 2009); the Census (Han, Rotermann, Fuller-Thomson, & Ray, 2009; Rothon et al., 2009; Smythe, 2009; Urquia et al., 2009); the Youth in Transition Survey (Thiessen, 2009); the Ethnic Diversity Survey (Abada, Hou, & Ram, 2009; Abada & Kenkorang, 2009a, 2009b); the Labour Force Survey (Thiessen, 2009); the Understanding the Early Years Community Survey (Kohen, Oliver, & Pierre, 2009); the National Longitudinal Survey of Children and Youth (Kohen et al., 2009); and the Maternity Experiences Survey (Han et al., 2009). At the provincial level, population-based data sets included the Quebec Birth Registry (Moore, Daniel, & Auger, 2009); Ontario Birth Records (Urquia et al., 2009); the RAMQ Database (Bérard & Lacasse, 2009); and the Ontario Student Drug Use Survey (Hamilton, Noh, & Adlaf, 2009).

In addition to methodological elements that nurse researchers may wish to consider in conducting research on immigration and health, policy-makers find research results to be most useful to them if reported by immigration class and by identity markers. Reports were found specific to economic class immigrants (Bernhard, Landolt, & Goldring, 2009; Frideres, 2009; Gagnon, Joly, & Bocking, 2009; Newbold, 2009; Thiessen, 2009; Urquia et al., 2009; Yohani & Larsen, 2009); family class immigrants (Bernhard et al., 2009; Frideres, 2009; Gagnon et al., 2009; Newbold, 2009; Thiessen, 2009; Urquia et al., 2009; VanderPlaat et al., 2009); refugees (Abada et al., 2009; Abada & Tenkorang, 2009a, 2009b; Alaggia et al., 2009; Bernhard et al., 2009; Chiu et al., 2009; Dumbrill, 2009; Este & Tachble, 2009a, 2009b; Frideres, 2009; Gagnon et al., 2009; Grenon et al., 2009; Kanu, 2009; Kreiner, 2009; Magro, 2009; Newbold, 2009; Stewart, 2009; Urquia et al., 2009; Vatz Laaroussi, 2009; Wahoush, 2009; Yohani & Larsen, 2009); and asylum-seekers (Bernhard et al., 2009; Gagnon et al., 2009; Wahoush, 2009). It should be noted that studies with migrants often report their results applying unspecific labels such as "immigrant," "foreigner," or "migrant," without specifying status, thus rendering the research less useful than it might otherwise be. In terms of identity markers, reports included results by *gender,* with the majority including both genders (61.0%) and a minority looking exclusively at men (Este & Tachble, 2009a, 2009b); *age,* with the vast majority between 15 and 64 years of age; recommended *migration indicators* (Gagnon, Zimbeck, & Zeitlin, 2010) — these commonly included "country of birth," "fluency in host country language," and "length of time in Canada," with "ethnicity," as defined by maternal parents' place of birth, only infrequently reported (Auger, Giraud, & Daniel, 2009; Gagnon et al., 2009; Moore et al., 2009); *religion,* which was reported infrequently (Abada & Tenkorang, 2009a, 2009b; Alaggia et al., 2009; Brar et al., 2009; Guo, Lund, & Arthur, 2009; Merali, 2009); *visible minority status,* with a variety of definitions applied by several authors; *citizenship,* which was recorded in several studies; and *others,* including "ethnicity," with either a definition that was different from that given above or with no definition used, "country/region of origin" with an unclear meaning, since birth countries of participants were not specified, and with two articles reporting "age at arrival" (Aydemir et al., 2009; Roessingh & Elgie, 2009).

The volume and quality of literature on health-care utilization and language acquisition made it possible to summarize what was learned about these issues. The health-care utilization literature covers a range of topics across the lifespan, from pre-conception to elder care. The majority of this literature is based on reports from southern Ontario (*n* = 5), although it includes studies from the Prairies (*n* = 3), Vancouver (*n* = 2), and Quebec (*n* = 2), and also national studies (*n* = 1); this distribution reflects the distribution of immigrant communities across Canada. Studies are, for the most part, qualitative in nature, and this seems appropriate in attempting to understand the reasons for accessing or not accessing available services. Language continues to be a key stumbling block to full access to the range of services available in Canada. The groups at greatest risk are those who are or who perceive themselves to be dependent on their sponsors (e.g., spousal sponsorships and family sponsorships of elders), as they are at the greatest risk for abuse/neglect by their sponsors. Holders of insurance through the Interim Federal Health Program are also at risk, because this program is not well known by health-care providers and is administratively burdensome for them. Missing from this body of literature are studies focused directly on interventions, especially concerning language difficulties related to health-care utilization.

Literature on language acquisition by migrants to Canada covers topics from preschool age to adulthood, with more emphasis on university educational achievement than the literature of the preceding 2 years. This literature includes national studies (*n* = 3), with Vancouver and suburban British Columbia equally represented (*n* = 3) and with one report each from Calgary, Toronto, Montreal, and New Brunswick. Although this geographic distribution does not reflect the distribution of immigrant communities across Canada, the national studies serve to strengthen this body of literature. The reports describe the use of both quantitative and qualitative methods. The population groups that appear to need greater attention now are not those children who are learning English in early primary school (as they seem to be doing well) but, rather, students who are at a later stage in their schooling, when gaps in their educational successes begin to appear. The fact that these inequalities exist as late in the educational trajectory as university — as the literature suggests — indicates a need for closer scrutiny of second-language learners over the years.

This snapshot of Canadian research on immigration and health, even with the methodological limitations inherent in a review of a single year of literature, does offer nurse researchers a glimpse of the state of knowledge in this very broad field of inquiry. A range of themes related to health and determinants of health are being examined, with only two themes appearing to have enough studies to permit syntheses of what is known. Reviewing a greater number of years of literature would no doubt result in an ability to synthesize additional aspects. The review shows that research themes and methodologies identified as key by those responsible for taking action on behalf of migrant health are being taken up, and reports of these studies are including results presented by immigration classes and by relevant identity markers. Qualitative and quantitative studies are included in this body of literature, and a range of determinants of health are being examined. This review serves to challenge nurse researchers to examine their approaches to studying and reporting on migrant health, to ensure that their research activities can ultimately be optimally used by key stakeholders to optimize migrant health.

This focus issue of *CJNR* on Health and Immigration extends our knowledge in this area by offering readers a set of articles covering both a range of relevant issues and a range of research methodologies. We begin at the end of the research process by presenting a Commentary suggesting how results of studies by nurse researchers might be used for the benefit of a specific group of migrants to Canada. "Nursing Research With Refugee Claimants: Promoting the Protection of Human Rights" refers to the current public debate on Bill C-4, *Preventing Human Smugglers From Abusing Canada's Immigration System Act.* The next article examines social support on a broad scale. "Immigrant and Refugee Social Networks: Determinants and Consequences of Social Support Among Canadian Women Newcomers" describes the effects of situational and personal variables on the benefits and limitations associated with the social networks of migrant women. The study involved 87 women from seven ethnocultural communities currently living in the Toronto area.

From this broad perspective, we move to the care of individual women with a specific health concern. "Social Support for Breast Cancer Management Among Portuguese-Speaking Immigrant Women" presents the results of an applied ethnographic study conducted in Toronto with 12 women from Brazil, Portugal, and Angola, who describe their need for, access to, and use of social support in the management of breast cancer.

The next two contributions in this issue describe investigative functions that are usually carried out at the beginning of the research process. "The Health of Women Temporary Agricultural Workers in Canada: A Critical Review of the Literature" synthesizes the theoretical and empirical literature on gendered and temporary migration in the context of globalization and the health of temporary agricultural workers, particularly women in Canadian programs. And finally, "Population Health Intervention Research in Canada: Catalyzing Research Through Funding" provides an overview of the activities of the Institute of Population and Public Health of the Canadian Institutes of Health Research as they apply to research on health and immigration and related funding opportunities.

The editorial team is happy to share this focus issue with you and, in addition to contributing to the body of knowledge on immigration and health, to further stimulate inquiry in this area by nurse researchers in Canada and elsewhere.

References

Abada, T. P. D., Hou, F. P. D., & Ram, B. P. D. (2009). Ethnic differences in educational attainment among the children of Canadian immigrants. *Canadian Journal of Sociology, 34*(1), 1–28.

Abada, T., & Tenkorang, E. (2009a). Gender differences in educational attainment among the children of Canadian immigrants. *International Sociology, 24*(4), 580–608.

Abada, T., & Tenkorang, E. (2009b). Pursuit of university education among the children of immigrants in Canada: The roles of parental human capital and social capital. *Journal of Youth Studies, 12*(2), 185–207.

Alaggia, R., Regehr, C., & Rishchynski, G. (2009). Intimate partner violence and immigration laws in Canada: How far have we come? *International Journal of Law and Psychiatry, 32*(6), 335–341.

Auger, N., Giraud, J., & Daniel, M. (2009). The joint influence of area income, income inequality, and immigrant density on adverse birth outcomes: A population-based study. *BMC Public Health, 9,* 237.

Aydemir, A., Chen, W. H., & Corak, M. (2009). Intergenerational earnings mobility among the children of Canadian immigrants. *Review of Economics and Statistics, 91*(2), 377–397.

Bérard, A., & Lacasse, A. (2009). Validity of perinatal pharmacoepidemiologic studies using data from the RAMQ administrative database. *Canadian Journal of Clinical Pharmacology, 16*(2), e360–e369.

Bernhard, J. K., Landolt, P., & Goldring, L. (2009). Transnationalizing families: Canadian immigration policy and the spatial fragmentation of care-giving among Latin American newcomers. *International Migration, 47*(2), 3–31.

Bouchamma, Y. (2009). *Francisation, scolarisation et socialisation des élèves immigrants en milieu minoritaire francophone du Nouveau-Brunswick : quels défis et quelles perspectives?* Halifax: Atlantic Metropolis Centre.

Brar, S., Tang, S., Drummond, N., Palacios-Derflingher, L., Clark, V., John, M., et al. (2009). Perinatal care for South Asian immigrant women and women born in Canada: Telephone survey of users. *Journal of Obstetrics and Gynaecology Canada, 31*(8), 708–716.

Chiu, Y., Ortiz, L., & Wolfe, R. (2009). Beyond settlement: Strengthening immigrant families, communities and Canadian society through cultural brokering. *Our Diverse Cities,* 6(Spring), 170–175.

Chuang, S. S., & Su, Y. (2009a). Do we see eye to eye? Chinese mothers' and fathers' parenting beliefs and values for toddlers in Canada and China. *Journal of Family Psychology, 23*(3), 331–341.

Chuang, S. S., & Su, Y. (2009b). Says who? Decision-making and conflicts among Chinese-Canadian and Mainland Chinese parents of young children. *Sex Roles, 60*(7/8), 527–536.

Chuang, S. S., & Tamis-LeMonda, C. (2009). Gender roles in immigrant families: Parenting views, practices, and child development. *Sex Roles, 60*(7/8), 451–455.

Collicelli, A. (2009). Affording discretion to immigration judges: A comparison of removal proceedings in the United States and Canada. *Boston College International and Comparative Law Review, 32*(1), 115–128.

Costigan, C., Su, T. F., & Hua, J. M. (2009). Ethnic identity among Chinese Canadian youth: A review of the Canadian literature. *Canadian Psychology, 50*(4), 261–272.

Dumbrill, G. C. (2009). Your policies, our children: Messages from refugee parents to child welfare workers and policymakers. *Child Welfare, 88*(3), 145–168.

Este, D. C., & Tachble, A. (2009a). Fatherhood in the Canadian context: Perceptions and experiences of Sudanese refugee men. *Sex Roles, 60*(7/8), 456–466.

Este, D., & Tachble, A. (2009b). The perceptions and experiences of Russian immigrant and Sudanese refugee men as fathers in an urban center in Canada. *Annals of the American Academy of Political and Social Science, 624*(1), 139–155.

Frideres, J. (2009). The new ethnic identity? Young people on the Prairies. *Our Diverse Cities,* Spring, 76–81.

Gagnon, A., Joly, M. P., & Bocking, J. (2009). Aligning research to meet policy objectives for migrant families: An example from Canada. *Health Research Policy and Systems,* 7(1), 15.

Gagnon, A. J., Zimbeck, M., & Zeitlin, J. (2010). Migration and perinatal health surveillance: An international Delphi survey. *European Journal of Obstetrics and Gynecology and Reproductive Biology, 149*(1), 37–43.

Grenon, E., Kerisit, M., & Magunira, F. (2009). An analysis of the challenges faced by francophone female refugees living in Ontario and separated from their children. *CERIS Policy Matters, 40,* 1–5.

Guo, Y., Lund, D. E., & Arthur, N. (2009). *My culture, your culture: What pre-service teachers say about intercultural competence.* PMC working paper 04-09. Edmonton: Prairie Metropolis Centre.

Hamilton, H. A., Noh, S., & Adlaf, E. M. (2009). Adolescent risk behaviours and psychological distress across immigrant generations. *Canadian Journal of Public Health, 100*(3), 221–225.

Han, A., Rotermann, M., Fuller-Thomson, E., & Ray, J. G. (2009). Pre-conceptional folic acid supplement use according to maternal country of birth. *Journal of Obstetrics and Gynaecology Canada, 31*(3), 222–226.

Health Canada. (2010). Migration health: Embracing a determinants of health approach. *Health Policy Research Bulletin 17.* Ottawa: Author.

International Organization for Migration. (2011). *Migration typologies.* Retrieved September 13, 2011, from http://www.iom.int/jahia/Jahia/about-migration/migration-management-foundations/terminology/migration-typologies.

Kanu, Y. (2009). Educational pathways to successful social integration for African refugee students in Manitoba. *Our Diverse Cities,* Spring, 114–119.

Kohen, D., Oliver, L., & Pierre, F. (2009). Examining the effects of schools and neighbourhoods on the outcomes of kindergarten children in Canada. *International Journal of Speech-Language Pathology, 11*(5), 404–418.

Kreiner, M. (2009). Delivering diversity: Newly regulated midwifery returns to Manitoba, Canada, one community at a time. *Journal of Midwifery and Women's Health, 54*(1), 1–10.

Lu, Y., Zong, L., & Schissel, B. (2009). To stay or return: Migration intentions of students from People's Republic of China in Saskatchewan, Canada. *Journal of International Migration and Integration, 10*(3), 283.

Magro, K. (2009). *Building bridges to social inclusion: Researching the experiences and challenges of the lost boys and girls of Sudan community in Winnipeg.* PMC working paper 01-09. Edmonton: Prairie Metropolis Centre.

McElroy, R., Laskin, M., Jiang, D., Shah, R., & Ray, J. G. (2009). Rates of rubella immunity among immigrant and non-immigrant pregnant women. *Journal of Obstetrics and Gynaecology Canada, 31*(5), 409–413.

Merali, N. (2009). Experiences of South Asian brides entering Canada after recent changes to family sponsorship policies. *Violence Against Women, 15*(3), 321–339.

Moore, S., Daniel, M., & Auger, N. (2009). Socioeconomic disparities in low birth weight outcomes according to maternal birthplace in Quebec, Canada. *Ethnicity and Health, 14*(1), 61–74.

Newbold, B. (2009). The short-term health of Canada's new immigrant arrivals: Evidence from LSIC. *Ethnicity and Health, 14*(3), 315–336.

Newbold, K. B., & Willinsky, J. (2009). Providing family planning and reproductive healthcare to Canadian immigrants: Perceptions of healthcare providers. *Culture, Health and Sexuality, 11*(4), 369–382.

Pratt, G. (2009). Circulating sadness: Witnessing Filipina mothers' stories of family separation. *Gender, Place and Culture, 16*(1), 3–22.

Roessingh, H., & Elgie, S. (2009). Early language and literacy development among young English language learners: Preliminary insights from a longitudinal dtudy. *TESL Canada Journal, 26*(2), 24–45.

Rothon, C., Heath, A., & Lessard-Phillips, L. (2009). The educational attainments of the second generation: A comparative study of Britain, Canada and the US. *Teachers College Record, 111*(6), 1404–1443.

Rousseau, C., Hassan, G., Measham, T., Moreau, N., Lashley, M., Castro, T., et al. (2009). From the family universe to the outside world: Family relations, school attitude, and perception of racism in Caribbean and Filipino adolescents. *Health and Place, 15*(3), 721–730.

Smythe, S. (2009). Investigating sociohistorical contexts and practices through a community scan: A Canadian Punjabi-Sikh example. *Language and Education, 23*(1), 37–57.

Stewart, J. (2009). *Children affected by war: A bioecological investigation into their psychosocial and educational needs.* Winnipeg: University of Manitoba.

Stroink, M. L., & Lalonde, R. N. (2009). Bicultural identity conflict in second-generation Asian Canadians. *Journal of Social Psychology, 149*(1), 44–65.

Thiessen, V. (2009). The pursuit of post-secondary education: A comparison of First Nations, African, Asian, and European Canadian youth. *Canadian Review of Sociology, 46*(1), 5–37.

UN High Commissioner for Refugees. (2005). *Asylum levels and trends in industrialized countries – second quarter, 2005.* Geneva: Division of Operational Support, UNHCR.

United Nations Department of Economic and Social Affairs. (2009). *Trends in international migrant stock: The 2008 revision.* New York: United Nations.

Urquia, M. L., Frank, J. W., Glazier, R. H., Moineddin, R., Matheson, F. I., & Gagnon, A. J. (2009). Neighborhood context and infant birthweight among recent immigrant mothers: A multilevel analysis. *American Journal of Public Health, 99*(2), 285–293.

Urquia, M. L., & Gagnon, A. J. (2011). Glossary: Migration and health. *Journal of Epidemiology and Community Health, 65*(5), 467.

VanderPlaat, M., Ramos, H., & Yoshida, Y. (2009). *A preliminary investigation of the contributions of sponsored parents and grandparents in Canada.* Working paper 25. Halifax: Atlantic Metropolis Centre.

Vatz Laaroussi, M. (2009). *Mobilité et rétention des familles immigrante et réfugiées installées dans les régions du Québec.* Montreal: Centre Métropolis du Québec – Immigration et métropoles, Capsule Recherche.

Wahoush, E. O. (2009). Equitable health-care access: The experiences of refugee and refugee claimant mothers with an ill preschooler. *Canadian Journal of Nursing Research, 41*(3), 186–206.

World Health Organization. (2008, May 19–24). *Resolutions and decisions. Annexes – document WHA61/2008/REC/1. Resolution 61.17: Health of migrants.* Paper presented at Sixty-First World Health Assembly, Geneva.

Yohani, S. C., & Larsen, D. J. (2009). Hope lives in the heart: Refugee and immigrant children's perceptions of hope and hope engendering sources during early years of adjustment. *Canadian Journal of Counselling, 43*(4), 246–264.

Acknowledgements

The literature review described here was funded by the National Metropolis Committee. I am supported by a McGill Dawson Scholarship and by the Research Institute of the McGill University Health Centre through a Centre grant from Le Fonds de la Recherche en Santé du Québec.

I would like to thank Jacqueline Bocking for her oversight of the literature and Laure Lafrance (CIC, Ottawa) for practical support of the review.

Anita J. Gagnon, RN, PhD, is Associate Professor, School of Nursing and Department of Obstetrics and Gynecology, McGill University, and Nurse Scientist, McGill University Health Centre, Montreal, Quebec, Canada.

CJNR 2011, Vol. 43 Nº 4, 21–24

Commentary

Nursing Research With Refugee Claimants: Promoting the Protection of Human Rights

Lisa Merry

In August 2010, 490 Tamil migrants arrived on a ship off the coast of British Columbia, Canada, seeking refuge. They had fled Sri Lanka, a country known for its human rights abuses (UN News Service, 2011). For more than 25 years fighting endured between the Sri Lankan government and the Tamil Tigers, a militant organization seeking to create an independent Tamil state in the North East region of Sri Lanka. The effects and aftermath of the war have been devastating for thousands of civilians.

This event spurred negative public opinion in Canada towards refugee claimants ("persons who have fled their country and are asking for protection in another country"; Canadian Council for Refugees, 2010) and the Canadian immigration and refugee system. A short time later, the federal government introduced Bill C-49, *Preventing Human Smugglers From Abusing Canada's Immigration System Act.* This bill was initially rejected by Parliament, but with the election of a majority Conservative government in the spring of 2011 the proposed legislation was re-introduced as Bill C-4 (Public Safety Canada, 2011).

C-4 is an aggressive bill. It is meant to penalize human smugglers (people "who facilitate, for a profit, those who enter Canada illegally"; Public Safety Canada, 2011), but in actuality the legislation would punish refugee claimants by depriving them of certain rights and by reducing their access to health care. Proposed changes include increased use of detention; prohibition of appeals for rejected claims; restriction of the scope of health-care benefits under the Interim Federal Health Program (Canada's health insurance scheme for refugee claimants); and denying, for a period of 5 years, those accepted as refugees ("persons who were forced to flee their countries due to persecution"; Canadian Council for Refugees, 2010) the right to (1) sponsor their family members, (2) apply for residency, and (3) travel outside of Canada.

As a signatory to the Geneva Convention, Canada is bound to respect, protect, and provide for those who seek refuge within its borders. Further, the Canadian Nurses Association (2004) has stated that human rights must be safeguarded and that nurses are pivotal in promoting and upholding human rights. Bill C-4 violates the right to health care and other rights known to be necessary for health. Detention, reduced health-care benefits, restricted social networks, and continuous precarious status have been shown to be detrimental to one's health (Robjant, Hassan, & Katona, 2009; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Silove, Steel, & Watters, 2000). Limited health-care coverage will translate to unaddressed health concerns and exacerbate conditions that constrain nurses and others from providing adequate care. Bill C-4 clearly violates human rights. Efforts by health professionals such as nurses are urgently needed in order to build public support for refugee claimants as well as for refugees.

Promoting the Protection of Human Rights Through Research

Nursing research has a longstanding commitment to social justice and has provided vital leadership in studying vulnerable populations. A significant proportion of the literature on the health of minorities, cross-cultural care, and research methods for working with diverse groups has been contributed by nurses. Working closely with communities — reaching out to the most isolated and marginalized to learn about the social conditions that influence well-being and how psycho-social concerns might be addressed through nursing care — has been central to many nursing studies. Refugee claimants are an understudied population requiring prompt attention.

In 2008 the World Health Assembly adopted a resolution calling on member states, including Canada, to improve the health of migrants (World Health Organization [WHO], 2008). A Global Consultation on the health of migrants was held subsequently, in 2010, to achieve consensus on priority areas and to formulate strategies for meeting identified objectives (WHO, 2010). Key priorities included monitoring migrant health; improving the social security of migrants; increasing the capacity of the health-care system to address the health concerns of migrants; ensuring that health services are culturally, linguistically, and epidemiologically appropriate; and promoting the right of all migrants to health and equal access to health services. Research on the health concerns of refugee claimants, the conditions affecting the health of this population, and the service needs of this population could well produce evidence to support these objectives and would give voice to this group. Most importantly, the research could produce evidence questioning the validity of measures such as those proposed under Bill C-4 and would promote the rights of refugee claimants.

Action Is Needed Now

Bill C-4 is one example of a growing anti-immigrant sentiment in Canada. The implications of its passage go beyond the immediate and harmful effects it would have on refugee claimants. Passage of this bill would mean that Canadians are willing to accept the notion that some human beings are of lesser value than others. While C-4 targets refugee claimants, future legislation could target any group. Nurses are in a privileged and powerful position and have a duty to act on human rights issues. Research is one means of combating the unfair and destructive discourse that portrays refugee claimants as less than human. Through collective action nurses can counter the anti-refugee/immigrant rhetoric in health care and beyond.

More information on Bill C-4 can be found at http://ccrweb.ca/en/c4-action.

References

Canadian Council for Refugees. (2010). *Refugees and immigrants: A glossary*. Retrieved November 29, 2011, from http://ccrweb.ca/en/glossary.

Canadian Nurses Association. (2004). *Position statement: Registered nurses and human rights.* Retrieved October 24, 2011, from http://www.cna-nurses.ca/CNA/documents/pdf/publications /PS78_Human_Rights_e.pdf.

Public Safety Canada. (2011). *Human smuggling: Preventing human smugglers from abusing Canada's Immigration System Act.* Retrieved October 24, 2011, from http://www.publicsafety.gc.ca/hmn-smgglng-eng.aspx.

Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *British Journal of Psychiatry, 194,* 306–312.

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: Assocations with pre-migration trauma and post-migration stressors. *British Journal of Psychiatry, 170,* 351–357.

Silove, D., Steel Z., & Watters, C. (2000). Policies of deterrence and the mental health of asylum seekers. *Journal of the American Medical Association, 284,* 604–611.

UN News Service. (2011). Panel of experts finds credible reports of war crimes during Sri Lanka conflict. *UN News Centre.* Retrieved November 29, 2011, from http://www.un.org/apps/news/story.asp?NewsID=38187&Cr=sri+lanka&Cr1.

World Health Organization. (2008, May 19–24). *Sixty-first World Health Assembly,* Geneva. Retrieved October 24, 2011, from http://www.who.int/mediacentre/events/2008/wha61/en/index.html.

World Health Organization. (2010, March 3–5). *Health of migrants – the way forward: Report of a Global Consultation,* Madrid. Retrieved October 24, 2011, from http://www.who.int/hac/events/consultation_report_health_migrants_colour_web.pdf.

Lisa Merry, RN, MScA, is a doctoral student, School of Nursing, McGill University, Montreal, Quebec, Canada.

