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COMMUNITY-BASED RESEARCH ON IMMIGRANT WOMEN: CONTRIBUTIONS AND CHALLENGES

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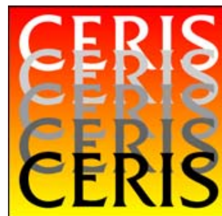

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COMMUNITY-BASED RESEARCH ON IMMIGRANT WOMEN: CONTRIBUTIONS AND CHALLENGES

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Abstract

This paper explores the profuse amount of community-based research being conducted about and with immigrant women, primarily in Toronto. Its objectives include highlighting both the growing and stagnant number of collaborative academic-community partnerships. Despite the fact that research on immigrant women is excelling in depth and scope, academic and community efforts remain relatively discrete, as each world is often unaware of the others interests and pursuits. Multi-tiered collaboration is vital in bridging this gap, including greater and ongoing communication between all researchers working in this field, as well as direct participation of community members in project development and implementation.

For the purposes of this report, community-based research on immigrant women has been classified into six categories. They include:

1. Health – physical and mental health and well-being;
2. Settlement and economic integration;
3. Homelessness and housing;
4. Domestic violence and disability and violence;
5. Disability and integration; and
6. Seniors, seniors and disability, and elder abuse.

As this paper will illustrate, academic-community research efforts are frequently limited to select areas, namely, health, economic participation, training, and settlement, while other issues related to housing, homelessness, domestic violence, disability, and seniors remain relatively unexplored. It is, however, noteworthy that many of these latter subject areas are extremely sensitive within the communities themselves, particularly as

[1] The opinions and views expressed in this report do not necessarily reflect those of the Community Social Planning Council of Toronto.

they impact the lives of immigrant women. Nevertheless, their exploration, including action-oriented recommendations and solutions, remains imperative.

Key Words: Immigrant women, Community-based action-oriented research, Health, Settlement, Economic integration, Homelessness, Housing, Violence, Disability, Seniors

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Introduction

Research on immigrant women is growing in depth and scope in both academic and community arenas. Nevertheless, these two worlds remain relatively discrete, each often uninformed of the others' interests and pursuits. In an effort to bridge this gap, an immigrant networking meeting comprised of academic, community, and civic representatives met in September 2003 in Toronto to discuss their respective work and share concerns with others undertaking similar research. The result was extremely positive. It highlighted, among other things, the need for multi-tiered collaboration, particularly working in and with communities in order to yield the most effective research with direct impact. This paper is a further offshoot of that meeting. Its purpose is to share the profuse amount of community-based research[2] being conducted about and with immigrant women, primarily in Toronto, in hopes of facilitating and expanding a network between all researchers working in this field.

When I first began my research, I was unaware of what a rich body of literature and information laid ahead. As a result, and for the purposes of this paper, I have organized my findings into six categories as they impact the lives of immigrant women. These include:

1. Health – physical and mental health and well-being;
2. Settlement and economic integration;
3. Homelessness and housing;
4. Domestic violence and disability and violence
5. Disability and integration; and
6. Seniors, seniors and disability, and elder abuse.

Before commencing a detailed discussion of the extent and nature of community-based research in these areas, however, I would like to share with you my initial experience in seeking out this information. Frankly speaking, I was overwhelmed. I was aware that research on immigrant women was occurring at the community level, but had not realized to what extent. Despite limited resources, many organizations have consciously undertaken research in efforts to enhance, tailor, and expand their programs, as well as train other service providers. According to many individuals with whom I have

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[2] Researchers in the HIV/AIDS arena describe the principles of community-based research as including the following: community benefit, capacity building, collaboration, equity, inclusion, accessibility, and empowerment. See *Casey House Access Project: Final Report*, October 2001 as cited in Kappel Ramji Consulting Group (2002).

spoken, research is limited not for lack of desire but due to inadequate funds. More specifically, with the exception of a needs assessment, funding organizations tend to provide grants as a means to implement and run programs and services, rather than develop research. Numerous community organizations, however, have increasingly been partnering with universities, hospitals, and research institutions in an effort to share knowledge and develop further areas of inquiry, with the hope of being able to more effectively respond to women's needs. Such partnerships have been occurring at a time when traditional research is recognizing and appreciating an alternative, more action- and participatory-oriented analytic approach, one often denoted as Participatory Action Research (PAR) (Khanlou, Gestaldo, and Gooden 2004). In short, this approach allots to participants, like researchers, multiple roles, enabling them to speak of, and contribute, their qualitative experiences to the project (Khanlou, Gestaldo, and Gooden 2004). According to Professor Nazilla Khanlou,[3] Professor, Faculty of Nursing, University of Toronto, PAR is empowering because it enables people to increase control over their own health and well-being (Khanlou, Gestaldo, and Gooden 2004). Yet, PAR is not without its challenges. For example, it represents a bridging of two worlds, which requires acceptance of an often-unappreciated research style.