CJNR 2011 Vol. 43 N° 4, 26–46

Résumé

Les réseaux sociaux des immigrantes et des réfugiées : les déterminants et les conséquences du soutien social chez les femmes nouvellement arrivées au Canada

Michaela Hynie, Valorie A. Crooks, Jackeline Barragan

Les immigrants et les réfugiés (nouveaux arrivants) diffèrent sur plusieurs points mais partagent des défis similaires. Les nouveaux arrivants doivent reconstruire des réseaux sociaux pour obtenir le soutien social dont ils ont grandement besoin mais ils doivent souvent affronter l'exclusion sociale en raison de leur race, leur langue, leur religion ou leur statut en tant qu'immigrants. Dans le cadre de cette étude, les auteures ont exploré les effets de variables circonstancielles et personnelles sur les avantages et les limites associées au réseaux sociaux de femmes nouvellement arrivées. Ayant recours à des entrevues et à des groupes de discussion auxquels ont participé 87 femmes de sept communautés, elles ont procédé à une analyse thématique et identifié cinq sources de soutien informel dans les sept communautés, qui étaient presque exclusivement limitées à des relations co-ethniques. Elles ont aussi relevé les types de soutien, les limites et l'élément de réciprocité pour chacune d'entre elles. Selon les perceptions, le plus important soutien reçu était celui de la famille et d'amis proches, et lorsque le soutien d'un proche n'était pas disponible, celui des fournisseurs de soins primaires. Les résultats suggèrent que les réseaux co-ethniques de soutien par des pairs présents dans les communautés de nouveaux arrivants peuvent s'avérer débordés en raison de leur ampleur limitée et du manque de ressources.

Mots clés : soutien social, exclusion sociale, immigrants, réfugiés, femmes

CJNR 2011 Vol. 43 N° 4, 26–46

Immigrant and Refugee Social Networks: Determinants and Consequences of Social Support Among Women Newcomers to Canada

Michaela Hynie, Valorie A. Crooks, Jackeline Barragan

Recent immigrants and refugees (newcomers) vary on many dimensions but do share similar challenges. Newcomers must rebuild social networks to obtain needed social support but often face social exclusion because of their race, language, religion, or immigrant status. In addition, most have limited access to personal, social, and community resources. Effects of situational and personal variables on the benefits and limitations associated with the social networks of female newcomers were explored through interviews and focus groups with 87 women from 7 communities. Using thematic analysis, the authors identify 5 sources of informal support across all 7 communities, which were almost exclusively limited to co-ethnic relationships, and the types of support, limitations, and reciprocity within each. Perceived support was strongest from family and close friends and, when support from close relationships was unavailable, from primary care providers. The results suggest that co-ethnic peer support networks may be overwhelmed in newcomer communities because of their limited size and resources.

Keywords: social support, social capital, social exclusion, immigrants, refugees, women, mental health

The term "newcomers" can be used to describe both immigrants and refugees who are within the first few years of their arrival in a new country. Newcomers vary widely in terms of their cultural background, the reasons for and manner of their migration, the resources they bring with them, and the environments they settle into. However, they typically share a number of characteristics. First, all have experienced a rupture in their social networks and must now build and establish new networks in their country of residence (McMichael & Manderson, 2004; Schellenberg & Maheux, 2007). Second, many face social exclusion from the community by virtue of their immigrant status and may even face discrimination because of their race, language, and/or religion (Galabuzi & Teelucksingh, 2010; Schellenberg & Maheux, 2007). Third, for many recent newcomers, access to social and material resources may be limited and inadequate

(Beiser, 2005; Galabuzi & Teelucksingh, 2010; Walters, Phythian, & Anisef, 2006).

The purpose of this article is to capture the structural and social forces common to recent women newcomers to Toronto, Canada, that limit and shape their social networks and the support available from these networks as well as the implications for their physical and mental health and for the provision of services in their communities.

Newcomers, Social Support, and Social Capital

Social networks have been investigated as a critical determinant of physical and mental health through a number of different lenses (Cohen, 2004; Galabuzi & Teelucksingh, 2010; Gottlieb & Bergen, 2010; Lakey & Orehek, 2011). Two dominant perspectives from which to frame the impact of social networks are social support and social capital. Social support refers to the extent to which one's needs are or could be met by others (Cohen, 2004). Social support is supportive behaviours that are enacted or the perception that adequate support is available when needed (Lakey & Orehek, 2011). Social support includes instrumental support, which is the provision of tangible assistance like child care, food, or money (Finfgeld-Connett, 2005); informational support, which refers to the provision of the advice and information necessary for resolving problems or difficulties (Cohen, 2004); and emotional support, which refers to listening behaviour, encouragement, distraction, and other means of easing distress (Finfgeld-Connett, 2005). Having a social support network and perceiving that one is able to elicit and receive effective social support have consistently been found to predict improved physical and mental health and decreased mortality (Beck, 2008; Lakey & Orehek, 2011; Uchino, 2006; Xu & McDonald, 2010).

The other relevant concept is social capital (Glanville & Bienenstock, 2009; Portes, 2000). To have social capital is to be able to invest resources in relationships that are marked by reciprocity and trust and to possess the cultural knowledge necessary to build these relationships. Investments of social capital are fungible; individuals obtain personal benefits in exchange for the investments they make in social relationships. The result is an ability to acquire needed resources and to take control of one's social circumstances (Sen, 2000).

Research suggests that newcomers experience reduced social networks relative to non-immigrants and can experience prolonged periods of social exclusion in their new community (Galabuzi & Teelucksingh, 2010; Schellenberg & Maheux, 2007). Because of the links between social networks, social support, and social capital, poor access to social networks means that recent newcomers may have fewer resources and be more vulnerable to physical and mental health problems in the face of multiple stressors, despite having implemented a range of strategies to rebuild their networks (Beiser, 2005; Yoon, Lee, & Goh, 2008).

Gender and Newcomer Status

While all newcomers can face the challenges of social exclusion and isolation, women may be even more socially isolated than their male counterparts. Women are less likely than men to speak the language of the new country and to be employed outside the home (Canadian Research Institute for the Advancement of Women, 2003). Because they possess fewer resources to invest and exchange, they are less likely to have opportunities to form new social relationships and the ability to build social capital through their relationships (Hao & Johnson, 2000). Furthermore, compared to male newcomers, women have been found to suffer more negative mental health consequences in the face of inadequate social networks (Haines, Beggs, & Hurlburt, 2008). The increased isolation of women newcomers, combined with a greater sensitivity to social isolation, may be a contributor to their elevated risk for developing mental health problems (Yakushko & Chronister, 2006). Women's participation in social networks is also complicated by gendered expectations regarding support: Women are expected to (and do) provide more social support than men (Armstrong, Armstrong, & Scott-Dixon, 2008). Thus, while female newcomers stand to benefit more than their male counterparts from mutually supportive relationships, gendered expectations may render these relationships more costly.

In summary, newcomers must actively build new social networks and relationships while simultaneously facing structural and social barriers to inclusion that result in social isolation and restricted social networks. Moreover, participation in reciprocal relationships has costs as well as benefits — costs that may be too high for those with limited personal resources, such as female newcomers. The aim of this study is to describe the support-seeking strategies of women across a range of cultural groups and to identify commonalities in the challenges that newcomers face in rebuilding their social networks and the structural as well as social forces that determine the success of these strategies in meeting their needs.

Methods

The analyses reported here entailed both one-on-one interviews with female newcomers (*n* = 35) from seven different cultural-linguistic communities and focus groups with female newcomers (*n* = 7 groups, 52 participants) from six of those communities (we were unable to arrange a focus group with the Afghan community). Method triangulation through the use of both interviews and focus groups was employed to deepen our understanding of women's support strategies by giving women an opportunity to not only report their own strategies in depth (interviews) but also to comment on and respond to each other's experiences (focus groups).

The three participating community centres identified different cultural-linguistic groups as a priority: Spanish-speaking from Latin America and English-speaking from the Caribbean (centre 1); Portuguese-speaking from Portugal, Brazil, and Angola (centre 2); and Urdu-speaking from Pakistan and Dari-speaking from Afghanistan (centre 3).

University ethics approval was obtained for all aspects of the study.

Background

The findings reported here are from a community-based research project on mental health and well-being among women newcomers in Toronto. Community-based research is grounded in a commitment to research as a tool for social change. One of its principles is that members of the community in which the study is conducted are considered equal partners in the research process and play a leading role in identifying the issues and concerns to be addressed (Israel, Schulz, Parker, & Becker, 1998). Consistent with the principles of community-based research, the research team comprised academics, representatives of community agencies, and women from the communities of focus.

The research was initiated by a community partner, who approached one of the academics on the team requesting an examination of the barriers faced by female newcomers with respect to accessing and using mental health services in her clinic. The team was expanded to include other community centres with similar interests, academics, and community members from the identified communities. The research questions broadened as the project was discussed. Community and agency partners participated fully in designing the study and collecting the data. They provided input into data coding and analysis and into the preparation and delivery of dissemination materials (for both academic and community audiences). They co-led the design and implementation of a subsequent participatory project with community members to disseminate the findings to the Latin-American community; this resulted in a mental health guide for Spanish-speaking women that was designed, researched, and written by community members (Hynie & Viveros, 2010).

The present study consisted of interviews and focus groups with women newcomers and interviews with health and social service providers on issues of stress, social support, beliefs about symptoms of well-being and distress, and willingness to use primary mental health services for coping with distress. The findings on stress and access to primary mental health services are reported elsewhere (Crooks, Hynie, Killian, Giesbrecht, & Castleden, 2011). In this article we concentrate on focus groups and interviews with community women regarding social support.

The interview questions and probes related to informal social support included the following:

- How have you dealt with these [previously discussed] problems or disappointments in the past?
- How are you dealing with your current biggest disappointment/ problem?
- Do you count on any supports to help you face these disappointments or to help you resolve your problems?
- Are the strategies and sources of support that you use today similar to or different from the ones you used when you were back in your country?
- Are there supports that are not available to you in Canada but could help you confront your difficulties and problems with more confidence as they arise?
- If you get sick or if you are not feeling well, to whom or where do you turn for help?
- Do you think you would receive the necessary help in one of those situations [that you described earlier]?

Participants

Female newcomers who were over 16 years of age and were within their first 6 years of Canadian residency were targeted for recruitment. The length of residency varied: 6 years was chosen for recruitment because, in the province of Ontario, free settlement services (e.g., language classes) are offered for the first 3 years of residency; therefore, 6 years included the period when services are free and an equal period when they are not, and when settlement could thus become more challenging.

Posters were placed in the three centres, publicizing the study in the appropriate languages (e.g., English and Spanish in centre 1, Portuguese in centre 2, Urdu and Dari in centre 3) and distributed by workers in the centres who also orally described the study for eligible clients. Also, participants were asked to share information about the study with other women newcomers in their community. Interviewees were paid $20 for their participation and given bus fare, a snack, and free child care during the interview. Focus group participants were recruited in the same manner as the interviewees but were paid $50 for their participation in this longer protocol.

Interview participants (n = 35) had emigrated from Colombia (n = 6), Afghanistan (n = 5), various Caribbean islands (Grenada, St. Vincent, Virgin Islands, St. Lucia) (n = 5), Pakistan (n = 5), Angola (n = 3), Brazil (n = 3), Mexico (n = 3), Portugal (n = 3), Costa Rica (n = 1), and Cuba (n = 1). Focus group participants (n = 52) came from Pakistan (n = 10), Angola (n = 9), Brazil (n = 9), Portugal (mainland, n = 8; Azores, n = 2), Mexico (n = 5), Colombia (n = 3), El Salvador (n = 2), Jamaica (n = 2), Ecuador (n = 1), and Trinidad (n = 1).

Participant characteristics are presented in Table 1, collapsed across methods and cultural groups. Most participants were between 35 and 50 years of age and lived with members of their nuclear family. Several had at least some university education, but, despite high levels of education across the groups, most were not employed. About one quarter had precarious migration status in that they did not have permanent residency status in Canada (cf. Goldring, Berinstein, & Bernhard, 2007). The vast majority did not speak English as a first language and almost two thirds were from a visible minority (those from Angola, the Caribbean, Latin America, and Pakistan), based on the definition of visible minority used by Statistics Canada.[1]

Procedures

Interviews. Interviews were conducted at the offices of the collaborating community centres and lasted 1.5 hours on average. All but one were audiorecorded and transcribed. One participant did not wish to be audiorecorded so in this case the analysis relied upon the interviewer's detailed notes. Informed consent was obtained prior to each interview.

The interviews were conducted in each participant's first language using a semi-structured guide. The interview guide covered the process of translation and back-translation for each language. It consisted of six sections: (1) demographics and background information; (2) hopes and expectations for life in Canada; (3) challenges, adjustments, and difficulties faced since arriving; (4) coping strategies; (5) availability of social support and health/social services; and (6) descriptions of feeling good about oneself and of experiencing mental stress and distress.

Focus groups. Focus groups were conducted by a facilitator and a note-taker who were fluent in the participants' language. Three focus groups were conducted at centre 1, two with Spanish-speaking women

---

[1] "The *Employment Equity Act* defines visible minorities as 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.' Using this definition, regulations specify the following groups within the visible minority population: South Asian, Chinese, Black, Arab, West Asian, Filipino, Southeast Asian, Latin American, Japanese and Korean." (Chui & Maheux, 2011, p. 5)

Table 1 ***Demographic Characteristics***

		N = 87	(%)
Age	19–35	29	(33.3)
	35–50	46	(52.9)
	> 50	10	(11.5)
Years in Canada	< 3	35	(40.2)
	3–6	34	(39.1)
	> 6	16	(18.4)
Marital status	Married	47	(54.0)
	Single/divorced	31	(35.6)
Children	0	10	(11.5)
	1–3	62	(71.3)
	4–5	13	(14.9)
Immigration status	Permanent	51	(58.6)
	Refugee	16	(18.4)
	Precarious[a]	15	(13.8)
Visible minority[b]	Yes	57	(65.5)
	No	30	(34.5)
First language	Language other than English	78	(90.0)
	English	9	(10.3)
Religion	Christian	67	(77.0)
	Muslim	20	(23.0)
Education	Less than high school completion	16	(18.4)
	High school completion	14	(16.1)
	At least some college/university	42	(48.3)
Employment	Employed	22	25.3)
	Not employed	50	(57.5)

[a] Those awaiting decisions on claims (e.g., on humanitarian and compassionate grounds) and those without official status.

[b] Based on Statistics Canada definition.

Note: Some data are missing as some participants did not respond to all questions.

from Latin America (*n* = 6, *n* = 5) and one with English-speaking women from the Caribbean (*n* = 3). Three groups were conducted at centre 2 in Portuguese, one each for women from Portugal (*n* = 10), Angola (*n* = 9), and Brazil (*n* = 9). Finally, one group was conducted at centre 3 in Urdu with women from Pakistan 3 (*n* = 10).

All but one of the focus groups were audiorecorded and transcribed; for the group from Portugal, the tape recorder failed and thus written notes were relied upon. Women provided oral or written consent before participating and completed demographic information sheets, which were kept separate from the consent forms to ensure anonymity.

The focus group guide was designed to explore in more depth the preliminary findings of the interviews. It probed (1) sources of support and information in the settlement process, (2) characteristics of health care in the country of origin, (3) knowledge about health care in Canada, and (4) how the women coped with stress and distress in Canada and in their country of origin. The focus groups lasted between 1.5 and 2.5 hours.

With respect to both the interviews and the focus groups, this article centres on issues of social support.

Data Analysis

Transcripts were translated and reviewed by a second first-language speaker to confirm the quality of each translation and, in the case of three Portuguese translations, were re-transcribed to improve accuracy. Transcripts were analyzed using NVivo, a qualitative data management program. Thematic analysis of the data set was employed (Aronson, 1994): Data were categorized according to themes (units that are identified from patterns within the data set), which were then refined, based on the literature, to those present in various interviews and to the study's overall purpose and objectives. Links between these themes were established in order to interpret the data and to transform the nature of the findings from descriptive to analytic.

One of the principal investigators and two members of the research team developed a coding scheme for the interviews and focus groups by reading two randomly selected transcripts from each data set, circulating them to the entire research team (including community and agency partners) for feedback, and then refining the coding scheme. Any issues encountered during the first stage of coding were discussed among the principal investigators and decisions were recorded and implemented during a second stage of coding. Throughout the analytical process, updates were shared with members of the research team, all of whom participated in the interpretation of the findings.

Results

Five kinds of informal support/social networks emerged as themes across the seven cultural groups: immediate family, transnational family, friendship networks, close friends, and community. Women also obtained support from community agencies, particularly those women who lacked informal support networks. A number of themes emerged across the different kinds of support. These included types of support given and received, the extent to which the support was reciprocal, gendered expectations about support, and perceived adequacy of the support. The sources of support are described below, and are discussed in terms of these themes. Because focus group participants provided demographic information on a separate survey, their comments are labelled by cultural group only, and not immigration status.

Immediate Family

Many of the women described family support as essential to their well-being. Family members provided all three kinds of support: instrumental support in the form of child care, housing, and money; relevant information; and the compassion and understanding that are associated with emotional support. Several women reported strong reciprocal relationships with their spouses. The following comment by a Latin-American woman sheds light on one pathway through which effective social support can improve health, in that the support she received from her husband helped her to engage in health promoting behaviours following the discovery that she had a health problem:

> *I take a lot of care . . . I can't work Saturdays and Sundays because I know that everything is about a balance in life. Here, you don't have that — but now I do. And my husband helps me too, but his problems affect me too, so I try to balance things.* (refugee from Colombia)

Gendered role expectations of women as support providers was evident in women's greater reliance on their female relatives, especially for emotional support, and in their emphasis on providing — and worrying about providing — support to members of their family. In the above comment, for example, the woman explains that her well-being is affected by that of her husband. Indeed, when asked about their own well-being, women often responded in terms of the well-being of their spouses and children.

Not all women reported positive experiences with support from their family. Some family members could not or would not provide the help that participants needed. Thus, the presence of family did not guarantee that women would receive the support that they desired. Moreover, some women reported violence and abuse from spouses or boyfriends. These women were particularly vulnerable and isolated; they were forced to negotiate different cultural expectations about resolving family conflict and a foreign legal system (Haj-Yahia & Sada, 2008), often with limited knowledge of English, and to choose between their abusive partner and surviving alone in a new culture.

Transnational Family

Almost all of the women reported maintaining phone and mail contact with immediate and extended family members from their country of origin. While these family members were primarily sources of emotional support, they were also recipients of emotional support from the participants. Gendered expectations of support were evident not only in women's emphasis on providing emotional support for their family members but also in cases where the woman did not wish to burden her relatives with her problems and so did not share them, implying an inequality in reciprocity. Some women also provided instrumental support to transnational family members by sending them money, despite their own difficult financial circumstances. The participants seemed to view this as a natural expectation:

> *Life here is not a bed of roses, you know. Everything is expensive, but at least I am trying to help [my family back home] and the rest of the family; that is what I came here to do and that is what I will do.* (refugee claimant from Grenada)

Frequency of contact varied, with some women reporting that they spoke with transnational family members daily or weekly and others reporting infrequent or irregular contact. Frequency of contact typically decreased the longer the woman lived in Canada, sometimes because of the costs of long distance calls, sometimes because of time constraints; thus, this source of emotional support apparently diminished over time. However, there was no evidence that those women who provided instrumental support intended to reduce their contribution, which suggests increasing inequality in the reciprocity of the relationship.

Friendship Network

Women participated in friendship networks that provided needed informational support, instrumental support in terms of assistance with child care and with accessing resources and material goods, and emotional support. These networks seemed to fulfil roles that would have been associated with the extended family in the women's country of origin, as evident in a comment by a member of the Pakistani focus group: "Here we expect help from our community members and friends, while in

Pakistan our parents and relatives can help us." Most women reported that their friends were from the co-ethnic community and shared similar challenges and experiences and that they all helped one another, implying that these were reciprocal relationships. When discussing networks, the women did not mention gender explicitly.

Although social networks often played an important role in supporting these women, many women described having a much smaller network of friends in Canada than they had had in their country of origin. Moreover, they did not speak of receiving emotional support from these networks, which suggests that the networks were somewhat impoverished. For example, a woman from the Brazilian focus group remarked, "I think here we don't have many friends. We meet many people but work all day. Our life here is always running." Women also spoke about the limits of friendship and how the friendship network could not provide the same level of support as the extended family in their country of origin. For example, a woman in the Angolan focus group noted that "in a given moment someone can help you, but friends don't fill all the expectations you have or things that you need suddenly." Women acknowledged that the amount of support available was limited by the demands that their friends were facing themselves. As a permanent resident from Pakistan noted, "It also depends on the status of the other, how much help they can provide." Thus, these friendship networks were not perceived as a reliable source of support and may not have provided all of the types of support needed.

These networks were all co-ethnic in nature. The women's tendency to join co-ethnic friendship networks may have been a matter of preference as well as lack of opportunity. Many women did not speak English, which precluded their participation in English-speaking networks, and most were not employed and therefore had limited opportunities to meet new people (see Table 1). Also, some reported discrimination on the basis of language, immigration status, or race:

> *Sometimes you're walking down the street and somebody's watching you. They call the cops: "I see two black people walking" — like, you don't have to do nothing! [It's] because you're black.* (member of Caribbean focus group)

The women's reliance on co-ethnic networks is consistent with the research finding that immigrants rely heavily on co-ethnic networks and relationships to meet their support needs (Barnes & Aguilar, 2007; Hao & Johnson, 2000; Simich, Beiser, & Mawani, 2003). Cultural differences have been found in preferred patterns of support (Kim, Sherman, Ko, & Taylor, 2006; Mortenson, Liu, Burleson, & Liu, 2006; Procidano & Smith, 1997; Simich, Mawani, Wu, & Noor, 2004), and support that is culturally appropriate and provided by someone with shared experiences has been found to be more effective (Barnes & Aguilar, 2007; Simich et al., 2003). However, reliance on co-ethnic networks limits newcomers' ability to build social capital (Sen, 2000) and thus may serve to restrict the ability of women newcomers to exert control over their life circumstances (Glanville & Bienenstock, 2009).

Close Friends

Some women reported relying almost exclusively on support from a small number of close friends, who were always other women and who typically were also recent newcomers, usually from the same ethnocultural community. The help provided included instrumental, informational, and emotional support. Women expected much more support from close friends than from friendship networks. In some cases support in these relationships seemed to be primarily unidirectional, while in others it was clearly reciprocal. In some cases a single friendship was reported as the only support the woman had to rely on, as shown in the following comments by a refugee claimant from Mexico:

> *I: She helped you. And do you still have this friendship now?*
>
> *R: Yes, of course, of course — I can't stop talking to her. She's a person who has helped me a great deal. She's helped me with the baby; when my baby was born she was there with me. She could be an angel from heaven — you say to yourself, wow!*
>
> *I: What are the sources of strength or support that you can rely upon to help you face your problems? You've already told me that one source of support is this woman. . . . Do you have other sources, either a place or other people?*
>
> *R: No, just her.*
>
> *I: You don't go to the centres any more?*
>
> *R: No, I don't go any more.*
>
> *I: You feel good just with her.*
>
> *R: Yes.*

Even when these women reported relatively small social networks, those with close friendships reported satisfaction with the support available to them, consistent with the research finding that it is the quality of support available, rather than quantity, that is more critical to health and well-being (Chandola, Marmot, & Seigrist, 2007). The conversation above also shows that women who found a reliable source of informal support stopped seeking formal support services (i.e., "from centres").

Community

Many women had received help from their co-ethnic communities and people in their immediate neighbourhood, particularly informational support, and a range of much appreciated instrumental support, from free meals at a local restaurant, to reduced rent, to a loan or gift of essential household items. Emotional support was typically not mentioned in this context unless the community in question was a religious community such as a church group; in these cases women reported receiving all three types of support.

Not all women reported positive experiences. Some viewed their co-ethnic communities as not very helpful, or as not organized or accessible, which suggests a lack of community-level social capital:

> *We didn't know if [any social service agencies] existed . . . we didn't know anything and there was no guidance . . . like, here in Toronto there are a lot of people from Pakistan. This building over there . . . is full of people from our country, one can ask about things from any one, but over there no one would tell us anything; it seemed as if we were in a jungle. Our cities — Lahore, Faisalabad — they were so good, people were so helpful. Whatever we need to do over here we do it ourselves, but at least someone should tell us how things work here. These were the problems.* (permanent resident from Pakistan)

The usefulness or desirability of support from their co-ethnic communities may have also depended on the types of assistance the women required. For newcomers struggling to adjust to a new community, support from co-ethnic community members may be particularly useful and desirable. For those with issues that they do not wish to have discussed in the community, or that they believe the community will be unable to address, such as marital problems or abuse (e.g., Haj-Yahia & Sada, 2008), co-ethnic community support may be less desirable or helpful.

Other cultural communities also offered assistance. For example, several women in the Brazilian community remarked that they received tremendous support from the Portuguese community, which in Toronto is an older and more established community. Support provision to communities was not discussed explicitly, although some women mentioned in passing that they did voluntary work with community agencies.

Although the women frequently described support from community members, they were unsure whether this support could be counted on when needed; it was often sporadic and unexpected. A permanent resident from Pakistan noted that when it came to providing needed help "they might do it . . . they might not." Thus, while co-ethnic communities may have been able to provide relevant support because of shared identity and experiences, this support varied considerably depending on the community in question and could not necessarily be relied upon. Since evaluations of perceived support are based on the expectation that support is available when needed, and since perceived support has a strong relationship to health and well-being (Lakey & Orehek, 2011), this finding suggests that community support for female newcomers does not promote health and well-being in the same way that other types of support do.

Social Isolation and Agency Support

Although the women spoke of mobilizing a variety of sources of social support, a common theme throughout was social isolation, associated with distress and feelings of helplessness, which is consistent with the literature linking social support and mental health (Cohen, 2004; Finfgeld-Connett, 2005). For example, one woman spoke of both her isolation and its toll on her well-being:

> *Ever since I got sick I have only been to my family doctor. They took my blood and it has been 3 weeks and I don't know my results. I don't know where else or who else to go to. These problems give me a lot of stress because if I get sick I ask myself where do I go and who do I speak to. An Afghan settlement worker . . . they helped me with my problems. I would go to them and tell them [about] my problem. They helped me because they are from my country.* (permanent resident from Afghanistan)

Two important themes emerge in this extract. First, in the absence of an informal support network, a professional care provider furnished both informational and emotional support in a satisfactory way. Second, the woman assumed that this support was offered because the care provider was from the same ethnic community.

A different perspective was provided by a woman from the Caribbean. This participant had family in Toronto but stated that if she needed help she would go to the local health centre rather than to friends or family members:

> *I: Are there any sources of strengths and supports that you rely upon to face your challenges?*
>
> *R: Basically, I pray, you know. . . . nobody is your friend if you get on your knees, because, basically, when you have your problems and you go to someone and say, "I need this and I need that," too many people hear about it on the street. . . . yeah, pray and [name of health-care centre] is there for counselling and advice.* (refugee applicant from St. Lucia)

There were individuals available in this woman's informal network, but the excerpt suggests that asking for help would result in her social isolation and thus the formal services available at the health-care agency were preferable, such as services provided by settlement workers, social workers, and nurses. Another study found that informal support was preferable to formal support (Finfgeld-Connett, 2005); however, this woman's comments seem to suggest that informal support was not really an option.

Not all experiences with community and government agencies were positive, but for many women community centres were the only source of informational, instrumental, and sometimes emotional support — or had been the only source when they first arrived. In many cases the participants had initially made contact with the centre to meet health or settlement needs but then realized that other forms of support could be accessed there as well. Often they reported an ongoing relationship with an individual at the centre, typically someone who shared their ethnic background, who became a central source of instrumental, informational, and emotional support. In these cases the agency support provider blurred the boundary between formal and informal support, a situation that may be necessary for the provision of effective emotional support (Lakey & Orehek, 2011) but that presents challenges around boundary issues and professional relationships (Repper & Carter, 2011).

As noted above, women also reported volunteering at these agencies, thus providing the same kind of peer support they themselves had received. Importantly, being able to offer as well as receive social support made a positive contribution to women's mental health, as noted in the following interview excerpt:

> *R: Since I started working here at [name of centre] as a volunteer doing the workshops, I have had an opportunity to meet Portuguese and Angolan people from the community. We learn a lot from each other. Sometimes what is right for me is wrong for them. We learn to respect the way other people live. This is very good for one's well-being. When you interact with someone else you are partaking in something.*
>
> *I: So you feel connected.*
>
> *R: Yes. I think it's good for the self-esteem. You feel needed and at the same time you are learning something.* (permanent resident from Angola)

This exchange speaks to the benefits that can be reaped when community agencies help to build peer-support networks, which provide not only culturally appropriate support but also opportunities for people to feel competent and valued.

Discussion

Across this varied group of newcomers, social support relationships and networks were shaped by social and structural variables inherent in the women's newcomer status, which may have contributed to lower perceived social support levels and unequal reciprocal relationships, and which in turn could have had consequences for their health and well-being. These women participated primarily in co-ethnic relationships, friendship networks, and communities. Even when they sought social support from care providers, they usually preferred co-ethnic staff. This could have been a by-product, partly, of social exclusion resulting from their migration status (e.g., those with precarious status might have had limits on their participation in society), ethnic or racial discrimination, or language barriers (Galabuzi & Teeklucksingh, 2010; Schellenberg & Maheux, 2007). However, social support is most relevant and helpful when it is provided by people from the recipient's cultural community (Simich et al., 2003); thus the building of reciprocal co-ethnic support relationships and networks ensures that the social support offered to and received by newcomers is appropriate and relevant. Reciprocal co-ethnic support networks also build social capital, allowing community members to assist one another in dealing with challenges (Boneham & Sixsmith, 2006; Wakefield & Poland, 2005).

However, although enacted support from friendship networks and the community could be generous and valuable, it was difficult to predict. Thus, although the women were grateful for support received, their perceived support from these sources was quite low unless they included close personal relationships. This finding is significant because, compared with enacted support, perceived support has more consistent associations with health and well-being (Lakey & Orehek, 2011). Newcomers' reliance on support networks consisting primarily of other newcomers can therefore be problematic, as the initial challenges of settlement can hinder one's ability to provide support to others (Stewart et al., 2008). This observation is borne out in the results of the present study. Moreover, communities that are excluded from the mainstream with its strong relationships are characterized by difficulty leveraging material benefits for their members (Sen, 2000), which in turn affects their ability to provide resources. Thus the development of reciprocal co-ethnic peer support networks should be encouraged, but only if the networks themselves and their members are provided with adequate personal and community resources.

There was also evidence of gendered support, with the women relying primarily on other women for support and feeling duty-bound to support family members both in Canada and in the country of origin.

Gendered patterns of unequal support provision can render mutual support networks and relationships harmful (Chandola et al., 2007), particularly for women with low levels of support and/or resources (Osborne, Baum, & Ziersch, 2009). For newcomer women, for whom expectations of support provision, especially by family members, can be too high, family relationships and social networks might be as much a burden as a benefit. Thus it cannot be assumed that the building of multiple reciprocal relationships will guarantee success in coping with the stresses of immigration. Attention must be paid to the resources available to the women engaged in such relationships (Armstrong et al., 2008).

Finally, women reported relying on and sometimes favouring primary care providers such as nurses and social workers for all kinds of assistance, including emotional support. This is a surprising finding, since the literature indicates a preference for emotional support by informal support providers (e.g., Finfgeld-Connett, 2005), which requires intimate relationships (Lakey & Oherek, 2011). However, the participants did appear to form meaningful relationships with primary care providers and to place their trust in these professionals to be available when needed. Thus primary care by nurses and other health-care providers may be an important form of social support for female newcomers, even though this type of support could require a commitment on the part of care providers and therefore might be difficult to develop and negotiate.

Limitations

Our sample was not large enough for between-culture comparison, although this would be an interesting consideration for future research. Also, while interviewing women in their first language serves to put them at ease and to ensure their full understanding of the issues being discussed, the interpretation of concepts may not always translate easily between cultures and languages. Finally, since participants were recruited through community centres we may have recruited women who were biased in favour of primary care providers. Also, we may have failed to reach those who were particularly isolated and did not know how to access resources at these centres; the responses of female newcomers who do not use these centres could be quite different from those reported here.

Conclusions

Women newcomers in Toronto, Canada, showed a clear preference for co-ethnic support networks, including co-ethnic primary care providers. Co-ethnic networks and communities provided much-needed enacted support to these women but were perceived as unreliable unless they included close personal relationships. The reliability of such networks may be limited by the challenges associated with social, personal, and structural circumstances inherent in the migration experience.

These findings highlight the importance of health-care providers and health-care systems to the efforts of newcomers to rebuild their support networks. It is crucial that we support policies and practices that help newcomers to build personal and community resources and that we be mindful of recent newcomers' need for culturally sensitive support by primary care providers such as nurses.

References

Armstrong, P., Armstrong, H., & Scott-Dixon, K. (2008) *Critical to care: The invisible women in health services.* Toronto: University of Toronto Press.

Aronson, J. (1994). A pragmatic view of thematic analysis. *Qualitative Report, 2*(1), 1–3.

Barnes, D. M., & Aguilar, R. (2007). Community social support for Cuban refugees in Texas. *Qualitative Health Research, 17*(2), 225–237.

Beck, L. (2008). Social status, social support, and stress: A comparative review of the health consequences of social control factors. *Health Psychology Review, 1*(2), 186–207.

Beiser, M. (2005). The health of immigrants and refugees in Canada. *Canadian Journal of Public Health*, *96* (Suppl 2), S30–S44.

Boneham, M. A., & Sixsmith, J. A. (2006). The voices of older women in a disadvantaged community: Issues of health and social capital. *Social Science and Medicine, 62,* 269–279.

Canadian Research Institute for the Advancement of Women. (2003). *Immigrant and refugee women.* Ottawa: Author.

Chandola, T., Marmot, M., & Seigrist, J. (2007). Failed reciprocity in close social relationships and health: Findings from the Whitehall II study. *Journal of Psychosomatic Research, 63,* 403–411.

Chui, T., & Maheux, H. (2011). *Visible minority women.* Ottawa: Statistics Canada.

Cohen, S. (2004). Social relationships and health. *American Psychologist, 59*(November), 676–730.

Crooks, V. A., Hynie, M., Killian, K., Giesbrecht M., & Castleden H. (2011). Female newcomers' adjustment to life in Toronto, Canada: Sources of mental stress and their implications for delivering primary mental health care. *GeoJournal, 76*(2), 139–149.

Finfgeld-Connett, D. (2005). Clarification of social support. *Journal of Nursing Scholarship, 37*(1), 4–9.

Galabuzi, G.-E., & Teelucksingh, C. (2010). *Social cohesion, social exclusion, and social capital. Region of Peel, Canada.* Retrieved October 12, 2011, from http://www.peelregion.ca/social-services/pdfs/discussion-paper-1.pdf.

Glanville, J. L., & Bienenstock, E. J. (2009). A typology for understanding the connections among different forms of social capital. *American Behavioral Scientist, 52,* 1507–1530.

Goldring, L., Berinstein, C., & Bernhard, J. (2007). *Institutionalizing precarious immigration status in Canada.* CERIS Working Paper 61. Toronto: Ryerson University.

Gottlieb, B. H., & Bergen, A. E. (2010). Social support concepts and measures. *Journal of Psychosomatic Research, 69,* 511–520.

Haines, V. A., Beggs, J. J., & Hurlbert, J. S. (2008). Contextualizing health outcomes: Do effects of network structure differ for women and men? *Sex Roles, 59*(3–4), 164–175.

Haj-Yahia, M. M., & Sada, E. (2008). Issues in intervention with battered women in collectivist societies. *Journal of Marital and Family Therapy, 34*(1), 1–13.

Hao, L., & Johnson, R. W. (2000). Economic, cultural and social origins of emotional well-being: Comparisons of immigrants and natives at midlife. *Research on Aging, 22,* 599–629.

Hynie, M., & Viveros, M. (2010, May 2–4). *Community-led dissemination of ethno-specific mental health information: Benefits for community and participants.* Poster presented at the Second National Transcultural Health Conference, Calgary.

Israel, B. A., Schulz, A. J., Parker, E. A., & Becker, A. B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health, 19,* 173–202.

Kim, H. S., Sherman, D. K., Ko, D., & Taylor, S. E. (2006). Pursuit of comfort and pursuit of harmony: Culture, relationships, and social support seeking. *Personality and Social Psychology Bulletin, 32*(12), 1595–1607.

Lakey, B., & Orehek, E. (2011). Relational Regulation Theory: A new approach to explain the link beween perceived social support and mental health. *Psychological Review, 118*(3), 482–495.

McMichael, C., & Manderson, L. (2004). Somali women and well-being: Social networks and social capital among immigrant women in Australia. *Human Organization, 63,* 88–99.

Mortenson, S., Liu, M., Burleson, B. R., & Liu, Y. (2006). A fluency of feeling: Exploring cultural and individual differences (and similarities) related to skilled emotional support. *Journal of Cross-Cultural Psychology, 37*(4), 366–385.

Osbourne, K., Baum, F., & Ziersch, A. (2009). Negative consequences of community group participation for women's mental health and well-being: Implications for gender aware social capital building. *Journal of Community and Applied Social Psychology, 19*(3), 212–224.

Portes, A. (2000). The two meanings of social capital. *Sociological Forum, 15*(1), 1–12.

Procidano, M. E., & Smith, W. W. (1997). Assessing perceived social support: The importance of context. In G. R. Pierce, B. Lakey, I. G. Sarason, & B. R. Sarason (Eds.), *Sourcebook of social support and personality* (pp. 93–106). New York: Plenum.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392–411.

Schellenberg, G., & Maheux, H. (2007). *Immigrants' perspectives on their first four years in Canada: Highlights from three waves of the Longitudinal Survey of Immigrants to Canada.* Ottawa: Statistics Canada.

Sen, A. (2000). Social exclusion: Concept, application, and scrutiny. *Social Development Papers, 1.* Manila: Asian Development Bank.

Simich, L., Beiser, M., & Mawani, F. N. (2003). Social support and the significance of shared experience in refugee migration and resettlement. *Western Journal of Nursing Research, 25*(7), 872–891.

Simich, L., Mawani, F., Wu, F., & Noor, A. (2004). *Meanings of social support, coping, and help-seeking strategies among immigrants and refugees in Toronto.* CERIS Working Paper 31. Toronto: Ryerson University.

Stewart, M., Anderson, J., Beiser, M., Mwakarimba, E., Neufeld, A., Simich, L., et al. (2008). Multicultural meanings of social support among immigrants and refugees. *International Migration, 46*(3), 123–159.

Uchino, B. N. (2006). Social support and health: A review of physiological processes potentially underlying links to disease outcomes. *Journal of Behavioral Medicine, 29*(4), 377–387.

Wakefield, S. E. L., & Poland, B. (2005). Family, friend or foe? Critical reflections on the relevance and role of social capital in health promotion and community development. *Social Science and Medicine, 60,* 2819–2832.

Walters, D., Phythian, K., & Anisef, P. (2006). *Understanding the economic integration of immigrants: A wage decomposition of the earnings disparities between native-born Canadians and immigrants of recent cohorts.* CERIS Working Paper 42. Toronto: Ryerson University.

Xu, M. A., & McDonald, J. T. (2010). The mental health of immigrants and minorities in Canada: The social and economic effects. *Canadian Issues, Summer,* 29–31.

Yakushko, O., & Chronister, K. M. (2005). Immigrant women and counseling: The invisible others. *Journal of Counseling and Development, 83,* 292–298.

Yoon, E., Lee, R. M., & Goh, M. (2008). Acculturation, social connectedness, and subjective well-being. *Cultural Diversity and Ethnic Minority Psychology, 14*(3), 246–255.

Acknowledgements

Funding was made available through the Lupina Foundation.

We would like thank all the participants in the research, including the staff at the three participating centres. We wish to thank Niru Domani, Nighat Gilani, Nancy Johnston, Susan McGrath, Soheila Pashang, Paula Pinto, and Cristina Santos for their contributions to the project. We would also like to thank Anita Gagnon and two anonymous reviewers for their very helpful feedback on earlier drafts of this manuscript.

Michaela Hynie, PhD, is Associate Professor, Department of Psychology, York University, Toronto, Ontario, Canada. Valorie A. Crooks, PhD, is Associate Professor, Department of Geography, Simon Fraser University, Burnaby, British Columbia, Canada. Jackeline Barragan, MA, is Community Health Programs Manager, Black Creek Community Health Centre, Toronto.

Résumé

Le soutien social dans le cadre de la gestion d'un cancer du sein chez les immigrantes lusophones

Sepali Guruge, Christine Maheu, Margareth Santos Zanchetta, Francyelle Fernandez, Lorena Baku

Le cancer du sein est l'un des cancers les plus fréquemment diagnostiqués chez les Canadiennes. De nombreuses recherches en sciences de la santé se sont penchées sur cette question. L'importance du soutien social formel et informel dans le cadre de la gestion d'un cancer du sein a fait l'objet d'une attention particulière, mais peu d'études ont été réalisées auprès des femmes immigrantes. Cet article présente les résultats d'une étude ethnographique appliquée menée à Toronto, au Canada, auprès de 12 femmes lusophones du Brésil, du Portugal et de l'Angola. L'étude se penche sur leur besoin d'un soutien social pour gérer le cancer du sein, ainsi que sur leur accès et leur recours à un tel soutien. Les principales conclusions portent sur les peurs et les stigmates liés au cancer qui entravent l'accès et le recours à ce type de soutien. Elles portent aussi sur la résilience des femmes dans un contexte où le soutien social informel et formel est limité. Les auteures font état des implications à l'endroit des fournisseurs de soins de santé, à une micro, méso et macro-échelle.

Mots clés : cancer du sein, Canada, immigrantes lusophones, résilience, soutien social

CJNR 2011 Vol. 43 N° 4, 48–66

Social Support for Breast Cancer Management Among Portuguese-Speaking Immigrant Women

Sepali Guruge, Christine Maheu, Margareth Santos Zanchetta, Francyelle Fernandez, Lorena Baku

Breast cancer is one of the most commonly diagnosed types of cancer among women in Canada. Much health sciences research has examined this topic. The importance of formal and informal social support in managing breast cancer has received particular attention, but research with immigrant women has been limited. This article presents the findings of an applied ethnographic study conducted in Toronto, Canada, with 12 Portuguese-speaking women from Brazil, Portugal, and Angola about their need for, access to, and use of social support in the management of breast cancer. The key findings pertain to cancer-related fears and stigma that restrict access to and use of informal social support, barriers to obtaining formal social support, and women's resilience in the context of limited informal and formal social support. Implications for health-care providers are presented at micro, meso, and macro levels.

Keywords: applied ethnographic method, breast cancer, Canada, informal and formal social networks, Portuguese-speaking immigrant women, resilience, social support.

Breast cancer is one of the most commonly diagnosed cancers among women in Canada (Canadian Cancer Society, 2010). The Canadian Cancer Society (2010) estimated that, in the year 2010, 8,900 women would be diagnosed with breast cancer and 2,100 would die from the disease. However, no comparable statistics are available for immigrant women, and only limited data are available on immigrant women's need for, access to, and use of formal and informal social support in the management of breast cancer. A substantial body of literature (Antonucci, 1994; Cohen & Syme, 1985; Hall & Havens, 2001; Reevy & Maslach, 2001; Simich, Mawani, Wu, & Noh, 2004) indicates that social support has a positive effect on physical and mental health, ability to cope with major illnesses, and health-risk behaviours. Social support is positively correlated to participation in social networks (Smith & Christakis, 2008). Social support from social contacts is especially important to women, who tend to rely on social networks for support, self-esteem, identity, and perceptions of control (Antonucci, 1994; Cohen & Syme, 1985; Hall & Havens, 2001; Putland, 2000). Women tend to have larger and more diverse networks than men, and can more readily command support when in need (Antonucci, 1994; Belle, 1989; Kessler & McLeod, 1985). However, few studies have focused on the role of support derived from social networks among diverse immigrant communities, and no previous research has examined this topic among Portuguese-speaking women in Canada. This article draws from a study of social and cultural capital and readiness, intentions, and barriers to using social support among breast cancer survivors and general members of the Portuguese-speaking community in Toronto. It presents the study's key findings from the perspectives of Portuguese-speaking women on *their need for, access to,* and *use of* formal and informal social support in the management of breast cancer.

Literature Review

Social support can be informational, instrumental, emotional, or financial (Belsky & Rovine, 1984; House, 1981) and is usually provided by members of informal and formal social networks. Informal social networks include family, friends, and neighbours, whereas formal support may be provided by health professionals, social service workers, settlement workers, crisis hotline workers, police officers, and various other service providers (Guruge & Humphreys, 2009).

Social support from family members and close friends is of vital importance to women living with breast cancer (English, Wilson, & Olaman, 2008). Previous research has focused on how social support affects healing, rehabilitation, and survival among women with breast cancer. For example, community belonging and social involvement provide opportunities for contact with others, which is beneficial for physical and emotional healing (English et al., 2008). Perceived social support can act as a protective factor against anxiety, depression, and post-traumatic stress disorder in the context of rehabilitation following breast cancer care and treatment (Knobf, 2007), but its importance appears to vary among women of diverse ethnocultural origins (Gass, Weitzen, Clark, & Dizon, 2007). The influence of social support on survival is controversial (Falagas et al., 2007).

For women managing the "healthy-to-sick" transition, primary support often comes from their partner, who may have a profound effect on the transition process (Sawin, Laughon, Parker, & Steeves, 2009). During this process, spouses and other family members may require informational support regarding the provision of effective support for women with breast cancer (Makabe & Nomizu, 2007). Similarly, women who are living with a diagnosis of breast cancer may require information on how to ask for and receive social support to better manage their illness. For example, some studies (e.g., Ashida, Palmquist, Basen-Engquist, Singletary, & Koehly, 2009; Yoo, Levine, Aviv, Ewing, & Au, 2010) report that older women diagnosed with breast cancer often feel that they do not want to be a burden on others but when they are able to accept their need for support, and are able to ask for it, family support can help them to deal with breast cancer. In other words, social support for patients and for family members is interlinked (Osborn, 2007).

Immigration usually results in the loss of informal social networks and support (Guruge & Humphreys, 2009; Simich, Beiser, Stewart, & Mwakarimba, 2005), the impact of which is compounded by language barriers, un/underemployment, unsafe living conditions, and racism and sexism in society at large (Guruge & Collins, 2008). Accessing health information can be a challenge, especially for newcomers (Caidi, 2008; Zanchetta & Poureslami, 2006). In addition, culturally and linguistically appropriate services specific to disease prevention and illness management are not often readily available in Canada (Guruge & Collins, 2008). All of these factors can impede successful access to and use of formal support by immigrants.

Purpose

The interest in this study came from a university-affiliated, hospital-based breast cancer survivorship program in Toronto. The staff there noticed that the Portuguese-speaking women who accessed their services tended to be living with advanced stages of breast cancer. Wondering why these women had not accessed breast cancer services earlier, they contacted the second and third authors of this article to conduct a study on the topic. The large-scale study examined social and cultural capital and readiness, intentions, and barriers with respect to the use of social support among breast cancer survivors and general members of the Portuguese-speaking community in Toronto. The study entailed individual as well as focus group interviews with both breast cancer survivors and general members of the Portuguese-speaking community. This article presents the findings in relation to the following research question: *From the perspective of Portuguese-speaking immigrant women diagnosed with breast cancer, what are their needs for, access to, and use of social supports in the context of breast cancer management?*

Method

The method used in this study was applied ethnography, which is "concerned with understanding sociocultural problems and using these understandings to bring about positive change in communities or groups" (LeCompte & Schensul, 1999, p. 6). In general, ethnography helps to generate explanations for how members of a cultural group think, believe, and behave in a particular time and space (LeCompte & Schensul, 1999). The study and its method were negotiated with key community leaders and gatekeepers. The goal was to move beyond mere description of the topic from an outsider's point of view to in-depth examination of the meanings, organizations, and interpretations of culture from an emic and etic perspective. This was achieved by including Portuguese-speaking co-investigators on the team (including one with 15 years of clinical experience in oncology nursing); by working closely with community members and agencies to ensure a cyclical, dynamic, and collaborative process; by engaging in lengthy involvement and data collection with and within the community; and by liaising with cultural insiders to locate and identify prospective participants as well as to immerse the research team in their cultural and social life in order to gather data on cultural values and beliefs and ways of living, interacting, and networking, with the aim of understanding how culturally based social networks support Portuguese-speaking women with breast cancer.

Potential participants had to meet five inclusion criteria: (a) be living in metropolitan Toronto; (b) be older than 18 years; (c) speak Portuguese as their first language; (d) self-identify as an immigrant to Canada; and (e) have undergone treatment for breast cancer. Women were recruited via postings at various community locations frequented by Portuguese-speaking immigrants to Toronto, a presentation on a Portuguese television network, a posting on the Web site of the Portuguese consulate, and flyers in clinics of family doctors offering services in Portuguese. Women who expressed an interest in the study were contacted by the second or third author, who described the study and answered any questions about participation. All prospective participants were given a week to think about the invitation, after which they received a follow-up phone call. Of the 13 women approached for the study, only one chose not to participate (due to concerns at the time about possible brain metastasis).

Following ethics approval from York and Ryerson universities, data were generated through individual interviews. Interviews were conducted by the second or third author (both oncology nurses) in English and Portuguese, respectively, during 2009 and 2010; each participant decided which language her interview would be conducted in. Interviews were generally held during evenings and weekends at locations convenient for participants, such as their home, researchers' offices, or a public setting. All potential participants were informed, verbally and via a consent form, of their right to refuse to participate or to answer any questions or to terminate their participation at any time. All information sheets and consent forms were developed in English and translated into

Portuguese and tested for linguistic appropriateness by Brazilian- and Portuguese-born women. All refined documents were pilot-tested with two women, one from Brazil and one from Portugal (the latter was a cancer survivor). Participants also received a list of community-based resources.

Each participant was interviewed only once, because participants noted that they had said all they could about their perceptions and experiences related to the topic within the first interview. The interviews averaged 80 minutes in length and were audiorecorded and transcribed. The transcriptions were coded using ATLAS ti 6.0 software. Interviews conducted in Portuguese (n = 10) were coded in Portuguese by the third author and the two research assistants, all of whom were bicultural and bilingual native Portuguese speakers. The third author and the two research assistants independently drew up a list of 56 preliminary codes, which they then reviewed together for similarities and differences. The output of all coding processes was summarized per code by these three members of the research team. A general summary in English was then prepared by the third author. Interviews conducted in English (n = 2) were coded using the same procedure. The team then conducted a thematic analysis to see how the codes converged or diverged within and across interviews and grouped the codes into subcategories and categories for analysis. All authors collaborated on the interpretation of the findings.

Trustworthiness of the study was ensured through interviewer triangulation (interviews were conducted by two interviewers); data triangulation (data were collected in two languages); and member checking (with each participant during individual interviews and other participants during subsequent interviews) and prolonged engagement and debriefing (over a 1-year period) (LeCompte & Schensul, 1999; Lincoln & Guba, 1999). In addition, as per Creswell (1998) the results and interpretations were presented to other researchers, both within and outside of the community, to ascertain whether similar interpretations would be drawn.

Results

The final sample comprised 12 Portuguese-speaking breast cancer survivors. The participants were diverse in terms of country of origin (Brazil = 3, Portugal = 8, Angola = 1), age (27 to 60 years), education (less than elementary school to university), marital status (single, married, divorced/separated), length of residency in Canada (8 months to 37 years), and time since diagnosis (3 months to 27 years). Stage of cancer was not solicited from participants.