My research for this particular paper extended over a four-week period. Throughout these weeks, I contacted a total of 18 community and non-profit organizations, three government departments, three provincial organizations, one public hospital, and three independent consultants; these numbers include neither additional email contacts nor unsuccessful attempts. To my initial surprise, persons contacted were extremely receptive and interested in my inquiry; I am thankful to them all. These individuals referred me to multiple organizations, persons, documents, and websites that could further enrich my search. Given the time constraints and contact obstacles, however, all resources regretfully were not exhausted. Nevertheless, the process highlighted an intricate cross-Canada network of persons and institutions that have prioritized immigrant women as a focus in research.

Health

I would like to begin now with the first category of inquiry – **Health**. This category includes 32 references, the large majority community-based, retrieved specifically in areas of physical- and mental-health and well-being. The majority of research collected is primarily Toronto-based, though some out-of-province-based

[3] Professor Khanlou participated in a multi-disciplinary research project with persons from CAMH, Faculty of Medicine, University of Toronto, Department of Sociology, Ryerson, and Public Health investigating mental health promotion among newcomer female youth, a project funded by Status of Women Canada. This study, conducted in Toronto between 2000 and 2001, employed a PAR approach and sought to contribute to the well-being and mental health promotion policies geared to newcomer female youth attending secondary school in Canada. For further detail, please see Khanlou et al. (2002).

materials were also gathered.[4] Funding agencies cited in this material include Status of Women Canada, Ontario HIV Treatment Network (OHTN), Canadian Institute of Health Research (CIHR), Canadian Race Relations Foundation, Canadian Breast Cancer Foundation (Ontario Branch), National Health Research and Development Program, National Network on Environments and Women's Health (NNEWH), the Trillium Foundation, Maritime Centre of Excellence for Women's Health, Women's Health Bureau, and Le centre d'excellence pour la santé des femmes - consortium université de Montréal (CESAF).

Research on immigrant women and health is an area experiencing great collaboration between community organizations, public hospitals, and provincial networks. For instance, the Toronto-based Women's Health in Women's Hands Community Health Centre (WHIWH), a team of health professionals working from an inclusive, feminist, anti-racist, and anti-oppression framework, specializes in working with Black women and women of colour from Africa, the Caribbean, Latin America, and South Asia, with a particular emphasis on those living in poverty. This organization has been at the forefront of researching health issues, specifically through a participatory-action research (PAR) approach. In addition, it has and continues to engage in multi-collaborative efforts with the Faculty of Nursing, University of Toronto, Canadian Race Relations Foundation, and independent consultants among others, to expand its research capacity and, thus, more effectively respond to issues confronting its clientele. According to Notisha Massaquoi, the centre's program manager:

> … participating in research benefits both the clinic and the women who are its clients. But … it is important for researchers to understand that they should not merely come to the clinic, get the information they want, and then leave. They should also give something back to the community.…[5]

One of the Centre's more recent studies focuses on health promotion, examining breast health awareness for immigrant and refugee women (Women's Health in Women's Hands Community Health Centre 2003). This project, funded by the Canadian Breast Cancer Foundation (Ontario Branch), investigated the level of knowledge women from the Caribbean, Africa, South Asia and Spanish-speaking communities have surrounding breast health and breast cancer. The project, with an objective to increase the level of understanding among women of the resources available to them, involved a total of 214 women who were themselves integral in the research process, with some participating on the advisory committee. Some of the research findings include the following revelations:

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[4] Documents include those by: Gentium Consulting and the Canadian Ethnocultural Council (1996); Mailloux and Mulvihill (2000); MacKinnon and Howard (2000); Coté et al. (2001); and Gastaldo et al. (1999).