Three themes emerged from the data: *cancer-related fears and stigma that restrict access to and use of informal social support, barriers to obtaining formal social support,* and *resilience in the face of limited informal and formal social support.*

Cancer-Related Fears and Stigma That Restrict Access to and Use of Informal Social Support

Cancer-related fears and stigma shaped the type and quality of informal social support the participants were able to obtain as they lived with a diagnosis of breast cancer. Regardless of their country of origin, participants believed cancer was a taboo subject. Cancer was commonly perceived as a debilitating condition that leads to suffering and death, and participants believed that members of their community also held such views. These fears and stigma led most participants to believe that a diagnosis of cancer should be kept secret. Some of these ideas are captured below:

> *To our people, the word "cancer" means an incurable disease. When a person has cancer, she dies.* (Portuguese, age 47, married)
>
> *My experience is with my mother and my aunts . . . I do not know about the new generation but I see a lot of taboo about cancer. People do not talk about cancer. People do not want to know about it. They prefer not to be tested or undergo examinations.* (Brazilian, age 42, married)
>
> *My friends don't really want to know a lot about the disease . . . they are scared. In Angola, people are scared to enter the oncology centre because they think cancer is contagious.* (Angolan, age 45, separated)
>
> *In the Portuguese community . . . there are people who are afraid to come near us or to talk to us.* (Portuguese, age 48, married)

Some Portuguese participants expressed a fear of becoming a target of gossip within the community. Most said that they avoided chatting and mingling with community members to escape potentially embarrassing encounters — for example, in neighbourhood shops where someone might comment on their diagnosis. Participants noted that such a response was in stark contradiction to their "normal" day-to-day life in the community, whereby they chatted, shared information, and supported one another.

While most participants noted that they were not able to obtain support from members of their community at large, they reported considerable support from immediate and/or close family members and close friends. For those who were married, husbands and children were the main support providers. However, not all husbands were supportive:

> *Three weeks after my chemo, my husband started to drink and smoke. At the end of my treatment, my husband filed for divorce.* (Portuguese, age 40, divorced)

Some participants reported that other immediate or close family members provided instrumental support (such as taking care of housework during treatment phases) and/or financial support:

> *I didn't have money for a wig that looks natural, so my stepmother gave me one as a gift. Even my friends collected almost $3,000 and gave [it] as a gift.* (Brazilian, age 37, single)

Immediate and close family members living nearby were the most frequent support providers for almost all participants, but some spoke of close relatives travelling to Toronto to care for them during and after treatments. Some participants also received emotional support from family and friends in their country of origin, who contacted them regularly via telephone and social networking Web sites.

The only Angolan participant spoke of difficulty sharing information about her diagnosis, even with her sister, with whom she was living, to keep her from worrying:

> *I went home crying. It was hard to tell my sister. When I told her what the doctors told me, she couldn't handle it and started crying as well.* (Angolan, age 45, separated)

Consequently, this participant sought support from other Portuguese-speaking breast cancer survivors who had undergone treatments in Brazil, Portugal, or the United States. She also reported contacting close friends from Angola, who provided the emotional support she felt she needed to face the diagnosis and preparation for treatment. Interestingly, regardless of country of origin, almost no participants intended to share their diagnosis with or ask for help from extended family members.

The eight Portuguese participants noted that, apart from that provided by their husbands, children, and daughters-in-law, immediate support came from neighbours and co-workers:

> *My neighbour was so positive that I started to believe I would be able to deal with the chemo . . . every time I fell apart, I ran to her. She also had breast cancer. She was very optimistic and my best help . . . better than the help from my husband.* (Portuguese, age 50, married)

> *My colleagues in the factory gave me a lot of support. When I cried they consoled me, saying that it would not be complicated. I felt some comfort in that.* (Portuguese, age 40, married)

Those who were more educated, were fluent in English, or remained professionally active or employed during their treatment reported no significant contact with, or desire to seek support from, members of their communities. In general, they felt free to disclose their cancer status with friends and colleagues, regardless of their cultural background. In contrast, participants who were less educated, not fluent in English, and/or unemployed maintained contact with other Portuguese speakers when they were asymptomatic but during treatment generally limited their contact to other breast cancer survivors (whom they met in clinics or hospitals). Participants explained that they wanted to protect their family members in Canada and back home from any gossip generated by fear or stigma. Those who were able to connect with other breast cancer survivors from their own community felt supported by being able to disclose personal and emotional issues related to their struggles during breast cancer management.

Barriers to Obtaining Formal Social Support

Several barriers to obtaining formal social support emerged. Some of these were related to the women themselves. For example, most participants expressed psychological distress following their diagnosis and during and after treatment:

> *I lost all dreams in my life . . . Now I have no ambition of working, doing this or that.* (Portuguese, age 56, married)

> *I loved singing while working. I do not have the same joy. I do not have the same voice. And I do not remember the lyrics either.* (Portuguese, age 53, married)

However, they did not consider accessing psychological support because of a desire, for example, to preserve their reputation in the community as a mother and wife who leads a "normal" life. For some, being able to rely on oneself, self-sufficiency, and self-determination were important:

> *There were days I could not concentrate and I knew that it was due to treatment. Then I stopped and talked to myself: "Hey, I cannot stay like this! My psychological work I do myself. If I want to fight and win, I must do it myself. I must have strengths." For this reason, I did not want a psychologist. I usually take a deep breath, I pray, and that's it! The ball is rolling once more!* (Brazilian, age 27, married)

For others, it was cancer-related fear and stigma, concerns about how their use of formal social support would affect their children and husbands, or a sense of futility that prevented them from accessing formal social support. For example, the Angolan participant said she did not readily access formal social support because she believed that cancer is a deadly disease and that seeking care and treatment and additional support would be futile.

Other barriers to the use of formal social support were related to the support services available. First, participants noted a lack of age-appropriate services. For example, the youngest participant revealed that she could not find a self-help group to learn about issues of particular importance to younger women:

> *I was looking for groups or services [for] young women. I went to a few . . . but they only had older women. They said, "Sorry but we do not have material for young women."* (Brazilian, age 27, married)

Lack of linguistically appropriate services was a key concern for many women, who could not find professional interpreters. In some cases, this led to confusion:

> *Through the help of my cousin, we asked the doctor what would be the best advice that he could give me, and he said, "The best we can do is to take out the nipple and clean up everything." After the doctor left, we asked the surgeon, who seemed to know a lot about the disease, what he thought about it. He said, "By my own experience, the best is to take off the breast." We did not know what to do.* (Portuguese, age 58, married)

One participant highlighted the role played by her family members in the translation/interpretation of information:

> *With this disease I realize that I needed to learn English. Thanks to God and the Holy Spirit, my sons came to the hospital with me. Also thanks to Heavenly Father that my husband's cousin helps me a lot and a friend of mine that helps so much, much, much.* (Portuguese, age 59, married)

Participants commented on a lack of information about breast cancer in terms of survival rates, treatment options, coping with the psychological impact of cancer, and managing or coping with concerns about body image:

> *She did not explain very well the benefits [of a breast implant]. She looked like she was doing some other business. I looked at my husband and I said to him, "I will think about it" . . . and I did not go back.* (Portuguese, age 64, married)

Participants also mentioned a lack of information about available financial, instrumental, and other support and services. Some participants expressed interest in free physiotherapy services and lymphedema home-care services because most became unemployed or retired after their diagnosis, or could not afford the additional costs pertaining to such services. Many were also unaware of a major cancer survivorship program in Toronto that works collaboratively with a Portuguese community centre:

> *For instance, when the hair starts to fall [out] it would be useful to know where to go to get a wig. In terms of medications, if I did not have private insurance, which type of aid could I have?* (Brazilian, age 37, single)

Participants also identified a dearth of services for family members. Some of the Portuguese women, for example, expressed an interest in psychological support, not for themselves but for their husbands and children:

> *My dream is to find help for my children, help them face all the difficulties . . . there are many. I want to be able to help my son and my daughter to have strength and courage to move forward.* (Portuguese, age 47, separated)

> *Since my husband learned that I had cancer, he was not able to sleep. He [did] not know what to do and where to go . . . he needed help.* (Brazilian, age 42, married)

These barriers in the formal social support system limited participants' ability to cope with and manage their diagnosis, treatment, and care.

Resilience in the Face of Limited Informal and Formal Social Support

Despite the many challenges the participants faced in obtaining social support, both within their own community and in the larger society, they demonstrated remarkable resilience in coping and living with a diagnosis of breast cancer and engaging in care and treatment:

> *I was raised as a Catholic but I was never able to understand the power of believing in oneself, that we are not just a body, we're a soul too, and our spirit goes to get some strength and there is potential within us. [I have this understanding now.]* (Portuguese, age 49, married)

> *After I had cancer, I perceived that my previous lifestyle was unhealthy and it did not help my health problem . . . Now I am able to face everything better because now I see things differently. I was able to free myself from negative energy.* (Portuguese, age 47, separated)

> *My plans are to retire as soon as possible and then travel around the world. I do not have any long-term plan. I live today, and tomorrow I will see. I think about what happened to me and I am overcoming obstacles as they come to me.* (Brazilian, age 42, married)

> *People were surprised with the way I reacted to the treatment; many of them passed by me and commented, "Strong woman!"* (Portuguese, age 47, married)

For those who were employed, neither the diagnosis nor the treatment changed their motivation to work and plan for the future:

> *For my future I would like to be in a better professional and financial condition than what I have today. I plan to travel to Greece and also stay 2 weeks in New York. . . . All my plans are about travelling and evolving as a person.* (Brazilian, age 37, single)

Some participants engaged in sports, outdoor activities, and/or religious or spiritual activities. Close bonds with other women increased their sense of personal strength, even if such connections were unrelated to surviving breast cancer. To increase their personal strength and to palliate for their non-access to support services, many participants learned about breast cancer by watching health-related programs on television, listening to radio programs about health issues, reading self-help books, obtaining information from relatives who browsed Web sites, and speaking with other breast cancer survivors. The Angolan participant said she relied on the Canadian Cancer Society's recommendations.

Discussion

The assumption that individuals can and do receive support from their informal social networks during stressful situations such as chronic illness has shaped the movement in Canada to relocate care from institutional settings to the home (Armstrong, 2007). Another common assumption is that support is available within ethnocultural communities for immigrant women (Guruge, 2007) who are diagnosed with an illness (Guruge & Collins, 2008; Guruge, Hunter, Barker, McNally, & Magalhães, 2010; Guruge, Lee, & Hagey, 2001). Our findings reveal that a diagnosis of breast cancer may evoke fear and stigma, significantly affecting the quantity and quality of women's support during breast cancer management. This finding supports previous research: Wilkinson (2007) reports that the women in her study were "often worried about other people's reactions to their breast cancer diagnosis and sometimes withheld the news for a considerable period of time from those close to them [and that] telling others was carefully managed" (p. 413). Other researchers (e.g., Clarke, 1985; Peters-Golden, 1982) report various negative responses from members of informal social networks after a diagnosis of breast cancer. Most of the participants in Peters-Golden's (1982) study reported that others appeared to fear and avoid them, even to the point of crossing the road. Over time, knowledge and attitudes about cancer have changed but fear and stigma continue. Limited information is, however, available about these changes for immigrant communities.

Husbands, children, and other immediate family members were the primary informal support providers to most of our participants. English et al. (2008) also note the importance of social support from "household members" during recovery from breast cancer (p. 73). However, the quality and quantity of support provided by these household members might be insufficient for some women (Sawin et al., 2009), especially those who are single or divorced/separated. Armstrong (2007) notes that "women provide the overwhelming majority of both paid and unpaid care" (p. 529); when they become chronically ill, they might not receive quality care. Such situations leave immigrant women who are further socially isolated owing to immigration to a new country even more vulnerable.

Some of our participants were able to obtain instrumental, emotional, and financial support from immediate family members and close friends (whether they lived nearby or far away). However, regardless of their country of origin, participants were not eager to share their diagnosis or ask for help from extended family members or members of their community. Those who were employed in paid work and/or were well educated found some support from colleagues outside their community. Those who were not engaged in paid work sought support, comfort, and advice from close friends and family and from breast cancer survivors in their community; they felt a sense of support in being able to disclose personal issues about their struggles with breast cancer management. This finding supports the results of English et al. (2008), who report that (non-immigrant) participants spoke about "positive social support as important in contributing to healing and recovery from cancer for women" (p. 73); they note that engagement in a variety of activities (e.g., regular physical activity in community spaces) was an important way to obtain the social support that is vital to the physical and psychological healing process.

One of our key findings was two categories of barriers related to participants' lack of or minimal use of formal support. Barriers originating with the women themselves included lack of acknowledgement of the need for external/formal social support; concerns about how the use of formal support might affect their immediate family; a sense of futility about care, treatment, and support; and a desire to project the image of a "normal" woman, wife, and mother. More pronounced barriers related to formal social support services — the dearth of (1) age-appropriate services, (2) linguistically appropriate services, (3) information about breast cancer, (4) information about services, and (5) services for family members. Studies with non-immigrant participants have highlighted similar problems with formal social support services. Wilkinson reports that "support for partners and others living with, or close to, women with breast cancer has barely been addressed" (2007, p. 422). Arora, Finney Rutten, Gustafson, Moser, and Hawkins (2007) and Salminen, Vire, Poussa, and Knifsund (2004) note that little is known about the range or evolution of the informational, decisional, and emotional support needs of people diagnosed with cancer over time as they move from initial diagnosis to treatment, care, and rehabilitation, and that services based on limited information are problematic. Our participants relied primarily on information from Portuguese-language newspapers, television shows, and radio programs, as well as from friends who accessed various Web sites and from other breast cancer survivors. This finding highlights the limitations of the traditional modes of information delivery commonly used by hospitals in Canada. A related concern was the lack of age- and language-appropriate services. Other researchers (e.g., Wilkinson, 2007) also question the extent to which generic organizations and support groups (i.e., a fit-all program for all types of cancer or all women) are sufficient to meet the diversity of women's needs.

We observed remarkable resilience among our participants in coping and living with a diagnosis of breast cancer. Despite periods of psychological distress, the majority of participants relied on self-determination and self-control to become active self-carers and perceived survival as an opportunity to be reborn as a strong and independent woman. Studies with non-immigrant samples report similar findings: Clarke's (1985) participants expressed a desire to do things they had never done before and were "developing a sense of adventure" (p. 107). Wilkinson's (2007) participants claimed that uncertainty about the future made them appreciate and enjoy life. Our participants spoke of going on trips, engaging in activities they had always wanted to do, and taking better care of themselves.

Limitations

We used a small convenience sample. We chose to include Portuguese-speaking women from various countries to maximize the breadth of experiences, but, given the small samples from each country, we may have missed both similarities and differences between the diverse groups within this population. It is also possible that we lost some cultural nuances during the translation from Portuguese to English. Despite these limitations, a number of key implications can be drawn.

Implications

Implications are presented at micro, meso, and macro levels. At the micro level, health-care providers could work more closely with women living with breast cancer to help foster social connectedness and support to ensure that they have the informational, psychological, instrumental, and financial support necessary to manage breast cancer. Information should be provided about prognosis, survival rates, treatment options, coping with the psychological impact of cancer, and coping with body image concerns. Health-care providers are also encouraged to screen all women for psychological distress at various times in their cancer trajectory and to offer linguistically appropriate information and services. Many of our participants indicated that, despite struggling with the fear and stigma associated with cancer, they did not seek psychological support because they wanted to be self-sufficient. It is critical, therefore, that practitioners present support for women (and their families) as complementary to self-sufficiency.

At the meso level, health-care providers must engage immigrant communities in raising awareness about breast cancer and must stress the importance of screening, early treatment, and involvement in cancer survivorship programs. Such work will require the support of key community leaders and the use of ethnocultural media. Health-care providers could collaborate with immigrant communities to build and maintain the social networks needed to support women with breast cancer, particularly to overcome the effects of social isolation resulting from the stigma of cancer (Vahabi, 2010, 2011; Working Women Community Centre, n.d.). Self-help and social-exchange groups (telephone, face-to-face, online) within and outside the community could be encouraged to provide informational, psychological, and instrumental support for husbands and children. Given their tendency to restrict social contact when diagnosed with breast cancer, Portuguese-speaking women might be more responsive to indirect approaches such as (a) telephone calls by trained community volunteers as an alternative to formal psychological counselling; (b) distribution of educational material in family doctors' offices; (c) creation of support groups for breast cancer survivors who speak the same language; (d) dissemination of critical information via language- or community-specific television programs; and (e) a network of community members providing domestic and instrumental support, especially for those who are single, separated, or divorced and who may have no family support in coping with the debilitating effects of chemotherapy and radiation therapy. The effectiveness of such approaches needs to be carefully evaluated.

At the macro level, it is important that health policies and formal social services reflect Canada's diverse demographics and offer an integrated and multi-tiered approach appropriate to the needs and interests of diverse groups of immigrant women (Vissandjee, Thurston, Apale, & Nahar, 2007, p. 233). It is also important that attention be paid to the financial needs that arise from cancer care and treatment and/or illness-related loss of employment and income.

Conclusion

This is the first Canadian study to focus on the need for, access to, and use of social support in the management of breast cancer among Portuguese-speaking immigrant women, and the first to highlight the resilience of this group when faced with breast cancer. The study is an important first step in identifying implications for health-care providers when caring for immigrant women diagnosed with diseases such as cancer, when stigma and fear can diminish the informal social supports available to them, and in identifying the ongoing problems in the formal social support system for immigrant women with breast cancer. Further research is needed to clarify the similarities and differences within and between various immigrant communities in their need for, access to, and use of informal and formal social support in the management of breast cancer.

References

Antonucci, T. C. (1994). A life-span view of women's social relations. In B. F. Turner & L. E. Trill (Eds.), *Women growing older* (pp. 239–269). Thousand Oaks, CA: Sage.

Armstrong, P. (2007). Relocating care: Home care in Ontario. In M. Morrow, O. Hankivsky, & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 528–553). Toronto: University of Toronto Press.

Arora, N. K., Finney Rutten, L .J., Gustafson, D. H., Moser, R., & Hawkins, R. P. (2007). Perceived helpfulness and impact of social support provided by family, friends, and health care providers to women newly diagnosed with breast cancer. *Psychooncology, 16*(5), 474–486.

Ashida, S., Palmquist, A. E. L., Basen-Engquist, K., Singletary, E., & Koehly, L. M. (2009). Changes in female support network systems and adaptation after breast cancer diagnosis: Differences between older and younger patients. *Gerontologist, 49*(4), 549–559.

Belsky, R., & Rovine, M. (1984). Social network contact, family support and the transition to parenthood. *Journal of Marriage and the Family, 46,* 455–482.

Caidi, N. (2008). *Information practices of ethno-cultural communities: Citizenship and social, cultural, and civic integration.* Toronto: Ontario Metropolis Centre. Retrieved April 24, 2008, from www.ceris.metropolis.net/Virtual%20 Library/RFPReports/CaidiAllard2005.pdf.

Canadian Cancer Society. (2010). *Canadian cancer statistics 2010.* Retrieved March 22, 2011, from http://www.cancer.ca/Ontario/About%20cancer/Cancer%20statistics/Ontario%20cancer%20statistics.aspx?sc_lang=en#ixzz1HO583cUE.

Clarke, J. N. (1985). *It's cancer: The personal experiences of women who have received a cancer diagnosis.* Toronto: IPI Publishing.

Cohen, S., & Syme, S. L. (1985). Issues in the study and application of social support. In S. Cohen & S. L. Syme (Eds.), *Social support and health* (pp. 3–22). Orlando, FL: Academic Press.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

English, J., Wilson, K., & Olaman, S. (2008). Health, healing and recovery: Therapeutic landscapes and the everyday lives of breast cancer survivors. *Social Science and Medicine*, *67,* 68–78.

Falagas, M. E., Zarkadoulia, E. A., Ioannidou, E. N., Peppas, G., Christodoulou, C., & Rafailidis, P. I. (2007). The effect of psychological factors on breast cancer outcome: A systematic review. *Breast Cancer Research, 9*(4), 44.

Gass, J. S., Weitzen, S., Clark, M., & Dizon, D. S. (2007). Defining social support systems for women with breast cancer. *American Journal of Surgery, 194,* 501–503.

Guruge, S. (2007). *The influence of gender, racial, social, and economic inequalities on the production of and responses to partner violence in the post-migration context.* Doctoral dissertation, Graduate Department of Nursing Sciences, University of Toronto.

Guruge, S., & Collins, E. (2008). *Working with immigrant women: Issues and strategies for mental health professionals.* Toronto: Centre for Addiction and Mental Health.

Guruge, S., & Humphreys, J. (2009). Barriers that affect abused immigrant women's access to and use of formal social supports. *Canadian Journal of Nursing Research, 41*(3), 64–84.

Guruge, S., Hunter, J., Barker, K., McNally, M. J., & Magalhães, L. (2010). Immigrant women's experiences of receiving care in a mobile health clinic. *Journal of Advanced Nursing, 66*(2), 350–359.

Guruge, S., Lee, R. N. F., & Hagey, R. (2001). When conventional diabetes care is viewed as complementary: Perspectives of a Chinese client. *Alternative and Complementary Therapies Journal,* 7(2), 117–120.

Hall, M., & Havens, B. (2001). The effect of social isolation and loneliness on the health of older women. *Centre of Excellence for Women's Health Research Bulletin, 2*(2), 6.

House, J. (1981). *Work, stress, and social support.* Reading, MA: Addison-Wesley.

Kessler, R. C., & McLeod, J. D. (1985). Social support and mental health in community samples. In S. Cohen & S. L. Syme (Eds.), *Social support and health* (pp. 219–240). Orlando, FL: Academic Press.

Knobf, M. T. (2007). Psychosocial responses in breast cancer survivors. *Seminars in Oncology Nursing, 23*(1), 71–83.

LeCompte, M. D., & Schensul, J. J. (1999). *Analyzing and interpreting ethnographic data.* Walnut Creek, CA: Altamira.

Lincoln, Y., & Guba, E. (1999). Establishing trustworthiness. In A. Bryman & R. G. Burgess (Eds.), *Qualitative research* (Vol. 3) (pp. 397–444). Thousand Oaks, CA: Sage.

Makabe, R., & Nomizu, T. (2007). Social support and psychological and physical states among Japanese women with breast cancer before and after breast surgery. *Oncology Nursing Forum, 34,* 883–889.

Osborn, T. (2007). The psychosocial impact of parental cancer on children and adolescents: A systematic review. *Psycho-Oncology, 16,* 101–126.

Peters-Golden, H. (1982). Breast cancer: Varied perceptions of social support in the illness experience. *Social Science and Medicine, 16*(4), 483–491.

Putland, C. (2000). Social trust and women volunteers straddling the public/private divide. *Third Sector Review, 6*(1/2), 27–42.

Reevy, G. M., & Maslach, C. (2001). Use of social support: Gender and personality differences. *Sex Roles, 44,* 437–459.

Salminen, E., Vire, J., Poussa, T., & Knifsund, S. (2004). Unmet needs in information flow between breast cancer patients, their spouses, and physicians. *Support Care Cancer, 12*(9), 663–668.

Sawin, E., Laughon, K., Parker, B., & Steeves, R. (2009). Breast cancer in the context of intimate partner violence: A qualitative study. *Oncology Nursing Forum, 36*(6), 686–692.

Simich, L., Beiser, M., Stewart, M., & Mwakarimba, E. (2005). Providing social support for immigrants and refugees in Canada: Challenges and directions. *Journal of Immigrant Health, 7,* 259–268.

Simich, L., Mawani, F., Wu, F., & Noh, A. (2004). *Meanings of social support, coping, and help seeking strategies among immigrants and refugees in Toronto.* CERIS working paper 31. Toronto: Centre of Excellence for Research on Immigration and Settlement.

Smith, K. P., & Christakis, N. A. (2008) Social networks and health. *Annual Review of Sociology, 34,* 405–429.

Vahabi, M. (2010). Iranian women's perception and beliefs about breast cancer. *Health Care for Women International, 31*(9), 817–830.

Vahabi, M. (2011). Knowledge of breast cancer and screening practices among Iranian immigrant women. *Journal of Community Health, 36*(2), 265–273.

Vissandjee, B., Thurston, W., Apale, A., & Nahar, K. (2007). Women's health at the intersection of gender and the experience of international migration. In M. Morrow, O. Hankivsky, & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 221–243). Toronto: University of Toronto Press.

Wilkinson, S. (2007). Breast cancer: Lived experience and feminist action. In M. Morrow, O. Hankivsky, & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 408–433). Toronto: University of Toronto Press.

Working Women Community Centre. (n.d.). *Breast Cancer Education Project for Immigrant and Refugee Women: Facilitator's guide.* Toronto: Author.

Yoo, G. J., Levine, E. G., Aviv, C., Ewing, C., & Au, A. (2010). Older women, breast cancer, and social support. *Support Care Cancer, 18,* 1521–1530.

Zanchetta, M. S., & Poureslami, I. M. (2006). Health literacy within the reality of immigrants' culture and language. *Canadian Journal of Public Health, 97*(Suppl 2), S26–S30.

Sepali Guruge, PhD, is Associate Professor, Daphne Cockwell School of Nursing, and Director, Centre for Global Health and Health Equity, Ryerson University; and Co-director, Ontario Multicultural Health Applied Research Network, Toronto, Ontario, Canada. Christine Maheu, PhD, is Associate Professor, School of Nursing, York University; and Butterfield Drew Fellow, Breast Cancer Survivorship Program, Princess Margaret Hospital, Toronto. Margareth Santos Zanchetta, PhD, is Associate Professor, Daphne Cockwell School of Nursing, Ryerson University. Francyelle Fernandez is a Year 4 undergraduate student, Daphne Cockwell School of Nursing, Ryerson University. Lorena Baku is a Year 4 undergraduate student, Daphne Cockwell School of Nursing, Ryerson University.

Résumé

La santé des travailleuses agricoles temporaires au Canada : une recension critique de la littérature

Kathryn Edmunds, Helene Berman, Tanya Basok, Marilyn Ford-Gilboe, Cheryl Forchuk

Les pays à revenu élevé comme le Canada dépendent de plus en plus d'une main-d'œuvre étrangère temporaire « peu spécialisée » dans divers secteurs. Cette recension vise à synthétiser et analyser de façon critique la littérature théorique et empirique portant sur la migration sexospécifique et temporaire en contexte de mondialisation et sur la santé des travailleurs agricoles temporaires, notamment les femmes recrutées dans le cadre de programmes canadiens. Bien que la littérature en sciences sociales présentent des conceptualisations sexospécifiques très élaborées sur la migration, les chercheuses se sont particulièrement penchées sur les femmes qui occupent des emplois traditionnellement féminins, comme le travail ménager. Des recherches multidisciplinaires n'ont révélé que 11 publications de recherche et de recension critique traitant des contraintes liées au genre ou de la santé des travailleurs agricoles temporaires au Canada. D'autres recherches devront être réalisées pour explorer et intégrer la question des forces, de la résilience et des besoins des travailleuses agricoles migrantes en matière de santé, qui œuvrent au Canada. Elles devront aussi se pencher sur les obstacles auxquels elles font face, dans une perspective tenant compte du croisement des forces sexospécifiques de l'iniquité à tous les paliers, soit local, national et mondial.