[5] 'Women's Health in Women's Hands' – Researchers at this Ontario, Canada, clinic must be prepared for a new way of thinking about responsibility to subjects. *Protecting Human Subjects*; U.S. Department of Energy, Office of Biological and Environmental Research, **No. 9**, Fall 2003, www.science.doe.gov/ober/humsubj.

(I) Perceptions of breast cancer as a death sentence, an issue thus better left unspoken;

(ii) Cancer as stigmatic, associated with AIDS patients who, the women feel, claim to be inflicted with the disease;

(iii) Doctors not informing young women of colour about breast cancer, but rather only STDs and pregnancy;

(iv) Difficulties encountered by women with disabilities in performing self-breast examinations and/or accessing mammography clinics;

(v) Fears of potential cancer impeding women from accessing mammograms;

(vi) Belief by African and Caribbean women in traditional cures;

(vii) Misperceptions of causes – i.e. being struck in the breast, North American food, and/or high stress levels as causes of breast cancer; and

(viii) Breast cancer as contagious (Women's Health in Women's Hands Community Health Centre 2003).

The report recommended the need for language-specific information on breast cancer, as well as community outreach and more workshops at health centres specific to these issues.

At least five other research projects were undertaken at or in collaboration with WHIWH. These included:

- *Research Skills Building/Enhancement and Research Protocol Development Project* (funded by the Ontario HIV Treatment Network) (Tharao et al. 2002);

- *Silent Voices of the AIDS Epidemic: African and Caribbean Women, Their Understanding of the Various Dimensions of HIV/AID and Factors That Contribute to Their Silence* (funded by the National Health Research and Development Program) (Tharao et al. 2004);

- *Racial Discrimination as a Health Risk for Female Youth: Implications for Policy and Healthcare Delivery in Canada* (funded and published by the Canadian Race Relations Foundation, 2003);

- A Brief on Bill C-11 – an act representing immigration to Canada and the granting of refugee protection to persons who are displaced, persecuted or

in danger (Women's health in Women's Hands Community Health Centre, March 2001); and

- Uncovering the majority: women and the health reform process. Prepared for WHIWH by D. Rajan Eastcott and J. T. Wortley (August 1994).

Another community-based research project in health promotion, namely, the Immigrant Women's Health Promotion Project (IWHPP), also is worthy of discussion. This project was an effort undertaken by the Working Women Community Centre (WWCC) in Toronto, and represented a three-year collaborative effort between the WWCC, community partners and health centres, hospitals and health networks, Toronto public health, and volunteers. Its objective was to emphasize and create awareness of barriers confronting immigrant, refugee, and racialized women in accessing institutionalized health care. Immigrant women from all backgrounds, religious affiliations and sexual orientations participated in this project; they included women from Chinese, South Asian, Caribbean, African, Portuguese, Spanish-, Arabic-, and Farsi-speaking communities. Throughout its duration, the IWHPP provided assistance in areas such as 'train-the-trainer' for agencies and union members who either sought to build organizational capacity or increase their respective abilities to respond more effectively to the health needs of immigrant women. Additional activities included conducting an environmental scan, developing breast- and cervical-, as well as other health-related, workshops for women in Toronto, particularly for under-serviced Portuguese-speaking women in the downtown west area of Toronto, conducting focus groups with women and interviews with hospital staff members, disseminating health promotion materials in immigrant communities, and initiating an anti-violence campaign to promote education and prevention of violence against women. A series of key outcomes and recommendations resulted, including the call to recognize immigrant women's health as a universal, rather than an individual, issue, one in need of women-specific strategies (Jalil 2003/04).

Next, I would like to briefly elaborate on a community-based research project specific to immigrant women and mental health, namely, that conducted by Across Boundaries, a community ethnoracial mental health organization in Toronto. This project, funded by the Trillium Foundation, produced a report in 2001 entitled The Healing Journey – a Report on Ethnoracial Communities and Mental Health within an Anti-Racist Framework (Across Boundaries 2001). This project initially grew from the recognition that there is a greater and disproportionate number of people of colour coping with mental illness in Toronto, a fact that may be directly correlated to rising numbers living in severe poverty, increasingly confronting more and more barriers. The 'Healing Journey' research project was conceived in three phases:

I Literature review (1996);

II Focus groups with ethnoracial mental illness survivors and service providers – researching experiences of women of colour with mental health problems (completed at the end of 1997); and

III Focus groups with ethnoracial mental illness survivors and service providers – researching experiences of men of colour with mental health problems (completed in 1999).