Mot clé : sexospécifique

CJNR 2011 Vol. 43 Nº 4, 68–91

The Health of Women Temporary Agricultural Workers in Canada: A Critical Review of the Literature

Kathryn Edmunds, Helene Berman, Tanya Basok, Marilyn Ford-Gilboe, Cheryl Forchuk

Among high-income countries such as Canada, there is growing dependency on "low skilled" temporary foreign workers in a variety of sectors. The purpose of this review is to critically synthesize and analyze the theoretical and empirical literature on gendered and temporary migration in the context of globalization and the health of temporary agricultural workers, particularly women in Canadian programs. While the social sciences literature contains well-developed conceptualizations of gendered migration, the research has focused on women in feminized occupations such as domestic work. Multidisciplinary searches produced only 11 research and review publications on the gendered constraints or health of temporary agricultural workers in Canada. Further investigation is needed to explore and integrate the strengths, resiliencies, and health-care needs of women migrant agricultural workers in Canada, as well as the barriers they face, within the intersecting and gendered forces of inequities at all levels: local, national, and global.

Keywords: determinants of health, gender, health disparities, underserved populations, vulnerable populations, women's health

Introduction

It has been estimated that 214 million people are now international migrants (International Labour Organization [ILO], 2010). The number of women migrants is increasing at a faster pace than that for men, as more women are migrating independently and seeking employment (ILO, 2010; Oishi, 2005; Piper, 2008). Repeated relocation for temporary work, reflecting the intersection of economic globalization and local necessity, is becoming progressively widespread. Among high-income countries such as Canada, there is growing dependency on "low skilled" foreign workers and temporary contract work in a range of sectors (Sharma, 2006; Walia, 2010). These workers accept employment for long hours at minimal wages while engaging in demanding and often hazardous labour. Foreign workers accepted into employment programs must migrate alone and return to their country of origin at the end of their work contract before applying for another temporary stay. The health of those employed in this circular migration pattern is influenced by a variety of factors, including gendered roles and expectations, precarious migration status and working conditions, repeated separation from family and home, and the social determinants of health in both the sending and the receiving country (McGuire & Martin, 2007; McLaughlin, 2009b).

Agriculture, representing approximately 8% of national GDP, is a major component of Canada's economy and remains the country's largest employer (Canadian Agri-Food Policy Institute, 2011). Dependence on foreign workers to meet labour needs has become necessary as decreasing numbers of citizens and permanent residents are willing to accept the minimal wages and arduous realities of farmwork (Brem, 2006; Weston, 2007). Globally as well, the business of food production relies on inexpensive and easily replaceable labour, divided into gender-specific tasks (Becerril, 2007; Mills, 2003; Preibisch & Encalada Grez, 2010; Rojas Wiesner & Cruz, 2008).

The Canadian Seasonal Agricultural Worker Program (SAWP), introduced by the federal government in 1966 to address a longstanding shortage of farm labour, is a set of formal bilateral agreements between Canada and the worker source nations of Mexico, Trinidad and Tobago, and Barbados, as well as the Organization of the Eastern Caribbean States (Brem, 2006). Employer requests through SAWP have been steadily increasing, to almost 24,000 workers in 2010 (Citizenship and Immigration Canada [CIC], 2011). Employer demand for workers recruited in another federal temporary worker program, the Pilot Program for Occupations Requiring Lower Levels of Formal Training: National Occupational Classification codes C and D (NOC C and D Pilot), which is not restricted to specific countries, resulted in almost 15,000 filled positions in 2010 (CIC, 2011). More than 4,000 people from countries such as Guatemala, the Philippines, and Thailand are employed in agriculture through the NOC C and D Pilot (Pysklywec, McLaughlin, Tew, & Haines, 2011). Workers accepted into SAWP are eligible for employment for up to 8 months each year, and can return every year if offered an employment contract. Those hired through the NOC C and D Pilot can be offered a contract for 2 years. That contract can be renewed for an additional 2 years, but then the worker must leave Canada for 4 years before reapplying to the program. People seek employment in both programs due to the scarcity of economic resources and adequately paying jobs in their home country. Despite the personal and family sacrifices, temporary work is regarded as an essential and often fortunate prospect, one that provides an income for current needs and future opportunities for workers' families, especially their children.

In recent years, the global feminization of labour, gendered approaches to the study of migration, and the vulnerabilities of women who are made invisible through isolated and temporary working conditions have received increased attention. However, the focus of investigation has been women migrants employed in feminized fields such as domestic labour and caregiving, rather than those employed in masculinized fields such agriculture. Though women make up only 4% of temporary agricultural workers in Canada (Pysklywec et al., 2011), their numbers are increasing and there is a need for research "on migration to go beyond women-only focuses and situate gender and its intersectionality with other relations of power as constitutive elements of (im)migration, even in masculinized migration flows" (Preibisch & Hermoso Santamaria, 2006, p. 107).

Due in part to the relatively small numbers of women participating in temporary agricultural work, inquiry with this population has been lacking, especially with regard to their health while in Canada. Gender and international migration are increasingly significant determinants of women's health (Vissandjee, Thurston, Apale, & Nahar, 2007), as is precarious employment, which disproportionately affects women (Menendez, Benach, Muntaner, Amable, & O'Campo, 2007). Many Canadians, including nurses, are unaware of the large and growing number of temporary workers currently employed in this country; the global, national, and local contexts that shape the experiences of and affect the well-being of these workers; and the implications for the health of women agricultural workers.

The purpose of this review is to critically synthesize and analyze the theoretical and empirical literature on gendered and temporary migration in the context of globalization and the health of temporary agricultural workers, particularly women, in Canadian programs. The strengths and limitations of the current state of knowledge in these areas will be assessed and addressed in relation to research and policy recommendations.

Methods

Multiple searches and search strategies were necessary to locate, assess, and integrate literature from diverse disciplines and sources. Through preliminary reading and collaboration among the five authors, significant contributors to the areas of interest were identified. The selected databases included CINAHL, Proquest Nursing, PubMed, PyschInfo, Sociological Abstracts, Web of Science, Scopus, and the University of Western Ontario Library Catalogue databases. English-language literature between 1993 and 2011 included quantitative and qualitative research articles; review and opinion articles; and books. Searches were also conducted within published reports on the Web sites of organizations with expertise on international migration (the ILO), global health (the World Health Organization [WHO]), and temporary work in Canada (Metropolis and the North-South Institute). Key search terms included gender, women, female, globalization, migration, migrant/temporary/seasonal, agricultural/farmworkers, work, health, immigrant health, determinants of health/social determinants of health, and Canada. Included as exploration strategies were searches of relevant journals; article and book reference lists; and Google Scholar and general Internet searches using identified authors and search terms.

In order to provide an international overview of the structural concepts and issues of interest, we conducted a broad-based review of the theoretical literature on gendered migration and temporary work in the context of globalization. The review of the empirical literature was more focused on women engaged in temporary work in Canada. Included were theoretical sources relating to gender, globalization, and temporary work; sources pertaining to Canadian temporary worker statistics, programs, and gendered streaming; the gendered nature of women participating in SAWP; and research on the gendered experiences of leaving children behind, including research conducted in the worker source countries of Mexico and the Philippines. Excluded were sources for statistics and programs in other countries. Based on the inclusion and exclusion criteria and multiple search strategies, the initial yield of 264 abstracts resulted in 57 fully reviewed sources, with 32 included in this section.

In order to provide context for the analysis of knowledge pertaining to the health of women agricultural workers in Canada, the purpose of the review of theoretical conceptualizations of health was to provide a global context for definitions of health and then focus on Canadian literature pertaining to social determinants of health, gender, migration and work, particularly in the nursing literature. The purpose of the review of the empirical literature was to assess the breadth of research pertaining to adult migrant agricultural workers in North America. Of particular interest were agricultural workers in Canadian temporary work programs and the qualitative literature pertaining to the health of women agricultural workers in relation to the systems and structural forces affecting their lives. Excluded was the literature on migrant agricultural workers outside North America, the health status of children and families of workers, and the development of research instruments or procedures. From an initial yield of 646 abstracts, 86 sources were fully reviewed, with 53 selected for this article.

Findings

Theoretical and empirical findings are organized under two themes: *gendered migration and temporary work in the context of globalization* and *health of temporary agricultural workers*. Although there is considerable literature on international gendered migration and globalization and on the health of migrant agricultural workers in the United States, there are very few Canadian studies. Therefore the results of this review may well provide a useful base for future research.

The multidisciplinary searches produced five research and review publications related to the gendered constraints of female workers in SAWP: three book chapters (Becerril, 2007; Preibisch & Hermoso Santamaria, 2006; Rojas Wiesner & Cruz, 2008), one research article (Prebisch & Encalada Grez, 2010), and one unpublished master's thesis (Scantlebury, 2009). Six publications were found related to the health of temporary agricultural workers in Canada, none of which focused only on women: two research articles (Hennebry, 2010; Mysyk, England, & Avila Gallegos, 2009), one unpublished doctoral dissertation (McLaughlin, 2009b), one research report specifically based on that dissertation (McLaughlin, 2009a), and two research review articles (Preibisch & Hennebry, 2011; Pysklywec et al., 2011). Perhaps not surprisingly given the range of disciplinary approaches, interests, and expertise, there is a need for research that synthesizes a social determinants of health approach within the contexts of gendered migration, temporary work programs in Canada, and women's work in masculinized occupations such as agriculture. Such research could serve to more fully inform policy development and suggest recommendations that address women's experiences of health and work.

Gendered Migration and Temporary Work in the Context of Globalization

Theoretical knowledge and understandings. The theoretical exploration of gendered migration within the context of globalization is characterized by examination of the interactions and effects of gendered ideologies and hierarchies on globalization and the consequences for women (Chow, 2003; Keough, 2006; Kofman, Phizacklea, Raghuram, & Sales, 2000; Mills, 2003; Oishi, 2005; Piper, 2006; Rodriguez, 2010; Steans, 2003). In its most basic form, globalization "describes a constellation of processes by which nations, businesses and people are becoming more connected and interdependent via increased economic integration and communication exchange, cultural diffusion (especially of Western culture) and travel" (Labonte & Torgerson, 2005, p. 158). What is emphasized in the literature addressing gendered migration in the context of globalization, however, is that the process of globalization is occurring within a neoliberal political ideology (Chow, 2003; Keough, 2006; Rodriguez, 2010;

Sharma, 2006; Stasiulis & Bakan, 2005). This ideology is based on the promotion of free and unregulated markets, where the role of the state is reduced in publicly funded programs and where individual autonomy and responsibility for one's own success are accentuated. What is hidden within such an ideology is the reality that success for a few is possible only through the exploitation of many — individuals, countries, and regions (Chow, 2003). The consequences of international monetary policies based on these assumptions are exacerbated conditions of poverty, constrained economic growth, and state-supported migration from low-income countries as a means of generating revenue through remittances (Keough, 2006; Rodriguez, 2010; Stasiulis & Bakan, 2005). Yet the capitalistic forces of globalization are not inescapable, and, though so often represented as monolithic in the dominant discourse, are intertwined with contested and situated interests and expressions of agency and change (Barndt, 2008; Steans, 2003).

Gendered migration for low-skilled temporary work brings a complex mixture of potential benefits in the form of economic opportunity and autonomy and real constraints in the form of restricted, dangerous, and vulnerable work situations away from one's family. An important contribution to the theoretical discussion of gendered migration is the identification of the feminization of labour, which refers both to the gendered nature of occupations and opportunities and to work that is devalued. The feminization of labour has resulted in international migration for work that is increasingly temporary, circular, and stratified and that contributes to violence against women (Piper, 2003). Stratification, as defined by Piper (2008), accentuates the processes by which gender, race, citizenship, and skill level combine to place (and keep) workers in certain segments of employment. Ideologies of gendered work mean that female workers fill different positions to male workers, often because women are considered an inexpensive, compliant, and submissive workforce (Freeman, 2010; Preibisch & Encalada Grez, 2010; Steans, 2003).

Research on women and migration commenced in the 1970s. Yet, as Piper (2006) asserts, the study of gender and migration is still accorded a marginalized place within the interdisciplinary field of migration studies. Globalization as a gendered phenomenon is neither well acknowledged nor well understood (Chow, 2003; Oishi, 2005; Parrado & Flippen, 2005), particularly as it relates to repeated temporary work. Gender remains undervalued as an influential component at all levels of the migration process, although a gendered perspective is required for explanatory depth and enhances our understanding of the complexity and heterogeneity of migration (Davids & van Driel, 2005; Kofman et al., 2000). To assume that the study of migration and related policies is gender-neutral is to ignore women's specific and collective experiences.

Empirical knowledge and understandings. Empirical research into gendered migration in the context of globalization has been conducted in Asia (Oishi, 2005; Parrenas, 2005, 2008; Piper, 2008), Europe (Kofman et al., 2000), and Canada (Becerril, 2007; Preibisch & Encalada Grez, 2010; Preibisch & Hermoso Santamaria, 2006; Rojas Wiesner & Cruz, 2008; Stasiulus & Bakan, 2005). In Canada, women from low-income countries are usually relegated to work that is designated as low skilled and that is largely unregulated (Gibb, 2010; Sharma, 2006). Most of the skilled temporary workers entering Canada come from the United States and Europe, while the low-skilled workers come from Mexico, the Caribbean (mainly men), and the Philippines (mainly women) and compete for jobs that are poorly paid and considered less desirable (Boyd & Pikkov, 2008). Women temporary migrants are more likely than men to be streamed into work that is considered low skilled (Sharma, 2006). Such is the case with the Canadian Live-In Caregiver Program; caregiving is classified as a low-skilled occupation, reflecting the gendered devaluing of caring work and of women's educational credentials (Stasiulus & Bakan, 2005). Gendered stereotyping of female workers, including temporary workers, has identified women as more caring, docile, and reliable than men. In their research specifically looking at the gendered nature of work performed by women participating in SAWP, Becerril (2007), Preibisch and Encalada Grez (2010), Preibisch and Hermoso Santamaria (2006), and Rojas Wiesner and Cruz (2008) describe gendered ideologies whereby women are consigned to specific types of work "suited" to their aptitudes — tasks that require "special care," such as packing fruit and vegetables.

In 2010 a total of 432,682 temporary workers were living in Canada; this number included the 182,276 workers who initially entered or re-entered the country, a larger number than that for permanent residents admitted for work that year (CIC, 2011). As high-income countries have become increasingly protectionist, opportunities for low-skilled workers and their families to immigrate have decreased (Boyd & Pikkov, 2008; Sharma, 2006). Temporary worker programs are viewed as preferable because employment contracts are time-limited, yet renewable over many years, and entail little or no obligation by the employer or the host country once the contract has ended. For low-skilled workers, employment is confined to sectors where it is difficult to find local labour and where the work is not mobile, such as agriculture, construction, and hospitality (Preibisch, 2007). Migrant temporary workers are not granted the rights of citizenship and usually would not meet the Canadian requirements for skilled worker status leading to permanent residency (Goldring, Berinstein, & Bernard, 2009). However, they have become necessary labour for high-income countries, precisely because they are relegated to restrictive and constraining temporary contractual work (Basok, 2002; Walia, 2010).

A central topic in the literature is the experiences of women and their families when women migrate independently for work. The similarities and gender-based differences affecting women are both broadly based and particular to local circumstances. A number of qualitative studies found strong evidence of women accepting low-paying, low-skilled foreign contract work in order to provide for their families' current needs and their children's future (Becerril, 2007; Keough, 2006; McGuire & Martin, 2007; Parrenas, 2005; Pe-Pua, 2003; Preibisch & Encalada Grez, 2010; Preibisch & Hermoso Santamaria, 2006; Scantlebury, 2009). Although it was difficult for mothers to leave (and return), the authors found differences in the gendered role expectations of men and women, both while with their families and while apart. Migrant mothers most often assumed the responsibility for arranging care for their children, usually by a female relative or a paid caregiver, thus taking on the contradictory role of providing economic support from a distance in order to provide reproductive care to their families back home. McGuire and Martin (2007) describe this ambivalence for women as a paradox of hope and despair, where the economic benefits are intertwined with emotional suffering and physical separation. Families are placed at risk by the woman's absence, yet separation is seen as essential to their current and future economic security. Not surprisingly, ambivalence was also expressed by young adults, who as children had experienced parental migration for work (Parrenas, 2005; Scantlebury, 2009). While understanding the reasons for migration, they frequently stated that they had missed the enjoyment and stability of experiencing daily parenting.

Representations of women and mothers who migrate were found to be contradictory. Positive representations included providing economic support and material care for their children, extended families, and communities; negative representations included being absent and therefore unable to provide emotional care and becoming "corrupted" in their new lives through the potential for increased independence, assertiveness, and exposure to different values and standards regarding women's behaviour (Guevarra, 2006; Keough, 2006; Parrenas, 2005; Pyle, 2006). In the reviewed research, all family members were transformed by migration, yet the costs and burdens of maintaining a transnational family fell disproportionately on women. The act of migration can both destabilize and affirm the family, and also has the potential to perpetuate and/or challenge prevailing ideologies regarding gender and family configuration and function. Because they remain primarily responsible for family caretaking, migrant women "continue to shoulder the 'pains and gains' of simultaneous embeddedness in 'home' and 'host' countries, and the need for constant mobility in linking the two in order to sustain the family" (Yeoh, 2005, p. 65). Women workers remain disadvantaged in the labour market, caught between their reproductive and productive responsibilities and roles.

Health of Temporary Agricultural Workers

Theoretical knowledge and understandings of health. While definitions of health may be numerous and varied, what is consistent is that to be healthy is valued as positive and desirable (Young & Wharf Higgins, 2011). Health is understood to be a holistic and inclusive process by Oxman-Martinez et al. (2005), who view this concept as socially and culturally constructed. Guruge and Khanlou (2004) and Lynam (2005) discuss health in terms of the intersectionality of multiple influences acting on and through micro, meso, and macro levels of society. Lynam also reminds us of the tensions between structural constraints and individual agency, and notes that the multiple influences on health include restrictions on choice when material resources are limited. According to WHO (2008), "the structural determinants and [social] conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries" (p. 1). Indeed, the WHO Constitution asserts that health is a human right and that the attainment of the highest standard of health requires attention to the underlying determinants. It is now recognized that one of the most influential and pervasive determinants of health is gender, primarily the gendered relations of power, which include access to and control over health resources and which are related to the disparities in status between women and men (Karolinska Institutet, 2007; Marmot, 2007; Oxman-Martinez et al., 2005; WHO, 2008).

Women living in Canada within an immigration category that prohibits permanent residency are considered to have a precarious immigration status, which is an influential and complex determinant of equitable access to health care (Oxman-Martinez et al., 2005). As demonstrated in the nursing literature with regard to precarious migration, gender, mobility, and relocation, discourses of health are congruent with a social determinants of health perspective (Oxman-Martinez et al., 2005; Thurston & Vissandjee, 2005; Vissandjee, Desmeules, Cao, Abdool, & Kazanjian, 2004; Vissandjee et al., 2007). These theoretical discussions are framed by an understanding of the contexts, intersections, and influences of such factors. However, migration is often conflated with culture and ethnicity, the result being that the existing diversity of migration pathways and experiences is disregarded or minimized. A social determinants of health perspective is needed for a full understanding and analysis of gender, migration, and women's health, due to the contextual focus on the structures that shape and influence individuals' lives (Thurston & Vissandjee, 2005; Vissandjee et al., 2004). Women carry an unfair health burden due to the intersections of gender, race, migration, globalization, economic disparities, and the strains of gendered work (Doyal, 2005; Falk-Rafael, 2006; Spitzer, 2005). Yet research "tends to look at the 'effects of migration on women' as opposed to the diverse ways that women, through migration, own, uphold, and mobilize resources for the welfare and well-being of their families" (Vissandjee et al., 2007, p. 229).

In their definition of globalization, Labonte and Torgerson (2005) emphasize the processes involved in order to highlight the social, political, economic, and environmental embeddedness of local actions. This is directly relevant to experiences of health, and Falk-Rafael (2006) and Labonte and Torgerson (2005) argue for the need to conceptualize and analyze global health as more than "a burden of disease"; attention needs to be paid to how locally experienced determinants of health in all countries are linked to the processes of globalization, shaping opportunities for health and health outcomes at different levels (Labonte, Mohindra, & Schrecker, 2011; Labonte & Torgerson, 2005; Marmot, 2007).

Research exploring the social determinants of health is limited, due partly to the prevalence of biomedical models and behavioural risk approaches that situate the individual as the focus for interventions (Marmot, 2007). Underlying these approaches are neoliberal assumptions and resulting economic policies that give primacy to individual autonomy and responsibility for health (WHO, 2007). Yet, while recognizing the influence of power on creating health inequities, WHO (2008) does not explicitly critique global systems based on these values (Green, 2010), and according to Raphael (2011) the public policy implications of addressing the structural inequities of power and health are in conflict with current government approaches in Canada. The complexity of a social determinants of health approach allows for nuanced understandings of health, the production of inequities, and multifaceted analytical frameworks. However, as Green (2010) observes, "we have a vast and growing body of evidence documenting inequalities, some evidence on the complex pathways which link social determinants to biological mechanisms and health outcomes, but almost no evidence on 'what works' to reduce health inequity" (p. 2).

Empirical knowledge and understandings of health. The majority of research into the health of migrant agricultural workers has been conducted within quantitative biomedical, epidemiological, and population health "at risk" perspectives, has been cross-sectional, and has been conducted primarily with men. Most of the research has been carried out in the United States, and it makes an important contribution to our understanding of the health status, risks, concerns, and barriers for this population. However, while the nature and conditions of agricultural work share many similarities in North America, almost half of the migrant farmworker population in the United States is without documentation (Hoerster et al., 2011) whereas most temporary agricultural workers in Canada are registered with federally sponsored programs (Goldring et al., 2009). Workers without documentation have restricted access to health care and other support programs (Hoerster et al., 2011). In Canada, employers are required to provide health insurance during the wait times for provincial coverage and most workers are eligible to be compensated for workplace injuries (Pysklywec et al., 2011). Health screening is a condition of employment. However, registered workers in Canada also face barriers to receiving comprehensive and appropriate health care as well as adequate compensation should an injury or illness occur, fear repatriation resulting in the loss of the economic gains that come with temporary employment, and are at risk for a variety of health conditions while in Canada and upon their return home (Hennebry, 2010; McLaughlin, 2009b; Preibisch & Hennebry, 2011).

The stressful conditions of migrant agricultural work are well documented; there is an extensive body of literature on the psychological stresses, occupational health risks, communicable disease risks, and barriers to health care pertaining to this population. The empirical literature describes migrant agricultural workers, both male and female, as at increased risk for substance abuse disorders (Borges, Medina-Mora, Breslau, & Aguilar-Gaxiola, 2007; Grzywacz, Quandt, Isom, & Arcury, 2007) and communicable diseases, particularly tuberculosis and HIV/AIDS (Apostolopoulos et al., 2006; Gadon, Chierici, & Rios, 2001; Varela-Ramirez, Mejia, Garcia, Bader, & Aguilera, 2005; Wolffers, Fernandez, Verghis, & Vink, 2002). Occupational hazards associated with agricultural work include increased rates of musculoskeletal injury, eye and skin conditions, and pesticide exposure (Anthony, Martin, Avery, & Williams, 2010; Cooper et al.; 2006; Culp & Umbarger, 2004; Farquhar et al., 2008; Pysklywec et al., 2011; Quandt et al., 2010; Whalley et al., 2009). Barriers to receiving sufficient, equitable, and comprehensive health services, including preventive and health promoting care, encompass cultural, linguistic, structural, legal, financial, and geographic factors (Arcury & Quandt, 2007; Hoerster et al., 2011; Mysyk et al., 2009).

Psychological stress, mental health concerns, and considerable ambivalence are experienced by Mexican migrant farmworkers, arising from the pressures of migration whereby family responsibilities are in continuous competition with employment opportunities and prolonged absences (Clingerman, 2006; Grzywacz et al., 2006; Johnston & Herzig, 2006; Rodriguez, 1993; Sullivan & Rehm, 2005; Ward, 2010a, 2010b).

Compared to their male counterparts, female migrant farmworkers have been found to have increased levels of depression (Mazzoni, Boiko, Katon, & Russo, 2007), loneliness, acculturative stress, obesity, and hypertension (Clingerman, 2006, 2007) and higher rates of skin reactions, heat exhaustion, physical injury, and diabetes (Anthony, Williams, & Avery, 2008). Poor health outcomes for all migrant agricultural workers are believed to arise from the interactions of migration, poverty, hazardous temporary work, communicable diseases, physical and psychological stress, and language barriers (Hansen & Donohoe, 2003; Ward, 2010b). Loneliness and separation from family, difficulty accessing health care due to long working hours, poor working and living conditions, and poor understanding by health providers of the broad structural forces that affect workers' lives result in complex health concerns and unmet physical and psychological needs (Johnston & Herzig, 2006; Preibisch & Hennebry, 2011). These findings have been confirmed in recent comprehensive investigations with male and female temporary agricultural workers in Canada, primarily employed through SAWP; this work was carried out by Hennebry (2010), who surveyed 576 workers in southern Ontario, and McLaughlin (2009a, 2009b), who as part of her dissertation research conducted 78 in-depth qualitative case studies with individual workers.