For the present purposes, I would like to highlight a few key findings from the literature review. Four issues stood out from this phase of the research:

- Ethnoracial women's issues are given less importance than those of immigrant communities as a whole;
- Few written materials exist that focus on mental health counseling and women of colour;
- Little research into the mental health issues of women of colour has been conducted; and
- There are few mental health service providers who are knowledgeable about specific mental health issues for women of colour.

These findings were particularly surprising given that the evidence suggests that more women are diagnosed with mental health problems than men (Across Boundaries 2001, 16-17). In addition, the report also noted that there is a lack of information about mental health services in both ethnoracial and mainstream communities. As well, it emphasized the importance of proper training for community-based service providers, many of whom are the points of first contact for immigrant women. The report recommended training and development, and information and consultation exchange, among social service practitioners (Across Boundaries 2001, 78-80).

Finally, I would like to quickly note some other areas of community-based research being conducted in the area of health; this list is by no means exhaustive. In addition, some references extend beyond immigrant women populations. For instance:

- Health promotion – including prenatal (Rajan Eastcott 1996) and mental health (Khanlou and Hajdukowski-Ahmed 1999) – funded by Status of Women Canada;
- Access, equity and sponsorship – (Coté et al. 2001) – funded by Status of Women Canada;

- Handbooks/Guides – including the immigrant women's health handbook [Rawji (Date unknown) – funded by the National Network on Environments and Women's Health (NNEWH)], and guide to women's health and community service (Ontario Women's Health Network (OWHN) 2001); *Training Guidelines for Counseling Staff* (Rajan Eastcott 1997); *Communication Strategy* (Rajan 1998);

- Analyses of lifestyle changes in newcomer women (Lai 2003) and food security (Berinstein and Tam 2002) [Access Alliance Multicultural Community Health Centre];

- HIV/AIDS – improving access to legal services and health care for persons who are immigrants, refugees or without status (The Committee for Accessible AIDS Treatment (CAAT) 2001) – funded by the Ontario HIV Treatment Network (OHTN)];

- Quality and perception of reproductive health (Gastaldo et al. 1999) – funded by la centre d'excellence pour la santé des femmes – consortium université de Montréal (CESAF));

- East downtown Toronto area profile (Oldfield and Hart 2004); and

- Synthesis of research [Mailloux and Mulvihill (2000 - work in progress). Immigrant Women's Health. Centres of Excellence for Women's Health. A Synthesis of Research. Women's Health Bureau Working Group on Metropolis Health Canada].

As these examples illustrate, community-based research on immigrant women in the area of health is growing. In short, community agencies and academic and health institutions are increasingly collaborating in participatory action-oriented research, whereby women are not only given voice but also are heard. It is through such an approach that issues affecting immigrant women may best be understood and translated into effective action.

Settlement and Economic Integration

The next category of community-based research on immigrant women that I would like to address is **Settlement and Economic Integration**, an area that has been extensively examined by both academic and community-based researchers. A total of 16 community-based reports and references were retrieved, the majority Toronto-based. This

area of inquiry has been extensively studied in the academic arena. A lot of attention has been directed towards a number of issues:

- ESL;
- Training;
- Education;
- Skills Development;
- Bridging; and
- Challenges/barriers to labour market participation and settlement.

Organizations funding this research have included:

- Status of Women Canada;
- Citizenship and Immigration Canada;
- Toronto Training Board;
- The Maytree Foundation; and
- Human Resources Development Canada.

I would like to briefly comment on one community-based research project that examined the economic integration of immigrant women in the Toronto labour market from a bilateral perspective. This research was a collaborative effort between the Canadian Centre for Women's Education and Development and the Children's Aid Society of Toronto, and was funded by Human Resources Development Canada (Sherkin and Demchuk 2003). The purpose of the study was to establish a direct bilateral correlation between the economy and immigrant women living in Toronto through the examination of economic factors and social experiences, both as individual and community-related entities, a holistic approach that could ultimately identify and bridge gaps and propose creative solutions. Despite the fact that many researchers have focused on systemic barriers confronting immigrant women in the workplace, few have investigated the economy in its own right. Moreover, past and present labour-market dynamics as well as the needs and preferences among the local employer community, particularly as they relate to immigrant women's skills, qualifications, and experiences are in need of far more research attention. The collaborative effort between the Canadian Centre for Women's

Education and Development and the Children's Aid Society of Toronto, however, strove to link Toronto's economic environment with women's social experiences. Its researchers surveyed 433 immigrant women residing in Scarborough and East Toronto and, and conducted face-to-face survey interviews with 97 employers throughout the city. Additional elements included a thorough literature review of research conducted on immigrant women as well as an overview of the Toronto, Ontario, and Canadian labour markets. In short, study findings highlighted a significant dearth of communication between multiple stakeholders, namely, employers, immigrant women, community agencies, and governments, on a variety of issues ranging from poverty and recruitment to training and language. Such a situation, it was argued, has and continues to both consciously and unconsciously impede effective action. Recommendations for change thus focused on ways to improve communication between all social players, an integral ingredient for increasing effective and sustainable bilateral integration of immigrant women and the economy.

I would like to quickly note some other areas of community-based research being examined in the area of settlement and economic integration. Some examples include:

- Settlement in the workplace:
    - COSTI Immigrant Services R. J. Sparks Consulting Inc., WGW Services Ltd. 2001) – funded by Citizenship and Immigration Canada;
    - Working Skills Centre (Chetty 2002) – funded by Status of Women Canada with additional contributions from the Toronto Training Board;
    - Advocate for Community-based Training and Education for Women (ACTEW 2001) – funded by the Maytree Foundation;
    - Sexual and workplace harassment (London Sexual Assault Centre, Department of Sociology, University of Toronto, Centre for Research on Violence against Women and Children, University of Western Ontario, Community Representative) (Workplace Harassment Community Research Team 2000) – funded by Status of Women Canada; and

  - MicroSkills – Access for women to education and training for employment in Information Technology (IT) – funded by Status of Women Canada and Human Resources Development Canada.[6]

- Settlement and economic integration:

  - Needs assessment of immigrants and refugees living in Toronto (Access Alliance Multicultural Community Health Centre);[7]

  - Breaking isolation for low income women of colour in Toronto (Khosla 2003) – funded by the Women's Program, Status of Women Canada, with supplementary support from the City of Toronto's Access and Equity Grants Program;

  - Effects of budget cuts on settlement experiences of recent Latina immigrants and refugees [Israelite and Herman (1999)];

  - Settlement experiences of Somali Refugee Women in Toronto (Israelite et al. 1999); and

  - A training manual for working with South Asian and Chinese women and their families (Rajan Eastcott and Arora (1992).

The area of settlement and economic integration, like health, is one where much collaboration has and continues to exist between academic and community-based organizations. These partnerships, however, increasingly diminish in the categories that follow.

Homelessness and Housing

Community-based research retrieved in the areas of immigrant women, **Homelessness and Housing** in Toronto is less abundant than that found and collected in the previous two categories. Moreover, research and references retrieved were not specific

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[6] MicroSkills. Women and Technology Forum. "Developing Professionals for the 21st Century". October 20, 2000.

[7] This report strives to gain a better understanding of the pressures experienced by immigrants and refugees of both genders, and by organizations trying to balance increasing needs and shrinking budgets. See Access Alliance Multicultural Community Health Centre (2002), p. 4.

to immigrant women, but rather addressed these issues as they impacted all women. Nevertheless, this research has produced some insightful and action-oriented results. For instance, in June 2002, Sistering: A Woman's Place released a report examining the impact of homelessness on women's health (Kappel Ramji Consulting Group 2002). This report was based on a multi-phased project sponsored by Sistering and the Toronto Community Care Access Centre, and funded by Status of Women Canada, Health Canada, and The Population Health Fund. This community-based, participatory action research project (Kappel Ramji Consulting Group 2002, 2) began shortly following the release of the *Mayor's Task Force Report on Homelessness*.[8] More specifically, Sistering convened a forum in October 1999 where it was revealed that not only was little being heard of the lived reality of homeless women, but there was no affirmation that women experienced homelessness. Consequently, this research project commenced, with an aim to give voice to this aspect of women's reality.[9] Its objective was "to increase the knowledge and understanding of key health sector stakeholders about the profile and experiences of homeless women by examining the impact of homelessness on their health and the response of Toronto's health care system." (Kappel Ramji Consulting Group 2002, vii) Though not specific to immigrant women, homelessness, both visible[10] and hidden,[11] affects women from all backgrounds. Moreover, immigrant women are extremely vulnerable to the key factors contributing to homelessness. These include:

- Poverty;
- Barriers to economic self-sufficiency;
- Lack of affordable, appropriate and safe housing;
- Isolation; and
- Family violence.[12]

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[8] Common Occurrence Forum Report, Tuesday, June 12, 2002, Metro Hall, Toronto, Ontario, p. 4

[9] Ibid, pg. 4.