The results of a limited number of qualitative studies enhance our understanding of women's health in the context of migration and work. The meaning of health for Hispanic female migrant farmworkers is explored in Rodriguez's (1993) ethnographic study with 32 women. The central theme identified was defining health as the ability to "create peace" in one's current situation, so that one can live in peace. Another dominant theme was the "culture of transience," which extended beyond ethnicity and geographic location. Transience results from working away from home, living in isolated conditions, and being uncertain about whom to trust in the event of problems with health, employment, or housing. Similarly, Clingerman (2006, 2007) found that "being at peace" was a dominant conceptualization. In that study, 21 Mexican and Mexican-American women engaged in migrant agricultural work were asked to describe their experiences of health. The word most frequently used to represent health was "peace" *(la paz),* which was related to the participants' religious and cultural beliefs as well as the importance of family and was recognized as a healthy transition response to their migration. For the women in these studies, health — contextualized through structural factors such as gendered roles and relations, migration, and economic and political dynamics — emerged as a multifaceted and holistic experience within transience/transition.

The only study to explicitly identify and explore personal agency was that conducted by McGuire (2006), who characterizes the discovery of the importance of agency for her participants as "serendipitous." This grounded theory study with 22 indigenous Oaxacan migrant women explored facilitators of and obstacles to health. The women demonstrated much personal agency and determination by making "constant references to the difficulty of their experiences, yet they continued on their immigrant trajectory buttressed by the smallest gains and improvements in their conditions of life and in hopes for their children" (p. 373). This result is congruent with findings reported in the social sciences literature on gendered migration, a central theme of which is the situatedness of experience and expression of agency existing in tension with larger structural forces.

Health concerns and vulnerabilities are heightened for women due to gendered relations, expectations, and ideologies. Though health was not the primary focus of their research, Preibisch and Encalada Grez (2010) found, through in-depth interviews with 16 female workers in SAWP, that women who arrived pregnant or became pregnant while in Canada were seen as problematic by employers and often had their work contracts terminated. In order to avoid this perceived difficulty, the program required the women to have a pregnancy test before departing for Canada. Female reproductive capabilities in combination with negative stereotyping of women's sexual behaviour led to increased monitoring and surveillance of activities and relationships. Gendered stereotyping and lack of power also resulted in sexual harassment by co-workers, supervisors, and employers (Morales Waugh, 2010; Preibisch & Encalada Grez, 2010). Reluctance to state the reason for reproductive or sexual health appointments; fear of repatriation; and lack of access to information, clinics, health-care providers, and transportation resulted in unmet needs and increased health risks (McLaughlin, 2009b; Organista, Organista, & Solof, 1998; Preibisch & Hennebry, 2011).

Discussion

The various settings, systems, and processes of labour migration are reflected in the complex, and often conflicted and contested, relationships between gender and work. Consistent themes in the literature are the diversity of opportunities and constraints for women migrants and the interrelatedness of the health of individuals, their families, and transnational communities within local and global dynamics. However, there are striking differences in how the issues are framed, particularly between the social sciences and nursing. Issues related to temporary migrant workers and gender in the context of increasing globalization, neoliberalism, and structural economic disadvantage have been explored in the social sciences, principally in sociology. The relationships between personal agency, gendered expectations and ideologies, and systemic forces at home and in the host country are emphasized. However, in the social sciences literature the focus is on women engaged in feminized occupations, such as nursing and domestic service, and until recently temporary and repeated relocation received less attention than permanent migration (Oishi, 2005). In contrast, the evolving nursing literature (Oxman-Martinez et al., 2005; Thurston & Vissandjee, 2005; Vissandjee et al., 2004, 2007), which explicitly identifies gender and migration as highly influential determinants of health, is not specifically linked to the processes and consequences of globalization or neoliberal assumptions of individualism. Emergent nursing research that explores conceptualizations of health with migrant farmworker women (Clingerman, 2006; Rodriguez, 1993) reflects health as inclusive and multifaceted but is not clearly framed within a gendered analysis. Nor, with the exception of work by McGuire (2006) and McGuire and Martin (2007), has research been specifically linked to the influence of neoliberal assumptions on economic globalization and on women's health through the need for and dangers of migration. The cited nursing literature is relatively recent and is concentrated among a small number of researchers.

Implications for Research

In their discussion of seasonal agricultural workers, Rojas Wiesner and Cruz (2008) state that "more study is needed regarding the characteristics and working conditions of both male and female temporary workers in Canada, in order to identify the differences that account for disadvantage that women experience in employment opportunities as compared to men" (p. 209). Further research is also needed to more fully explore the strategies used and constraints experienced by all family members when women are required to migrate alone for work. There is a dearth of research with female agricultural workers in NOC C and D, whose countries of origin tend to differ from those of women in SAWP and whose continuous stays are longer. There is a need for research on the relationships among and processes entailed in the social determinants of health in general (Oxman-Martinez et al., 2005) and the interactions between social constructions of gender and the social determinants of health in particular (Karolinska Institutet, 2007). Research employing methodological and analytical frameworks that deepen our understanding of the relationships among globalization, gender, health, work, and power at all social levels could serve to advance knowledge and effect change at personal, collective, and structural levels and to support the much-needed development of gender-sensitive approaches to women's health.

The biological and physiological characteristics arising from the sex of being male or female act in synergy with gender roles, relations, and the institutionalization of gendered hierarchies. While differences between male and female temporary agricultural workers have been noted, none of the research reviewed in this article has specifically and comprehensively included sex as a determinant of health. There is a need not only to integrate sex and gender in research inclusive of the social determinants of health and broad contexts of structure and policy (Benoit et al., 2009), but also to integrate sex and gender into occupational health research (Messing & Mager Stellman, 2006). As in the research pertinent to the health of agricultural workers, women are also underrepresented in occupational health research.

The cited Canadian studies and reviews on the health of temporary agricultural workers have been conducted primarily by social scientists (Hennebry, 2010; McLaughlin, 2009a, 2009b; Mysyk at al., 2009; Preibisch & Hennebry, 2011; Pysklywec et al., 2011). While an interdisciplinary approach to the health of temporary workers from a human rights and social determinants of health perspective is valuable and necessary, greater involvement by nurses and other health-care researchers and providers is needed. Inquiry from a strength-based approach is also called for, to explore how women's resiliencies and forms of resistance influence their health. The findings of such research could inform nursing education, practice, and administration, particularly with respect to preparing nurses to work and advocate with uprooted, mobile populations and those engaged in precarious, stressful, and physically demanding work, while also taking into consideration the contexts of globalization and gendered migration.

Implications for Policy Development

There is a vital need for policy development that includes the participation of temporary workers and integration across local, national, and international levels. Until recently, immigration policies focusing on the control of infectious diseases were a significant priority internationally, with little attention given to the global factors and relationships that determine health (MacPherson, Gushulak, & Macdonald, 2007). As identified by Hennebry (2010) and McLaughlin (2009b) in their research, provincial, national, and international structural elements of Canada's temporary agricultural programs had a greater influence on the health of workers than individual actions. Health policies and guidelines should require enforceable procedures regarding the recruitment of workers, their access to health care, occupational health and safety standards, including living conditions and personal safety, and mechanisms to address grievances and human rights violations. The importance of personal agency in health, resilience, and change should also be supported. Policies affect men and women differently (Piper, 2006) and should reflect the influences of gender and sex, which have been largely overlooked in Canada (Hankivsky, 2007) and in the country's temporary foreign worker programs. Also needed are policy and program planning and development for appropriate, gender-sensitive and equitable health care — including the establishment of mobile clinics and community-based support centres for migrant workers — and for increasing the structural responsiveness of health-care institutions to support nursing practice with this population.

Conclusion

The many contradictions surrounding women's migration for agricultural work reveal outcomes arising from the convergence of structural and personal factors expressed through the dialectic between temporary work and globalization. Agricultural workers root and grow the food necessary for human survival, yet they are at increased risk for a variety of negative consequences for their own health and that of their families. The number of women engaged in temporary farmwork in Canada is increasing, and these women experience significant health inequities due to systemic, institutionalized, and gendered constraints that make it difficult for them to challenge the social and structural circumstances of their lives. There is very little evidence regarding their conceptualizations of health and health status in Canada within the broader contexts of repeated and gendered migration. Research to inform policy development and practice needs to explicitly acknowledge and explore the strengths and health-care needs of migrant farmworker women, as well as the barriers they face, within the intersecting forces of inequities, oppression, and social determinants of health at local, national, and global levels.

References

Anthony, M. J., Martin, E. G., Avery, A. M., & Williams, J. M. (2010). Self care and health-seeking behavior of migrant farmworkers. *Journal of Immigrant and Minority Health, 12,* 634–639.

Anthony, M., Williams, J. M., & Avery, A. M. (2008). Health needs of migrant and seasonal farmworkers. *Journal of Community Health Nursing, 25*(3), 153–160.

Apostolopoulos, Y., Sonmez, S., Kronenfeld, J., Castillo, E., McLendon, L., & Smith, D. (2006). STI/HIV risks for Mexican migrant laborers: Exploratory ethnographies. *Journal of Immigrant and Minority Health, 8*(3), 291–302.

Arcury, T., & Quandt, S. (2007). Delivery of health care services to migrant and seasonal farmworkers. *Annual Review of Public Health, 28,* 345–363.

Barndt, D. (2008). *Tangled routes: Women, work, and globalization on the tomato trail* (2nd ed.). Lanham, MD: Rowan & Littlefield.

Basok, T. (2002). *Tortillas and tomatoes: Transmigrant Mexican harvesters in Canada.* Montreal: McGill-Queen's University Press.

Becerril, O. (2007). Transnational work and the gendered politics of labour: A study of male and female Mexican migrant farm workers in Canada. In L. Goldring & S. Krishnamurti (Eds.), *Organizing the transnational: Labour, politics, and social change* (pp. 157–172). Vancouver: UBC Press.

Benoit, C., Shumka, L., Vallance, K., Hallgrímsdóttir, H., Phillips, R., Kobayashi, K., et al. (2009). Explaining the health gap experienced by girls and women in Canada: A social determinants of health perspective. *Sociological Review Online, 14*(5).

Borges, G., Medina-Mora, M., Breslau, J., & Aguilar-Gaxiola, S. (2007). The effect of migration to the United States on substance use disorders among returned Mexican migrants and families of migrants. *American Journal of Public Health, 97*(10), 1847–1851.

Boyd, M., & Pikkov, D. (2008). Finding place in stratified structures: Migrant women in North America. In N. Piper (Ed.), *New perspectives on gender and migration: Livelihood, rights and entitlements* (pp. 19–58). New York: Routledge.

Brem, M. (2006). *Migrant workers in Canada: A review of the Canadian Seasonal Agricultural Worker Program.* Ottawa: North-South Institute. Retrieved April 8, 2011, from http://www.nsi-ins.ca/english/pdf/MigrantWorkers_Eng_Web.pdf.

Canadian Agri-Food Policy Institute. (2011). *Canada's agri-food destination: A new strategic approach.* Ottawa: Author. Retrieved April 8, 2011, from http://www.capi-icpa.ca/destinations/CAPI-Agri-Food_Destination_FULL.pdf.

Chow, E. N. (2003). Gender matters: Studying globalization and social change in the 21st century. *International Sociology, 18*(3), 443–460.

Citizenship and Immigration Canada. (2011). *Canada facts and figures: Immigrant overview – permanent and temporary residents 2010.* Ottawa: Author. Retrieved October 20, 2011, from http://www.cic.gc.ca/english/pdf/research-stats/facts2010.pdf.

Clingerman, E. (2006). Conceptualizations of health among Mexican and Mexican American women employed in migrant farm work. *Hispanic Health Care International, 4*(1), 45–55.

Clingerman. E. (2007). A situation-specific theory of migration transition for migrant farmworker women. *Research and Theory for Nursing Practice, 21*(4), 220–235.

Cooper, S. P., Burau, K. E., Frankowski, R., Shipp, E. M., Del Junco, D. J., Whitworth, R. E., et al. (2006). A cohort study of injuries in migrant farm worker families in south Texas. *Annals of Epidemiology, 16*(4), 313–320.

Culp, C., & Umbarger, M. (2004). Seasonal and migrant agricultural workers: A neglected workforce. *AAOHN Journal, 52*(9), 383–390.

Davids, T., & van Driel, F. (2005). Gender and globalization: An analytical alliance. In T. Davids & F. van Driel (Eds.), *The gender question in globalization: Changing perspectives and practices* (pp. 217–228). Burlington, VT: Ashgate.

Doyal, L. (2005). Understanding gender, health, and globalization: Opportunities and challenges. In I. Kickbusch, K. Hartwig, & J. List (Eds.), *Globalization, women, and health* (pp. 10–27). New York: Palgrave Macmillan.

Falk-Rafael, A. (2006). Globalization and global health: Toward nursing praxis in the global community. *Advances in Nursing Science, 29*(1), 2–14.

Farquhar, S., Samples, J., Ventura, S., Davis, S., Abernathy, M., McCauley, L., et al. (2008). Promoting the occupational health of indigenous farmworkers. *Journal of Immigrant and Minority Health, 10,* 269–280.

Freeman, C. (2010). Myths of docile girls and matriarchs: Local profiles of global workers. In J. Goodman (Ed.), *Global perspectives on gender and work: Readings and interpretations* (pp. 289–303). London: Rowan & Littlefield.

Gadon, M., Chierici, R.-M., & Rios, P. (2001). Afro-American migrant farmworkers: A culture in isolation. *AIDS Care, 13*(6), 789–801.

Gibb, H. (2010. Missing from temporary foreign worker programs: Gender sensitive approaches. *Canadian Issues: Temporary Foreign Workers,* Spring, 94–95. Retrieved April 8, 2011, from http://canada.metropolis.net/pdfs/cdn_issues_CITC_mar10_e.pdf.

Goldring, L., Berinstein, C., & Bernard, J. K. (2009). Institutionalizing precarious migratory status in Canada. *Citizenship Studies, 13*(3), 239–265.

Green, J. (2010). Editorial: The WHO Commission on Social Determinants of Health. *Critical Public Health, 20*(1), 1–4.

Grzywacz, J. G., Quandt, S. A., Early, J., Tapia, J., Graham, C. N., & Arcury, T. A. (2006). Leaving family for work: Ambivalence and mental health among Mexican migrant farmworker men. *Journal of Migration and Minority Health, 8*(1), 85–97.

Grzywacz, J. G., Quandt, S. A., Isom, S., & Arcury, T. A. (2007). Alcohol use among immigrant Latino farmworkers in North Carolina. *American Journal of Industrial Medicine 50,* 617–625.

Guevarra, A. R. (2006). Managing "vulnerabilities" and "empowering" migrant Filipina workers: The Philippines' Overseas Employment Program. *Social Identities, 12*(5), 523–541.

Guruge, S., & Khanlou, N. (2004). Intersectionalties of influence: Researching the health of immigrant and refugee women. *Canadian Journal of Nursing Research, 36*(3), 32–47.

Hankivsky, O. (2007). Gender-based analysis and health policy: The need to rethink outdated strategies. In M. Morrow, O. Hankivsky, & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 143–168). Toronto: University of Toronto Press.

Hansen, E., & Donohoe, M. (2003). Health issues of migrant and seasonal farmworkers. *Journal of Health Care for the Poor and Underserved, 14*(2), 153–164.

Hennebry, J. (2010). Not just a few bad apples: Vulnerability, health and temporary migration in Canada. *Canadian Issues: Temporary Foreign Workers,* Spring, 73–77. Retrieved April 8, 2011, from http://canada.metropolis.net/pdfs/cdn_issues_CITC_mar10_e.pdf.

Hoerster, K. D., Mayer, J. A., Gabbard, S., Kronick, R. G., Roesch, S. C., Malcarne, V. L., et al. (2011). Impact of individual, environmental, and policy-level factors on health care utilization among US farmworkers. *American Journal of Public Health, 101*(4), 685–692.

International Labour Organization. (2010). *International labour migration: A rights-based approach.* Geneva: Author. Retrieved April 8, 2011, from http://www.ilo.org/public/libdoc/ilo/2010/110B09_59_engl.pdf.

Johnston, M., & Herzig, R. (2006). The interpretation of "culture": Diverging perspectives on medical provision in rural Montana. *Social Science and Medicine, 63,* 2500–2511.

Karolinska Institutet. (2007). *Unequal, unfair, ineffective and inefficient – gender inequity in health: Why it exists and how we can change it.* Stockholm: Author. Retrieved April 8, 2011, from http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf.

Keough, L. J. (2006). Globalizing "postsocialism" mobile mothers and neoliberalism on the margins of Europe. *Anthropological Quarterly, 79*(3), 431–461.

Kofman, E., Phizacklea, A., Raghuram, P., & Sales, R. (2000). *Gender and international migration in Europe: Employment, welfare and politics.* London: Routledge.

Labonte, R., Mohindra, K., & Schrecker, T. (2011). The growing impact of globalization for health and public health practice. *Annual Review of Public Health, 32,* 263–283.

Labonte, R., & Torgerson, R. (2005). Interrogating globalization, health and development: Towards a comprehensive framework for research, policy and political action. *Critical Public Health, 15*(2), 157–179.

Lynam, M. J. (2005). Health as a socially mediated process: Theoretical and practice imperatives emerging from research on health inequalities. *Advances in Nursing Science, 28*(1), 25–37.

MacPherson, D. W., Gushulak, B. D., & Macdonald, L. (2007). Health and foreign policy: Influences of migration and population mobility. *Bulletin of the World Health Organization, 85*(3), 200–206.

Marmot, M. (2007). Achieving health equity: From root causes to fair outcomes. *Lancet, 370,* 1153–1163.

Mazzoni, S. E., Boiko, P. E., Katon, W. J., & Russo, J. (2007). Depression and disability in seasonal and migrant Hispanic agricultural workers. *General Hospital Psychiatry, 29,* 450–453.

McGuire, S. (2006). Agency, initiative, and obstacles to health among indigenous immigrant women from Oaxaca, Mexico. *Home Health Care Management and Practice, 18*(5), 370–377.

McGuire, S., & Martin, K. (2007). Fractured migrant families: Paradoxes of hope and devastation. *Family and Community Health, 30*(3), 178–188.

McLaughlin, J. (2009a). *Migration and health: Implications for development. A case study of Mexican and Jamaican migrants in Canada's Seasonal Agricultural Workers Program.* Ottawa: FOCAL, Canadian Foundation for the Americas. Retrieved April 8, 2011, from http://www.focal.ca/pdf/migration_McLaughlin_health%20case%20study%20Mexican%20Jamaican%20migrants%20Canada%20seasonal%20agricultural%20workers_October%202009.pdf.

McLaughlin, J. (2009b). *Trouble in our fields: Health and human rights among Mexican and Caribbean migrant farm workers in Canada*. Unpublished doctoral dissertation, University of Toronto.

Menendez, M., Benach, J., Muntaner, C., Amable, M., & O'Campo, P. (2007). Is precarious employment more damaging to women's health than men's? *Social Science and Medicine, 64,* 776–781.

Messing, K., & Mager Stellman, J. (2006). Sex, gender and women's occupational health: The importance of considering mechanism. *Environmental Research, 101,* 149–162.

Mills, M. B. (2003). Gender inequality in the global labour force. *Annual Review of Anthropology, 32,* 41–62.

Morales Waugh, I. (2010). Examining the sexual harassment experiences of Mexican immigrant farmworking women. *Violence Against Women, 16*(3), 237–261.

Mysyk, A., England, M., & Avila Gallegos, J. A. (2009). A case for certified interpreters for participants in the Canada/Mexico Seasonal Agricultural Workers Program. *Human Organization, 68*(3), 318–327.

Oishi, N. (2005). *Women in motion: Globalization, state policies, and labor migration in Asia.* Stanford, CA: Stanford University Press.

Organista, P. B., Organista, K. C., & Solof, P. R. (1998). Exploring AIDS-related knowledge, attitudes, and behaviors of female Mexican migrant workers. *Health and Social Work, 23*(2), 96–103.

Oxman-Martinez, J., Hanley, J., Lach, L., Khanlou, N., Weerasinghe, S., & Agnew, V. (2005). Intersection of Canadian policy parameters affecting women with precarious immigration status: A baseline for understanding barriers to health. *Journal of Immigrant Health, 7*(4), 247–258.

Parrado, E. A., & Flippen, C. A. (2005). Migration and gender among Mexican women. *American Sociological Review, 70*(4), 606–632.

Parrenas, R. S. (2005). *Children of global migration: Transnational families and gendered woes.* Stanford, CA: Stanford University Press.

Parrenas, R. S. (2008). *The force of domesticity: Filipina migrants and globalization.* New York: NYU Press.

Pe-Pua, R. (2003). Wife, mother, and maid: The triple role of Filipino domestic workers in Spain and Italy. In N. Piper & M. Roces (Eds.), *Wife or worker? Asian women and migration* (pp. 157–180). Lanham, MD: Rowan & Littlefield.

Piper, N. (2003). Feminization of labor migration as violence against women. *Violence Against Women, 9*(6), 723–745.

Piper, N. (2006). Gendering the politics of migration. *International Migration Review, 40*(1), 133–164.

Piper, N. (2008). International migration and gendered axes of stratification. In N. Piper (Ed.), *New perspectives on gender and migration: Livelihood, rights and entitlements* (pp. 1–18). New York: Routledge.

Preibisch, K. L. (2007). Local produce, foreign labor: Labor mobility programs and global trade competitiveness in Canada. *Rural Sociology, 72*(3), 418–449.

Prebisch, K. L., & Encalada Grez, E. (2010). The other side of el otro lado: Mexican migrant women and labor flexibility in Canadian agriculture. *Signs, 35*(2), 289–316.

Preibisch, K., & Hennebry, J. (2011). Temporary migration, chronic effects: The health of international migrant workers in Canada. *Canadian Medical Association Journal, 183*(9), 1033–1038.

Preibisch, K., & Hermoso Santamaria, L. (2006). Engendering labour migration: The case of foreign workers in Canadian agriculture. In E. Tastsoglou & A. Dobrowolsky (Eds.), *Women, migration, and citizenship: Making local, national, and transnational connections* (pp. 107–130). Burlington, VT: Ashgate.

Pyle, J. L. (2006). Globalization and the increase in transnational care work: The flip side. *Globalizations, 3*(3), 297–315.

Pysklywec, M., McLaughlin, J., Tew, M., & Haines, T. (2011). Doctors within borders: Meeting the health care needs of migrant farm workers in Canada. *Canadian Medical Association Journal, 183*(9), 1039–1043.

Quandt, S. A., Chen, H., Grzywacz, J. G., Vallejos, Q. M., Galvan, L., & Arcury, T. A. (2010). Cholinesterase depression and its association with pesticide exposure across the agricultural season among Latino farmworkers in North Carolina. *Environmental Health Perspectives, 118*(5), 635–639.

Raphael, D. (2011). A discourse analysis of the social determinants of health. *Critical Public Health, 21*(2), 221–236.

Rodriguez, R. A. (1993). *Female migrant farmworkers: The meaning of health within the culture of transience.* Unpublished doctoral dissertation, Texas Women's University.

Rodriguez, R. M. (2010). *Migrants for export.* Minneapolis: University of Minnesota Press.

Rojas Wiesner, M. L., & Cruz, H. A. (2008). Gendered migrations in the Americas: Mexico as country of origin, destinations, and transit. In N. Piper (Ed.), *New perspectives on gender and migration: Livelihood, rights and entitlements* (pp. 189–245). New York: Routledge.

Scantlebury, T. (2009). *Shifting responsibilities in migrant matrifocal households: A look at transnational households in the Caribbean.* Unpublished master's thesis, University of Guelph.

Sharma, N. (2006). *Home economics: Nationalism and the making of "migrant workers" in Canada.* Toronto: University of Toronto Press.

Spitzer, D. (2005). Engendering health disparities. *Canadian Journal of Public Health, 96*(S2), S78–S95.

Stasiulis, D. K., & Bakan, A. B. (2005). *Negotiating citizenship: Migrant women in Canada and the global system.* Toronto: University of Toronto Press.

Steans, J. (2003). Gender inequalities and feminist politics in a global perspective. In E. Kofman & G. Youngs (Eds.), *Globalization: Theory and practice* (2nd ed.) (pp. 123–138). London: Continuum.

Sullivan, M. M., & Rehm, R. (2005). Mental health of undocumented Mexican immigrants. *Advances in Nursing Science, 28*(3), 240–251.

Thurston, W., & Vissandjee, B. (2005). An ecological model for understanding culture as a determinant of women's health. *Critical Public Health, 15*(3), 229–242.

Varela-Ramirez, A., Mejia, A., Garcia, D., Bader, J., & Aguilera, R. (2005). HIV infection and risk behavior of Hispanic farm workers at the West Texas-Mexico border. *Ethnicity and Disease, 15*(4), S92–S96.

Vissandjee, B., Desmeules, M., Cao, Z., Abdool, S., & Kazanjian, A. (2004). Integrating ethnicity and migration as determinants of Canadian women's health. *BMC Women's Health, 4*(S1), S32–S43.

Vissandjee, B., Thurston, W., Apale, A., & Nahar, K. (2007). Women's health at the intersection of gender and the experience of international migration. In M. Morrow, O. Hankivsky, & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 221–243). Toronto: University of Toronto Press.

Walia, H. (2010). Transient servitude: Migrant labour in Canada and the apartheid of citizenship. *Race and Class, 52*(1), 71–84.

Ward, L. S. (2010a). Farmworkers at risk: The costs of family separation. *Journal of Immigrant and Minority Health, 12,* 672–677.

Ward. L. S. (2010b). Psychosocial stress and health-related quality of life for Latino migrant farmworkers. *Southern Online Journal of Nursing Research,* 10(1). Retrieved April 8, 2011, from http://snrs.org/publications/SOJNR_articles2/Vol10Num01Art07.html.

Weston, A. (2007). *The changing context for Canada's Seasonal Agricultural Workers Program.* Ottawa: North-South Institute. Retrieved April 8, 2011, from http://www.nsi-ins.ca/english/pdf/economic_context%20_CSAWP.pdf.