[10] Visible homelessness includes women who stay in emergency hostels and shelters, as well as those who sleep in 'rough places' considered unfit for human habitation; for example, parks, ravines, doorways, vehicles and abandoned buildings (Kappel Ramji Consulting Group 2002, vii).

[11] Hidden homelessness includes women who temporarily stay with friends or family, as well as women staying with a man as the sole means of obtaining shelter. In addition, it includes situations where women live in households where they are subjected to family conflict or violence, where women pay so much of their income that they cannot afford basic necessities such as food, where they are at risk of eviction, and where they live in illegal, physically unsafe, or overcrowded households (Kappel Ramji Consulting Group 2002, vii).

[12] Ibid, pp. xi, 19.

The four major finding of this project included:

1. The full extent of women's homelessness is extremely underestimated due to a failure to understand the continuum of women's homelessness;

2. Visible and hidden homelessness is a significant women's health issue that affects their emotional, mental, spiritual, and physical health;

3. Toronto's system of supports and services does not completely respond to visible and hidden homeless women's health care issues and needs; and

4. In failing to tap into the strength and leadership skills of women experiencing visible and hidden homelessness, Toronto's system of supports and services does not support survivors in building solutions.[13]

The report put forward eleven recommendations and 62 specific actions for implementation. This report is extremely significant as it contributes to our knowledge of about both the visible and hidden homeless women in Toronto. In addition, it highlighted homelessness as a women's health issue, and underscored the importance of <u>hidden</u> homelessness and the numerous opportunities that exist for the health-care system to improve its responsiveness and effectiveness in supporting women.[14]

Some additional examples of work conducted in this area include:

- Barriers to equality – Centre for Equality Rights in Accommodation (CERA), funded by Status of Women Canada and the Department of Justice (Callaghan et al. 2002);

- Access to justice for abused immigrant women in New Brunswick – funded by Status of Women Canada [Miedema and Wacholz (1998)]; and

- Guides for service providers:

    - Persons working with immigrant and refugee women abused by their sponsors – (BC Institute Against Family Violence 2001);

    - Persons working with women with disabilities in shelter and sexual assault centres (Rajan Eastcott 1994b); and

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[13] Ibid, pg. viii.

[14] Ibid, pg. xix.

- a Training Kit which was prepared for Ontario's Disabled Women's Network (Rajan Eastcott and Odette 1994).

At this juncture, it is worth noting the names of some women's shelters in and around the City of Toronto, as well as information links specific to immigrant and refugee women:

- **Women's Shelters**:
  - Ernestine's Women's Shelter – Rexdale (for assaulted women and children);
  - Interim Place – Mississauga (for assaulted women and children);
  - Streethaven at the Crossroads – Toronto;
  - Interval House;[15]
  - YWCA of Metropolitan Toronto – Y Women's Shelter (for assaulted women and children); Stop 86; Woodlawn; and
  - Yorktown Shelter for Women.[16]
- **Information Links for Immigrant and Refugee Women**:
  - Provincial Association of Transitional Houses in Saskatchewan (PATHS);[17]
  - RoseNet;[18]
  - Immigrant and visible minority women against abuse;[19]
  - *Abuse Is Wrong in Any Language* – a publication produced by

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[15] 'Interval House, established in 1973, was Canada's first shelter for abused women and children [weblink: www.intervalhouse.on.ca/programs/].

[16] Established in 1984 as Shirley Samaroo House, this shelter was the first immigrant women shelter in Toronto. It slowly evolved into a shelter serving all women. This transition occured as other shelters began serving immigrant women. However, 80% of Yorktown Shelter for Women's clientele remain immigrant women. (Telephone conversation with Karen Engel, Executive Director, Yorktown Family Services, May 11 2004).