Whalley, L. J., Grzywacz, J. G., Quandt, S. A., Vallejos, Q. M., Walkup, M., Chen, H., et al. (2009). Migrant farmworker field and camp safety and sanitation in Eastern North Carolina. *Journal of Agromedicine, 14*(4), 421–436.

Wolffers, I., Fernandez, I., Verghis, S., & Vink, M. (2002). Sexual behaviour and vulnerability of migrant workers for HIV infection. *Culture, Health and Sexuality, 4*(4), 459–473.

World Health Organization. (2007). *A conceptual framework for action on the social determinants of health.* Geneva: Author. Retrieved April 8, 2011, from http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf.

World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health.* Geneva: Author. Retrieved April 8, 2011, from http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

Yeoh, B. (2005). Transnational mobilities and challenges. In L. Nelson & J. Seager (Eds.), *A companion to feminist geography* (pp. 60–73). Malden, MA: Blackwell.

Young, L. E., & Wharf Higgins, J. (2011). Concepts of health. In L. L. Stamler & L. Yiu (Eds.), *Community health nursing: A Canadian perspective* (3rd ed.) (pp. 76–88). Toronto: Pearson.

None of the authors has any conflict of interest and there are no financial disclosure statements to make.

Kathryn Edmunds, RN, is a doctoral candidate, Arthur Labatt Family School of Nursing, University of Western Ontario, London, Ontario, Canada. Helene Berman, RN, PhD, is Professor, Arthur Labatt Family School of Nursing, and Research Scholar, Centre for Research and Education on Violence Against Women and Children, University of Western Ontario. Tanya Basok, PhD, is Professor, Department of Sociology, Anthropology and Criminology, and Director, Centre for Studies in Social Justice, University of Windsor, Ontario. Marilyn Ford-Gilboe, RN, PhD, FAAN, is Professor, Arthur Labatt Family School of Nursing, University of Western Ontario. Cheryl Forchuk, RN, PhD, is Professor, Arthur Labatt Family School of Nursing, and Associate Director, Nursing Research, University of Western Ontario.

CJNR 2011 Vol. 43 N° 4, 93–98

Happenings

Population Health Intervention Research in Canada: Catalyzing Research Through Funding

Nancy C. Edwards, Sarah M. Viehbeck,
Erica Di Ruggiero, Meghan McMahon

"Population health intervention research involves the use of scientific methods to produce knowledge about policy and program interventions that operate within or outside of the health sector and have the potential to impact health at the population level" (Canadian Institutes of Health Research-Institute of Population and Public Health, 2006).

The growing field of population health is coming of age in Canada, with increasing interest in this area of research being expressed by provincial/territorial and international funding councils. Given their critical roles in developing, implementing, and studying population and public health interventions, nurses have an important contribution to make in this field of research. The Canadian Institutes of Health Research-Institute of Population and Public Health (CIHR-IPPH) supports researchers who generate relevant, credible, and timely evidence of what population health interventions work, for whom, and under what conditions. Issues of equity and considerations related to vulnerable populations are at the forefront of these efforts.

In its 2009–14 strategic plan, the CIHR-IPPH identifies four intersecting priorities: (1) understanding pathways to health equity; (2) examining the impacts of population health interventions on health and health equity; (3) examining how the systems in which population health interventions are implemented (both within and outside of the health sector) may influence their impacts; and (4) stimulating theoretical and methodological innovation in knowledge generation, synthesis, and integration in population and public health. (Additional information on this strategic plan is available at http://www.cihr.ca/e/27322.html.) We are working on several fronts to address these priorities.

To catalyze research in these areas, the Institute offers several strategic funding opportunities, including the ongoing Operating Grant in Population Health Intervention Research, Catalyst Grants related to

Table 1 ***Examples of Recently Funded Population Health Intervention and Health Equity Research Projects***

Funding opportunity and term	**Partners**	**Total investment by IPPH and partners**	**Examples of projects**
Operating grant: Programmatic Grants in Health and Health Equity (2011–12 to 2016–17)	The CIHR Institute of Population and Public Health in partnership with the Institutes of Aboriginal Peoples' Health, Circulatory and Respiratory Health, Gender and Health, Neurosciences, Mental Health and Addiction, Nutrition, Metabolism and Diabetes; the Heart and Stroke Foundation of Canada; the New Brunswick Health Research Foundation; the Ontario Ministry of Health and Long-Term Care through its Applied Health Research Networks Initiative; and the Public Health Agency of Canada	$21.3 million	11 funded projects, including: • *Browne, A., et al. (University of British Columbia): *Equity-Oriented Primary Health Care Interventions for Marginalized Populations: Addressing Structural Inequities and Structural Violence* • Martens, P., et al. (University of Manitoba): *PATHS Equity for Children: A Program of Research Into What Is Effective in Reducing the Gap for Manitoba's Children* • *Pauly, B., et al. (University of Victoria): *Reducing Health Inequities: The Contribution of Core Public Health Services in BC*

Operating grant: Population Health Intervention Research (Fall 2010 competition and Summer 2010 competition)	The CIHR Institute of Population and Public Health in partnership with the CIHR Institute of Nutrition, Metabolism and Diabetes; the Canadian Population Health Initiative of the Canadian Institute for Health Information; the Heart and Stroke Foundation of Canada; the Public Health Agency of Canada; the New Brunswick Health Research Foundation; and the Ontario Ministry of Health and Long-Term Care through its Applied Health Research Networks Initiative For the Fall 2010 competition, the CIHR Institutes of Cancer Research and Aboriginal Peoples' Health were also partners.	$3.26 million	18 funded projects in the Summer and Fall 2010 competitions, including: Campbell, S., et al. (University of Waterloo): *Improving Quitline Reach and Integration: Evaluating a Policy Intervention Aimed at Increasing Tobacco Cessation* • ⋆Waldner, C., et al. (University of Saskatchewan): *Water Regulations: Impact on First Nations Health Equity and Promotion* • ⋆Okoli, C., et al. (BC Centre of Excellence for Women's Health): *Smoking on the Margins: An Equity Analysis of the Outcomes of an Outdoor Smoke-Free Policy* • ⋆Benoit, C., et al. (University of Victoria): Interventions to promote health and health equity for pregnant and early parenting women facing substance use and other challenges • ⋆Dahinten, S., et al. (University of British Columbia): *Using Administrative Data to Evaluate a Population-Based Parenting Intervention*

⋆Team includes at least one nurse investigator.

(Continued on next page)

Table 1 ***(cont'd)***

Funding opportunity and term	**Partners**	**Total investment by IPPH and partners**	**Examples of projects**
Catalyst grant: Health Equity (2009–10)	The CIHR Institute of Population and Public Health in partnership with the Public Health Agency of Canada and the Population Health Improvement Network	$1.04 million	15 funded projects, including: • *Cohen, B., et al. (University of Manitoba): *Advancing the Evidence to Build a Research Program for Developing Public Health Capacity to Promote Health Equity* • *Gagnon, A., et al. (McGill University): *Developing Population Interventions for Migrant Perinatal Health Equity* • *Stewart, M., et al. (University of Alberta): *Mapping Policy Pathways for Community Action on Urban Respiratory Health Inequities in Children and Adolescents*

* Team includes at least one nurse investigator.

health equity, grants on the built environment and intervention research (led by the Heart and Stroke Foundation of Canada), and Programmatic Grants to tackle health and health equity. Nurse researchers are leading several of these initiatives (see Table 1). Along with the CIHR Institute of Aging and Institute of Health Services and Policy Research, we have re-launched a funding opportunity related to Advancing Theoretical and Methodological Innovations, recognizing that such advances are critical for understanding pathways to reduce inequities in population health. Researchers whose work focuses on immigrant populations are encouraged to apply for these types of funding opportunities.

To advance scientific dialogue and discuss theories and methods in population health intervention research, the Institute held an international symposium and workshop in November 2010, in collaboration with partners at the Population Health Intervention Initiative for Canada. This event reinforced Canada's leadership role in building the field of population health intervention research globally. Proceedings are available on the IPPH Web site (http://www.cihr.ca/e/43787.html). The Institute is partnering with colleagues at the US National Institutes of Health and the US Centers for Disease Control and Prevention on a follow-up event set for March 2012. Health equity and vulnerable populations was also the focus of an invitational knowledge-exchange workshop related to pH1N1 in September 2011 and will be prominent in a health equity and public health practice workshop to be co-led with the National Collaborating Centre on Social Determinants of Health early in 2012.

The Community-Based Primary Healthcare (CBPHC) Roadmap Signature Initiative, which we co-lead with the CIHR Institute of Health Services and Policy Research, is an example of efforts by CIHR and its partners to address challenging concerns about key elements of our health-care system that are fundamental to the delivery of high-quality, accessible, and client/family-centred care in the community. The overall goal of this initiative is to catalyze innovative research and translate results into the improved delivery, for Canadians, of community-based primary health care (including primary prevention, public health, and primary care services provided within the community). To achieve this goal, we target two priority areas for action: developing new or evaluating innovative models of delivery for chronic disease prevention and management in CBPHC, and improving access to appropriate CBPHC for vulnerable populations. Research related to immigrant health, immigrants' experiences with CBPHC, and how current CBPHC services are addressing the needs of immigrant populations align with both of these priority areas.

Through multi-year investments in cross-jurisdictional, multidisciplinary teams of researchers and decision-makers undertaking programmatic research, by providing superior training environments, and by developing a new cadre of scientists working at the coalface of CBPHC delivery, our initiative will generate robust research evidence; strengthen capacity for research excellence; and facilitate knowledge translation in policy, community, and clinical settings to transform the delivery of community-based primary health care in Canada. Provinces and territories across Canada and countries around the world are experimenting with primary health care reform. We are building partnerships with other funding organizations to provide novel opportunities for cross-jurisdictional collaborations, comparative research, and the scaling-up of promising innovations in the delivery of high-quality CBPHC to immigrant and other populations. A major funding opportunity for this initiative is expected to be launched in fall 2011.

The 2 years since the launch of the Institute's new strategic plan have been exciting and productive. As we explore the potential of these collaborative opportunities and advance our strategic priorities, the IPPH looks forward to partnering and also providing leadership to build the field of population health intervention research for health and health equity in Canada and globally. Nurse researchers in Canada are playing a critical role in these research initiatives.

References

Canadian Institutes of Health Research-Institute of Population and Public Health. (2006). *Population Health Intervention Research Initiative for Canada ("PHIRIC") workshop report.* Retrieved September 30, 2011, from http://www.cihr-irsc.gc.ca/e/33515.html#1a.

Acknowledgements

The authors gratefully acknowledge the input provided by Dr. Robyn Tamblyn on an earlier version of this article.

Conflicts of interest: None to declare

Nancy C. Edwards, RN, PhD, FCAHS, is Professor, School of Nursing and Department of Epidemiology and Community Medicine, University of Ottawa, Ontario, Canada; and Chief Scientist, Canadian Institutes of Health Research-Institute of Population and Public Health. Sarah M. Viehbeck, PhD, is Senior Evaluation Associate, Canadian Institutes of Health Research-Institute of Population and Public Health. Erica Di Ruggiero is a PhD candidate, Canadian Institutes of Health Research-Institute of Population and Public Health. Meghan McMahon, MSc, is Assistant Director, Canadian Institutes of Health Research-Institute of Health Services and Policy Research.

CJNR 2011 Vol. 43 N° 4, 100–117

Résumé

Les expériences d'accouchement des femmes autochtones en région rurale, mises en contexte : les implications en matière de soins infirmiers

Helen Brown, Colleen Varcoe, Betty Calam

L'influence importante qu'exercent la pauvreté, l'isolement, les possibilités économiques limitées et la diminution des services de maternité sur les expériences d'accouchement et les résultats que vivent les femmes en région rurale est un fait indéniable. Par ailleurs, peu de recherches ont été réalisées concernant l'aggravement de ces problématiques entraîné par le recoupement de diverses formes d'oppression que subissent les femmes autochtones et l'impact sur leurs expériences d'accouchement et les résultats qui en découlent. Les conclusions de cette étude sur les soins maternels aux femmes autochtones vivant en région rurale, notamment dans quatre communautés en Colombie-Britannique, démontrent l'impact de siècles de colonisation sur la réduction des possibilités d'accoucher dans leur région et sur leurs luttes pour acquérir du pouvoir et exercer des choix et un contrôle sur leur vécu. Les questions posées dans le cadre de la recherche portent sur les expériences que vivent les femmes autochtones en région rurale en ce qui a trait aux soins à l'accouchement et aux soins maternels, dans un contexte néocolonial, et à leur désir d'accoucher dans des milieux soutenants. Un modèle participatif et ethnographique communautaire a été utilisé et les données ont été principalement tirées d'entrevues individuelles, de groupes de discussion et de commentaires de participantes. Bien que les expériences des femmes de chaque communauté aient été façonnées par des antécédents historiques, des traditions et des contextes économiques, politiques et géographiques distincts, l'impact de la colonisation et du paternalisme médical ainsi que la lutte pour le contrôle du corps des femmes pendant l'accouchement se recoupent et infligent aux femmes un stress supplémentaire. Les implications sur le personnel infirmier d'une approche tenant compte des dynamiques qui se recoupent et qui façonnent les expériences des femmes autochtones et les résultats générés font l'objet d'une discussion.

Mots clés : autochtones, expériences d'accouchement

CJNR 2011 Vol. 43 N° 4, 100–117

The Birthing Experiences of Rural Aboriginal Women in Context: Implications for Nursing

Helen Brown, Colleen Varcoe, Betty Calam

It has been established that the birthing experiences and outcomes of rural women are shaped by poverty, isolation, limited economic opportunities, and diminishing maternity services. We lack research into how these dynamics are compounded by intersecting forms of oppression faced by Aboriginal women, to impact on their birthing experiences and outcomes. The findings of this study of rural Aboriginal maternity care in 4 communities in British Columbia show how diminishing local birthing choices and women's struggles to exert power, choice, and control are influenced by centuries of colonization. The research questions focus on rural Aboriginal women's experiences of birthing and maternity care in this neocolonial context and their desire for supportive birthing environments. A community-based participatory and ethnographic design was employed. Individual interviews, focus groups, and participant observation were the primary data sources. Although the women's experiences in each community were shaped by distinct histories and traditions, economics, politics, and geographies, the impacts of colonization and medical paternalism and the struggle for control of women's bodies during birth intersect, placing additional stress on women. The implications for nurses of accounting for the intersecting dynamics that shape Aboriginal women's experiences and birth outcomes are discussed.

Keywords: rural maternity care, Aboriginal, birthing experiences, medical colonialism, social determinants of health, maternity nursing practice

Introduction

Birthing and maternity care in rural communities in Canada has shifted dramatically over the past several decades (Benoit, Carroll, & Millar, 2002; Grzybowski, Kornelson, & Cooper, 2007; Kaufert & O'Neil, 1993). Increasing neoliberal economic priorities have led to hospital closures and consolidation of services, increasing urbanization, and regionalization of health care, all of which have led to a sharp decline in maternity services in rural locales and an increasing trend to evacuate women from their communities to give birth in urban settings. Rural women are impacted significantly by a lack of access to and choice of maternity care providers, discontinuous care, poor quality of care, and a lack of opportunity to have a voice in local health-service planning (Benoit et al., 2002).

Maternity care for rural Aboriginal[1] women, as with any aspect of health care for Aboriginal people, can be understood only within the context of historical and ongoing colonization. Deep-rooted practices of gender subordination combined with destruction of economic and cultural resources intersect in ways that silence and oppress Aboriginal women in all regions of Canada (Tait, 2008). Because it is well established that social and economic factors affect pregnancy complications and birth outcomes (Giscombe & Lobel, 2005), and because for every indicator of risk during pregnancy and birth in Canada (e.g., teen pregnancy, preterm birth, low birth weight, high birth weight, infant and neonatal mortality), outcomes are two to five times worse for Aboriginal people (British Columbia Provincial Health Officer, 2009), it is necessary to investigate how the neocolonial context of Aboriginal women's lives shapes their health and experiences in pregnancy and their birth outcomes. Despite significant research attention to rural maternity care, there is little specific consideration of Aboriginal women's particular experiences in context, especially in relation to differential birth outcomes. Although the influences of the context of past and present "colonization of childbirth" have been analyzed (Benoit, Carroll, & Westfall, 2007), such work has not been widely integrated with research on rural maternity care, nor used to inform the design and delivery of health services or professional practice. This qualitative study sought to contribute to rural maternity care in Aboriginal communities by exploring birthing experiences and traditional birthing practices among the Haida, Kwakwa̲ka̲'wakw, and Nuxalk First Nations.

Literature Review

Knowledge about the health of rural Canadians — particularly people experiencing intersecting forms of disadvantage on the basis of gender, race, and income, such as Aboriginal women — is considered "incomplete and unsystematic, with the social determinants of health virtually ignored" (Sutherns, McPhedran, & Haworth-Brockman, 2004, p. 3). Given that one in five Canadian women live in a rural area, research on their health across the lifespan has been limited. Women living in rural communities face particular health challenges related to poverty and iso-

---

[1] In Canada, the *Constitution Act* recognizes three groups of Aboriginal peoples: Indian, Inuit, and Métis. Under the *Indian Act,* the term "Status Indian" is used for a person whose name appears on the Indian Register maintained by the federal government. A 1985 amendment brought the *Indian Act* in line with the Canadian Charter of Rights and Freedoms. A non-Status Indian is a person of Indian ancestry who does not meet the criteria for registration under the *Indian Act* or who has chosen not to be registered (Muckle, 2007).

lation, economic opportunities, and health services in rural contexts (Ross, Scott, & Smith, 2000; Sutherns et al., 2004).

While Aboriginal women face the same health challenges as non-Aboriginal women who live in rural communities, they live with additional and intersecting forms of oppression that contribute to health inequities and poor access to health care (Fiske & Browne, 2004; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008; Tait, 2008). The history of the colonization of Aboriginal people in Canada by successive waves of European settlers has been characterized as welfare colonialism, in which Aboriginal people were forced into dependency through a system of reserves, compulsory residential schools for children, and a series of policies that prevented the people from pursuing their traditional ways of living and supporting themselves (Reinert, 2005). These factors have had profoundly gendered impacts (Fiske, 2006), with specific effects on mothering among Aboriginal women (Varcoe & Hartrick Doane, 2007). Contemporary health-care reforms, informed by neoliberal values, further disadvantage Aboriginal women (Fiske & Browne, 2004). According to Tait (2008), "In areas of health policy and delivery a growing association between health and personal responsibility has further added to the marginalization of Aboriginal women" (p. 2). With respect to maternity care, these political, economic, and social dynamics increase the risk among Aboriginal women for complications during pregnancy and adverse birth outcomes (Kaufert & O'Neil, 1993). Largely absent from research in the domain of rural maternity care and maternity nursing is a critical analysis of medicalization as the dominant frame contextualizing childbirth experiences, pregnancy risk, and maternal and neonatal outcomes (Fisher, Huack, & Fenwick, 2006). While there is growing evidence associating the neocolonial context of Aboriginal women's lives with ongoing inequities in health and access to health care, we have limited knowledge of how this context shapes maternity care and the birthing experiences and birth outcomes of rural Aboriginal women.

Birthing and Maternity Care in Rural Aboriginal Communities

Maternity care for Aboriginal women has evolved within the history of colonialism and the accompanying gendered experiences of oppression. Health care, and the specific domain of maternity care, has evolved within this context. The marginalization of Aboriginal women through colonial government policy and the decimation of indigenous reproductive health practices effectively destroyed traditional ways of birthing and shifted control over childbirth to colonizing medical forces (Benoit et al., 2002). Suffice to say that "doctor- and hospital-centred" childbirth practices in the early 1900s placed Aboriginal communities in the precarious position of having to fend for themselves during childbirth or, at other times, requiring access to "modern" medical services. Colonization undermined the self-sufficiency of Aboriginal women during childbirth and destroyed Aboriginal midwifery (Benoit et al., 2007).

Thus, in the intersection between loss of traditional practices and marginalization from "modern" health care, Aboriginal women fell through the maternity care cracks. Increased pregnancy- and birth-related complications for Aboriginal women followed colonization, loss of traditional occupations and natural resources, reliance on "white" food, and the erosion of traditional care. However, drawing on Western health models, colonial policy-makers and medical practitioners have attributed Aboriginal women's poor health outcomes to inadequate medical care and lack of contact with the colonizing society. Those within the colonizing society have believed Aboriginal women to be at higher risk of adverse birth outcomes than the rest of the Canadian population because of a lack of contact with health care and poor "choices," such as failure to regularly attend prenatal care, adolescent pregnancy, and inadequate nutrition during pregnancy (Kaufert & O'Neil, 1993).

The mechanism of colonization as a major determinant of health is often overlooked, and explanatory models appear to "blame the victims" — for example, for not having better nutrition and not accessing prenatal care — rather than attending to how poverty, appropriation of traditional food-gathering and hunting territories, destruction of wildlife and fisheries habitats, and rural transportation challenges lead to poor nutrition and health-care access.

The widespread perception of greater risk for Aboriginal women intensified surveillance and evacuation efforts by health-care providers, with discourses of "risk" encouraging and sustaining the trend towards evacuation to urban settings for birthing (Kaufert & O'Neil, 1993). Medical control over birth continues to serve as an expression of power in relation to all women, and Aboriginal women experience specific types of power relations in the form of "medical colonialism."[2] Because racism is a constant companion of colonization, and because research shows how racism operates to create the conditions for adverse birth outcomes (Parker Dominguez, 2008), we need to examine how the neocolonial context of women's lives causes inequities in maternal-infant health and infant mortality and their leading antecedents, low birth weight (LBW; < 2,500 grams) and preterm delivery (PTD; < 37 weeks).

---

[2] "Medical colonialism" refers to how "colonial governments appropriated medical power by encouraging the production of knowledge about indigenous bodies that justified racial hierarchies . . . where those hierarchies became reified by providing segregated and inequitable services on the basis of race" (Kelm, 2004, p. 335).

There exist wide knowledge gaps in relation to how differential perinatal outcomes and inequities in maternal-infant health are shaped by historical and ongoing "medical colonialism" (Kelm, 2004). This research project was developed to examine these gaps, particularly given that research on maternity care has focused on the experiences of health-care providers and predominantly non-Aboriginal women (Kornelson & Grzyboskwi, 2005).

Research Questions

The Rural Aboriginal Maternity Care project was a collaboration among Aboriginal women from the Nuxalk, Haida, and Kwakwa̱ka̱'wakw First Nations and academic researchers from nursing, medicine, and counselling psychology. The research questions were as follows: 1. *How are rural Aboriginal women's birthing experiences and outcomes shaped by the context of their lives?* 2. *What issues are important to the communities in the area of maternity care and birthing?* 3. *How can knowledge about past, present, and desired future birthing practices inform maternity care priorities and women's choice and methods for birthing that meet the cultural, spiritual, and physiological needs of women, their families, and their communities?*

Method

In order to build positively on previous research, and to more fully engage Aboriginal women through collaborative inquiry, it was clear that a "typical" research approach was inappropriate. In the spirit of a participatory design (Kemmis & McTaggart, 2000), any ideas about research needed to come from the communities themselves. Thus, we used an iterative process of discussion among academic and community-based researchers to investigate maternity care issues of relevance to each community. Ethical agreements were signed in communities where they existed and ethical approval was obtained from the University of British Columbia Behavioural Research Ethics Board.

In each community, we employed a purposive sampling strategy; that is, we followed the lead of the community researchers and participants on how to publicize the project and recruit participants. Using ethnographic methods, we participated in community events where potential participants could also express an interest in joining the study. We began by interviewing women who had given birth recently, and then purposely included other women, family members (including fathers), health-care providers, and community leaders. The sample size was determined in collaboration with the community researchers. Recruitment ended when community researchers indicated that a limited number of new insights and experiences were being shared by participants in each community. In total, 125 individuals participated in audiorecorded individual or focus group interviews: 66 mothers and 1 father participated in individual interviews; 36 mothers and 2 fathers joined focus groups; separate focus group interviews were held with 5 youths and 11 Elders; we also interviewed 4 health-care providers and local health leaders in two communities.

Guided by the principles of participatory and community-based research (Varcoe, 2006), we also collected data through participant observation and field notes, while the academic and community researchers joined in local events and meetings relevant to the research questions (e.g., Mother's Day luncheon, mother-and-tot groups, Christmas school celebrations, visits to traditional territories, baby-welcoming ceremonies). Guided by the research questions and the principles of respect, relevance, reciprocity, and responsibility as set out by the British Columbia Aboriginal Capacity and Developmental Research Environment, the community researchers developed interview questions and discussion guides relevant for their community. The questions were not identical for each community and the community researchers were encouraged to enlist their own skills and knowledge of their communities when developing questions. Despite the different words used, all community researchers conducted the interviews and focus groups by inquiring about (1) participants' birth experiences; (2) how history and tradition shaped the participants' experiences, hopes, and needs with respect to maternity care; and (3) the kinds of birthing environments that would best support participants, their families, and their communities.

We considered interviews and discussions with the women to be the main "primary" data, and used the other information to enhance the thematic approach to analysis to create an understanding of the women's experiences. In all communities, the community-based researchers led the analysis because they had the most extensive understanding of the community, history, and people. Together we used the principles of thematic and ethnographic analysis, reading the transcribed interviews together, coding the meaning of each section, and then comparing the meanings across interviews until no new information emerged. In this article we present the cross-community analysis, emphasizing those aspects of greatest relevance for nursing practice.

Findings

The central dynamics underlying rural Aboriginal women's birthing experiences in the four communities involved the intersections among the effects of historical and ongoing colonization, concurrent efforts towards cultural revitalization, self-determination and reclamation, and rural geography. The availability of birthing and economic resources in the wake of colonization created specific birthing expectations and stresses on birthing, both of which have shaped women's, families', and community-specific experiences. Thus, women's sense of power, control, and choice in each community, and various points of tension and resistance to local service models for low-risk maternity care, reflect both historical and ongoing power relations and the degree of colonial appropriation of resources in the community.

The Neocolonial Context of Birthing and Economic Resources

Although each community had unique experiences of colonization, and although the geography of each community has likely affected the dynamics of colonization, there were significant commonalities. The Haida, Kwakwa̱ka̱'wakw, and Nuxalk peoples all suffered devastating population losses from diseases introduced post-contact (Kelm, 2004). The dynamics of colonization and appropriation of resources and control over those resources has had different impacts in each community. Consequently, different levels of affluence exist in each community and the resources available to individual women therefore differ. For example, in one community many of the women had very low incomes compared to non-Aboriginal women. A lack of economic resources had direct effects on prenatal nutrition, which affected women's health during pregnancy and constrained their birthing choices. Several women, with no car or access to money, were unable to go to an urban centre to give birth and had to stay in their home community regardless of medical recommendations or their own preferences. Even Aboriginal women who had "status" and were thus eligible for a travel allowance found the allowance inadequate for travel, accommodation, and proper nutrition. Many spoke of having to choose between incurring significant debt or not having their family close by when living away from home prior to or even during birth. The wealth of nations and bands was viewed by women as facilitating or limiting birthing options; women were able to cope with being shipped "off island," "out," or "away" if additional resources were provided so family members could accompany them. All of these dynamics illustrate the impact of historical and ongoing forces on women's birthing experiences and outcomes.

In each community, we asked about issues that were important for understanding birthing and maternity care. The loss of traditional knowledge of birthing traditions was a dominant theme, described as central to understanding key issues facing the communities. In two communities, few women had memories of their traditional practices. In the other two communities, however, the Elders recalled how women routinely helped each other, how certain women constantly checked on pregnant women, supporting, encouraging, and teaching them as their pregnancy progressed. One Elder said, "They walked around and around, and they knew that was going to help the mother . . . and they never laid the way we lay." In each community, questions were raised about whether modern medical practice was necessarily a benefit. One Elder stated, "Everything's changed . . . that's the way it was . . . they introduced you to something different. It seems they always told you it was better, but whether it was or not, I don't know."

Ongoing colonization and economic erosion affected each community and differential material and cultural resources seemed to be related to the extent to which the women described experiences of racism within the context of maternity care. Women from one community described overt racism, while women from another community spoke about how they would not tolerate any form of discrimination. Thus, women's sense of personal power was often constituted by race relations, which in turn were shaped by various efforts to reclaim resources, culture, and independence. There continue to be efforts in all of the communities to reclaim governance, settle land claims, and develop economic opportunities, all of which were seen by participants in the study as integral to meeting the communities' maternity care priorities: promoting choice and methods for birthing that respond to cultural, spiritual, and physiological needs to create the context for healthy mothers, healthy babies, healthy families, and healthy communities.

Rural Geography as Birthing Context

Rural geography shaped participants' birthing experiences, first through the availability of employment and economic resources generally, then through the availability of resources for birthing, and, finally, through the challenges of travel for birthing outside the community. Together, these contextual factors created significant emotional and financial burdens. One woman said, "Becoming poorer and poorer, having to live down island, and being alone is the absolute worst stress when you're having a baby."

The geography of the communities, their degree of remoteness, and local natural resources determined the pattern of colonization and continue to shape the colonial dynamics. The four communities are located in remote coastal British Columbia. Thus, pregnant and labouring women in each of the communities have to cope with — to varying degrees — hours of road and ferry travel and air medevac across open ocean and inlets in order to travel "up," "down," and "off" island, "out" and "away." Snow-covered roads and reduced daylight hours in winter added to the stressful circumstances for women leaving their home communities to give birth.

In spite of the perception of greater "safety" for a baby born in an urban context, the impacts of evacuation on the mother, the children and families left behind, and even on medevac personnel are not well understood. All communities were faced with the effects of birthing outside the community, but the logistics and politics of evacuation varied. A number of women expressed fear for the safety of the children they had to leave behind; even when they had reliable, safe child care, they worried about the impact of weeks or months of separation from their children and infants while they awaited birth, alone, elsewhere. These dynamics are similar to those reported by Kaufert and O'Neil (1993), who examined how risk discourses operate to the detriment of Inuit women's birth experiences. Although nurses and physicians spoke of making birth "safe" by having the women leave the community, women described the safety of their other children, and their own emotional safety surrounded by culture and connection to family and community, as overlooked in the structure and delivery of health care. Rural geography and the related dynamics of planned or urgent evacuation profoundly impacted women's birth experiences. Although these dynamics played out differently in the participating communities, they affected the birthing expectations and birth stresses of all the women and in all four communities.

Birthing Expectations

The extent to which women, families, and communities felt that they had power, choice, and control intersected with community histories and resources to shape expectations about birthing. These expectations set up the possibilities and, depending on the extent to which expectations were met, influenced the stresses and tensions that accompanied birthing experiences. Expectations operated in relation to four key areas that set the context for women's experiences: the location of birthing, the meaning of giving birth in one's home territory, the presence of family, and the meaning and importance of a "natural birth."

The location of birth varied greatly among communities, from no birthing facilities, to limited options due to inconsistent resources and personnel, to comprehensive low-risk maternity care, all of which depended on the policies of the local health authority and the availability of skilled personnel. Women spoke of the meaningfulness of being able to give birth in or near their home community, where their families could be present to welcome the baby and support the mother; giving birth in one's community created a meaningful and long-lasting connection to the community, tradition, and territory. In one community an Elder said:

> *There is a breakdown in the traditional family structure, as the mom is away from her community and family while she is giving birth. The family is excluded from the joy of being at the birth — this is important to our community, to our families.*

Indeed the levels of stress and depression expressed in one of the study communities call into question whether births are being made "safer" through the structures and processes of care. The presence of family at birth was often a point of tension between hospital staff and women and their families. Women spoke repeatedly about efforts by hospital staff to limit visiting and their opposition to family presence, despite the support and understanding expressed by many health-care providers regarding the importance of family presence.

The idea of a "natural" birth seemed to be part of the women's expectations or hopes. Many women in each community said they wished to have a natural birth, were pleased to have had a natural birth, or were disappointed not to have had a natural birth. However, the meaning and importance of a natural birth seemed to vary from woman to woman and between the four communities. When women were put in the position of "choosing" early induction or evacuation, a natural birth was viewed as going into labour without medication or intervention. In these instances it was evident that the women's experiences and the meaning of "natural" were shaped by local hospital politics, maternity resources, and women's opportunities to be involved in decision-making that may or may not respect their needs and hopes. One woman said:

> *All of a sudden I had the gel, and then my water . . . broke and then, boom, I was in labour, like, right after, so I don't know what it's like to . . . go through the natural process. . . . I had them both vaginally, but I still don't know what [a natural birth is] like.*

Stresses on Birthing

The loss of traditional practices was extensive and the inability to give birth as a family and community threatened to complete the destruction. In all communities, there was expressed hope to reclaim traditional practices; reclaiming birthing and strengthening culture were seen as inseparable and necessary for enhancing the health of mothers, babies, families, and communities. As dynamics and impacts of rural geography, economics, and race relations differed in each community, the effects on women and their birthing experiences also varied. These contexts gave rise to a system-centred approach to maternity care that structured relationships with nurses and other health-care providers in ways that limited women's power, choice, and control, thereby increasing stress for all. The system-centred approach set a specific context for birthing. Maternity care was described as medicalized, technologized, and regionalized, and was only occasionally referred to as woman- and/or family-centred or responsive to the cultural, spiritual, and physiological needs of women.

Relationships with nurses and other health-care providers and negotiation of control over birthing were enacted within that specific context and within the colonial and rural context. Both the system-centred approach and the relationships created tension and stresses for the women. Women spoke of a "revolving door" experience with nurses and physicians that caused anxiety, undermined trust, and limited their options for developing a relationship with care providers who would see them through pregnancy and birthing. Several participants explained that positive relationships with nurses could mitigate the stresses associated with a lack of continuity of medical care. For example, a perinatal nurse working in one of the local hospitals was described as a "godsend" for women arriving at the hospital in labour.

Power, Choice, and Control

The dynamics of rural and colonial contexts shaped the power, choice, and control that communities, families, and women possessed generally but also in relation to maternity care and birthing. Women's economic power, political power, and support varied within and between the communities, and thus there was diversity in individual women's expectations and their power, choice, and control with regard to their birthing experiences. Women in the four participating communities had different experiences of the stresses associated with birthing. Themes of power, choice, and control were expressed variably across communities and often related to the style and attitude of specific nurses and physicians. In one community the overall impression was of women consistently exercising their power, choice, and control in birthing decisions, either through direct discussion and negotiation with their health-care providers, family members, and support people or through acts of resistance and empowerment. Women took matters into their own hands and delayed contacting their doctor or the hospital while they were in early labour, waiting until after the last ferry had left. However, in other communities the overarching theme was "no choice, no power, no control." The women described multiple ways in which their wants and needs were overridden: "I wasn't allowed an escort"; "I was refused care"; "I was all alone"; "they said, you can be sent out, or you can be induced now . . . I had a choice, if you call that a choice." They described their concerns and wishes being routinely dismissed. Most of the women who felt they lacked control described their birth experiences in negative terms: "I wouldn't wish inducement on my worst enemy." Stresses and points of tension, however, did not dissolve merely because a woman was able to give birth in her home community.

Points of Tensions and Acts of Resistance

Points of tension arose (a) at the community level, in relation to the degree of service provided; (b) between health-care providers and patients and their families and among providers with respect to how patients were treated regardless of birthing location; and (c) between health-care providers and patients and their families with respect to the birthing location.

Birthing expectations in light of community resources and power led to different points of tension and forms of resistance to control over the birthing process. Points of tension also arose between the community, the health authority, and the federal government regarding the level of services to be provided in a given community. In each community, birthing options were dictated by the availability of birthing facilities and professional support, for both first-time and experienced mothers. For example, in one community, because of the relatively consistent availability of birthing facilities and nearby professional support for first-time and experienced mothers, women were usually able to deliver near their home if they wished. In the other communities, where consistent surgical or anesthesia back-up for emergency Caesarean sections were not available, women faced decisions about the levels of risk associated with staying or going. Consequently, "acts of resistance" centred around the woman acting on her own evaluation of her capacities, beliefs, and worries balanced with her family's wishes and local traditions. Women spoke of feeling they had the "right" to give birth in their home community:

> *They have it. You know they have it . . . and that room across from the nurse's station here is all set up for it. So . . . if I can, I know I won't send my girls away. I don't want them to go through what I went through down there. And, who knows, by then there [may] be no monies to send anybody down there. So it would be nice if we could have our own here [at home].*

Discussion

Based on the above findings, our recommendations for nurses engaged in maternity care in rural Aboriginal communities are founded on two discussion points: the need to (1) account for the complex intersections shaping rural Aboriginal women's and families' birthing experiences and outcomes, and the need to (2) engage in culturally safe practice, to optimize birth experiences and outcomes in a rural Aboriginal context.

Accounting for Complex Intersections Shaping Birthing Experiences and Outcomes

A long history of colonization, systemic discrimination, and experiences such as residential schooling are considered root causes of inequities in maternal-infant health for Aboriginal peoples (British Columbia Provincial Health Officer, 2009). Thus, women's birthing experiences and their hope for change ought to be understood as integrally connected to efforts towards cultural (re)vitalization, self-determination, and the reclaiming of indigenous traditions and heritage. Improving the birthing experiences of women in our study was determined to require community-specific strategies aimed at supporting and optimizing women's choice, power, and control with respect to birthing.

Redressing such inequities and enhancing women's power, choice, and control requires a shift in how nurses view women's birth experiences and perinatal outcomes. These are not of women's own making, but are shaped by the social, cultural, political, and economic contexts of care. For example, promoting prenatal nutrition in the context of poverty and the lack of affordable fresh foods requires more than teaching about the nutritional values of particular foods. Healthy birthing is inseparable from the sociocultural, historical, and gendered contexts of women's lives. Therefore, strictly "lifestyle," individual prevention and "personal choice" understandings of health are inadequate and will do little to facilitate good birthing experiences and positive perinatal outcomes for Aboriginal women, families, and communities. Such understandings of maternal-infant health may in fact reinforce the very inequity that nurses aim to redress.

Culturally Safe Practice as Health Promoting Rural-Aboriginal Maternity Nursing Care

Our findings also illustrate the importance of maternity care that is culturally safe — that is, relevant for and responsive to women's and families' needs, strengths, and desire for control and choice in the birthing experience. Several studies suggest that "culturally appropriate" perinatal services improve indigenous women's satisfaction with care, although there is still no consensus on what makes particular practices "culturally appropriate" (Long & Curry, 1998). We propose that enhancing the cultural appropriateness of individual practices and maternity services for Aboriginal women fails to account for how ongoing colonial relations create *unsafe* rather than just inappropriate care. Unsafe care was created through the erosion of services and dismissive practices and contexts that impacted women's power, choice, and control with regard to birthing and that shaped their health outcomes. The silencing of women's voices is an act of "structural violence" (Kurtz et al., 2008); the limiting of power, choice, and control is a form of silencing.

Nursing Implications

The results of this study indicate that any experience of childbirth and pregnancy and birth outcomes can be understood only in context; this includes the impacts of colonial relations as they continue to shape women's experiences. To understand the health of rural Aboriginal women and infants in context, nurses must ask several questions: (1) What circumstances (i.e., knowledge, ideologies, assumptions, worldviews, values) are shaping my response to this women/family? (2) How does my social location enhance or constrain my ability to listen to what women need and expect in relation to birthing? (3) What are this woman's/family's experiences, needs, and hopes for birth? What choices can I facilitate? (4) What knowledge or ways of practising are dominant in this health centre/unit/clinic, and how might they hinder women's power, choice, and control? By bringing these kinds of questions to rural nursing contexts, we may help to develop knowledge about the unique pregnancy and birth needs and hopes of Aboriginal women, families, and communities, while also informing a "rural lens" for health policy, planning, and practice in order to promote health in rural and remote communities (Canadian Health Services Research Foundation [CHSRF], 2004).

A rural lens has been proposed as a way to uncover the realities of rural practice to realize "continuity of care and culturally appropriate care" (CHSRF, 2004). Based on our findings, we propose that a rural lens for maternity nursing practice be informed by the development of nurses' capacity to work from an understanding of birthing experiences and outcomes in context; that is, specifically how "medical colonialism" operates as a social determinant of health. Our findings indicate, however, that culturally appropriate care, while necessary, is not sufficient. Nurses need to engage with women, families, and communities in ways that are culturally *safe,* to specifically consider how traditional knowledge of Aboriginal childbirth practices can inform their practice in ways that best meet local cultural, spiritual, and physiological needs.

Culturally safe care requires that nurses (1) examine how the culture of Western biomedical approaches to childbirth is dismissive of Aboriginal knowledge and traditional practices, and (2) practise from a contextualized understanding of Aboriginal women's birthing experiences and perinatal outcomes. Addressing these aims in rural and remote nursing practice also requires the skills of reflective practice. This requires that nurses engage in reflective practice to develop a critical consciousness of how their own power, knowledge, and privilege is operating and how "system-centred" maternity care creates stressful birth experiences and contributes to adverse birth outcomes. Nurses practising in rural and remote Aboriginal communities are well positioned to advocate for the inclusion of women's voices in maternity care and the preservation of traditions and practices that bond babies to the community and the community to babies. Nurses can attend to this need for inclusion through one-to-one clinical encounters or at the organizational level. For example, in one community a perinatal nurse understood the importance of singing Kwakwa̱ka̱'wakw songs to newborn infants. This nurse sought out women Elders who knew the songs in their original language and arranged for their regular attendance at prenatal classes and mother-and-baby drop-ins at the local health centre. This is an example of a nurse practising from a view of the inseparability of cultural revitalization and the health of mothers, infants, and families. Nurses working in partnership with rural Aboriginal communities are well positioned to facilitate meaningful birthing experiences and positive birth outcomes that promote health equity and well-being for mothers, babies, families, and communities.

References

Benoit, C., Carroll, D., & Millar, A. (2002). But is it good for non-urban women's health? Regionalizing maternity care services in British Columbia. *Canadian Review of Sociology and Anthropology, 39*(4), 373–395.

Benoit, C., Carroll, D., & Westfall, R. (2007). Women's access to maternity services in Canada: Historical developments and contemporary challenges. In M. Morrow, O. Hankivsky, & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 507–527). Toronto: University of Toronto Press.

British Columbia Provincial Health Officer. (2009). *Pathways to health and healing — 2nd report on the health and well-being of Aboriginal people in British Columbia.* Provincial Health Officer's Annual Report 2007. Victoria: Ministry of Healthy Living and Sport.

Canadian Health Services Research Foundation. (2004). *The nature of nursing practice in rural and remote Canada.* Ottawa: Author.

Fisher, C., Huack, Y., & Fenwick, J. (2006). How social context impacts on women's fears of childbirth: A Western Australian example. *Social Science and Medicine, 63,* 64–75.

Fiske, J. (2006). Boundary crossings: Power and marginalisation in the formation of Canadian Aboriginal women's identities. *Gender and Development, 14*(2), 247–258.

Fiske, J., & Browne, A. J. (2004). *First Nations women and the paradox of health policy reform.* Vancouver: British Columbia Centre of Excellence for Women's Health.

Giscombe, C. L., & Lobel, M. (2005). Explaining disproportionately high rates of adverse birth outcomes among African Americans: The impact of stress, racism, and related factors in pregnancy. *Psychological Bulletin, 131,* 662–683.

Grzybowski, S., Kornelsen, J., & Cooper, E. (2007). Rural maternity care services under stress: The experiences of providers. *Canadian Journal of Rural Medicine, 12*(2), 89–94.

Kaufert, P. A., & O'Neil, J. (1993). Analysis of a dialogue on risks in childbirth: Clinicians, epidemiologists and Inuit women. In S. Lindenbaum & M. Lock (Eds.), *Knowledge, power and practice: The anthropology of medicine in everyday life* (pp. 32-54). Berkeley: University of California Press.

Kelm, M.-E. (2004). Wilp Wa'ums: Colonial encounter, decolonization and medical care among the Nisga'a. *Social Science and Medicine, 59,* 335–349.

Kemmis, S., & McTaggart, R. (2000). Participatory action research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 567–605). Thousand Oaks, CA: Sage.

Kornelsen, J., & Grzybowski, S. (2005). Safety and community: The maternity care needs of rural parturient women. *Journal of Obstetrics and Gynaecology Canada, 27*(6), 554–561.

Kurtz, D. L. M., Nyberg, J. C., Van Den Tillaart, S., & Mills, B. (2008). Silencing of voice: An act of structural violence. Urban Aboriginal women speak out about their experiences with health care. *Journal of Aboriginal Health, 4*(1), 53–63.

Long, C., & Curry, M. (1998). Living in two worlds: Native American women and prenatal care. *Health Care for Women International, 19*(2), 205–215.

Muckle, R. J. (2007). *The First Nations of British Columbia* (2nd ed.). Vancouver: UBC Press.

Parker Dominguez, T. P. (2008). Race, racism, and racial disparities in adverse birth outcomes. *Clinical Obstetrics and Gynecology, 51*(2), 360–370.

Reinert, E. S. (2005, March 14–15). *Development and social goals: Balancing aid and development to prevent "welfare colonialism."* Paper presented at United Nations Development Conference on Millennium Development Goals, New York.

Ross, D. P., Scott, K. J., & Smith, P. J. (2000). *The Canadian fact book on poverty 2000.* Ottawa: Canadian Council on Social Development.

Sutherns, R., McPhedran, M., & Haworth-Brockman, M. (2004). *Rural, remote and northern women's health: Policy and research directions – Final summary report.* Ottawa: Centres for Excellence in Women's Health.

Tait, C. L. (2008). Editorial: Canadian Aboriginal women and health. *Journal of Aboriginal Health, 4*(1), 2–3.

Varcoe, C. (2006). Doing participatory action research in a racist world. *Western Journal of Nursing Research, 28*(5), 525–540.

Varcoe, C., & Hartrick Doane, G. A. (2007). Mothering and women's health. In O. Hankivsky, M. Morrow, & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy* (pp. 297–323). Toronto: University of Toronto Press.

Acknowledgements

It is with respect and appreciation that we acknowledge the cooperation of the communities and men and women involved in the study and the community researchers: Miranda Talio and Thelma Harvey (Nuxalk Nation); Myrna Bell Wilson, Laura Bell, Mary Ann Wilson, and Melissa Edgars (Haida Nation); and Vera Newman, Karen Cook, and Barb Cranmer (Kwakwa̱ka̱'waka Nation).

We wish to thank the Canadian Institutes for Health Research for their financial support of the research.

There is no conflict of interest to be reported related to the submission of the manuscript nor are there relevant financial disclosures to be made.

Helen Brown, RN, PhD, is Assistant Professor, School of Nursing, University of British Columbia, Vancouver, Canada. Colleen Varcoe, RN, PhD, is Professor and Director (Pro Tem), School of Nursing, University of British Columbia. Betty Calam, MD, is Associate Professor, Department of Family Practice, University of British Columbia, and Site Director, St. Paul's Hospital, Vancouver.

INDEXES

Authors / *Auteures* — Volume 43: 2011

Titles / *Titres* Volume 43: 2011

Reviewers for Volume 43

CJNR is indebted to the persons below, who served as reviewers for Volume 43. They gave generously of their time and shared their knowledge, and in so doing have contributed greatly to the editorial process and to the development of nursing knowledge.

CJNR *est reconnaissante envers les personnes ci-dessous nommées pour leur participation en tant qu'examinatrices des articles publiés dans le volume 43. Ces personnes ont généreusement donné de leur temps et ont partagé leur savoir. Ce faisant, elles ont largement contribué au processus éditorial et au développement des connaissances en sciences infirmières.*

Maxine Alford
BC Cancer Agency

Joan Almost
Ryerson University

Barbara Aslte
Mount Royal College

Davina Banner
University of
Northern British Columbia

Marcia Beaulieu
McGill University

Jennifer Bell
University of British Columbia

Beth Black
University of North Carolina

Joan Bottorff
University of British Columbia
Okanagan

Susan Brajtman
University of Ottawa

Helen Brown
University of British Columbia

Camille Burnett
University of Western Ontario

Brenda Cameron
University of Alberta

Jane Chambers-Evans
McGill University

Andrea Chircop
Dalhousie University

Alexander Clark
University of Alberta

Robin Cohen
McGill University

Janice Collins-McNeil
Winston-Salem State University

Ed Connors
General Hospital Marymount
School of Nursing

Valorie Crooks
Simon Fraser University

Danielle Davidov
West Virginia University

Alba DiCenso
McMaster University

Carl-Ardy Dubois
Université de Montréal

Nancy Edgecombe
Dalhousie University

Carolyn Ells
McGill University

Keren Elumir
Sanctuary Ministries of Toronto

Nancy Feeley
McGill University

Betty Ferrell
City of Hope

Dorothy Forbes
University of Alberta

Sylvie Fortin
Université de Montréal

Joy Fraser
Athabasca University

Judith Gagnon
University of Alberta

Céline Gélinas
McGill University

Gary Goldsand
Royal Alexandra Hospital

Donna Goodridge
University of Saskatchewan

Thomas Hadjistavropoulos
University of Regina

Jill Hanley
McGill University

Gweneth Hartrick Doane
University of Victoria

Lorraine Fay Holtslander
University of Saskatchewan

Sonya Lee Jakubec
Mount Royal College

Lianna Jeffs
St. Michael's Hospital

Rachel Jones
Rutgers University

Sarah Kagan
University of Pennsylvania

Koushambhi Khan
University of British Columbia

Melissa Kimber
Hamilton Health Sciences

Karen Kirchhoff
University of Wisconsin

Judith Kulig
University of Lethbridge

Julie Lapinsky
University of British Columbia

Judith Lynam
University of British Columbia

Jane MacIver
University of Toronto

Martha Mackay
St. Paul's Hospital

Karen MacKinnon
University of Victoria

Janet Marshall
Florida A & M University

Joan McCarthy
University College Cork (Ireland)

Susan McClement
Cancercare Manitoba

Heather McDonald
University of British Columbia

Heather McGilton
University of Toronto

Kathy McGilton
University of Toronto

Joan McNeil
University of Victoria

Mary McQueen Reidy
Université de Montréal

Lisa Merry
McGill University

Judy Mill
University of Alberta

Dolores Mullings
St. John's College

Donna Anne Murnaghan
University of Prince Edward Island

Florence Myrick
University of Alberta

Filomena Nalewajek
Canuckplace

Cheryl Nekolaichuk
University of Alberta

Mary Ann O'Brien
University of Toronto

Linda Ogilvie
University of Alberta

Monica Parry
University of Toronto

Shelley Peacock
University of Alberta

Janice Penrod
Pennsylvania State University

Kelly Penz
Saskatchewan Institute of Applied Science and Technology

Caroline Porr
University of Alberta

Louise Racine
University of Saskatchewan

Carole Robinson
University of British Columbia Okanagan

Monica Ruiz-Casares
McGill University

Ellen Rukholm
Laurentian University

Luciana Ruppenthal
McGill University

Kathy Rush
University of British Columbia

Brenda Sabo
Dalhousie University

Irene Sarasua
McGill University

Meredith Schwartz
Dalhousie University

Sonia Semenic
McGill University

Pat Sevean
Lakehead University

Shannon Sibbald
University of Western Ontario

Anne Harriet Simmonds
University of Toronto

Andrea Smilski
Vancouver Island University

Victoria Smye
University of British Columbia

Oona Marie St-Amant
University of Western Ontario

Sannie Tang
University of Toronto

Denise Tarlier
Thompson Rivers University

Genevieve Thompson
University of Manitoba

Sally Thorne
University of British Columbia

Penny Tryph
University of New Brunswick

Madine VanderPlaat
St. Mary's University

Ellen Olive Wahoush
McMaster University

Allison Williams
McMaster University

Martin Woods
Massey University

Michael Yeo
Laurentian University

Heather Young
Oregon Health Sciences University

Margareth Santos Zanchetta
Ryerson University