[17] www.hotpeachpages.org/paths/

[18] www.rosenet-ca.org

[19] www.ivmwaa.ottawa.on.ca

Health Canada with information on abuse in ethno-cultural and new Canadian communities;[20]

- The Double Life Dilemma: Young South Asian women in violent relationships;[21]

- Immigrant women and domestic violence fact sheet – produced by Community Legal Education Ontario (CLEO);[22]

- Project Blue Sky – serving South Asian women in Ontario;[23] and

- Career Planning for Assaulted Women (CPAW) – Community MicroSkills Development Centre, Etobicoke.[24]

Domestic Violence and Disability and Violence

The fourth category of community-based research on immigrant women I encountered is best described as studies of **Domestic Violence and Disability and Violence**. Eleven references were retrieved for the former and six for the latter. Regarding the issue of domestic violence, itself a challenging area of study for reasons of data availability,[25] I would like to make a brief reference to a recently-released report (8 March 2004) by the Canadian Council on Social Development.[26] This report was based on a two-year study examining domestic abuse among immigrant and minority women. It was funded by the Department of Justice under the Sectoral Involvement in Departmental Policy Development program within the Voluntary Sector Initiative.[27] The aim of this

[20] www.hc-sc.gc.ca/hppb/familyviolence/html/1abusewrong.htm

[21] www.metrac.org/programs/safe/asian.htm

[22] www.cleo.on.ca/english/pub/onpub/PDF/june01/immwomen.pdf

[23] www.projectbulesky.ca/english/index.html

[24] www.microskills.ca/CPS/womenSupport.htm#WomenAssault

[25] 'The availability of empirical data is always a challenge when examining issues related to immigrants and visible minority groups. It is even more challenging when the issue in question concerns partner violence among these ethnic communities.' See Smith (2004), 36.

[26] Ibid.

[27] This project is also connected with identified priorities of the RCMP (learning about diversity), the Solicitor General of Canada (victims and diversity in the offender population), and Status of Women Canada (eliminating

project was to increase understanding of the factors involved in partner abuse experienced by immigrant and visible minority women, identify and develop effective ways to support victims, reduce the incidence of partner violence, and develop ongoing relationships between minority communities, the justice system, and the voluntary sector.[28] This qualitative analysis involved a series of focus groups with frontline workers from settlement agencies and social service groups in seven cities across Canada, each possessing relatively large populations of immigrant and visible minority communities. The cities included Toronto, Ottawa, Montreal, Vancouver, Calgary, Winnipeg, and Halifax. Findings revealed that domestic abuse of immigrant and minority women has been extremely under-reported, as these women were the least likely either to report abuse to the police or to utilize available social services. Moreover, these women often confronted an intricately complex situation, for not only did they share concerns experienced by all abused women, including those associated with physical safety and security, but they also were burdened by intersecting social, cultural, and systemic barriers, namely, immigration status, cultural-, financial-, linguistic- and legal-constraints, racial discrimination, stereotyping, social isolation, and marginalization.[29]

Another important community-based participatory research project was conducted in January of 2000 by Education Wife Assault and funded by Status of Canada Women's Program (Tsang 2001). The focus of this research was on child custody and access issues experienced by abused immigrant and refugee women, an area itself not thoroughly researched. Project objectives included:

- Raising awareness of this issue in mainstream society;
- Increasing women's knowledge of Canadian family law and their legal rights; and
- Enhancing the effectiveness of advocates and lawyers working with women on custody and access.

Community partners and the researcher collaborated closely in this study, convening eleven focus groups and five key-informant interviews with women,[30] eight key-informant interviews with lawyers, and 12 with counselors and advocates, and one roundtable discussion with three lawyers and 18 counselors and advocates. The study found that immigrant women, like their Canadian-born counterparts, often remained in an abusive relationship "for the sake of the children" (Tsang 2001, 6). Moreover, immigrant

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violence against women). See Ibid, p. 1.

[28] Ibid, pp. vii, 1.

[29] Ibid, p. 34.

[30] Ninety out of 92 women were abuse survivors (Tsang 2001, 6).

women feared numerous issues, such as losing their children to their partners' family (in other words, the concept of children as the father's 'property'), their children enduring community stigmatization due to parental separation, deportation without their children, and/or deportation for both women and children. Immigrant women in these situations confronted numerous barriers including:

- Attitudes of family, friends, and community members;
- Fear of poverty and homelessness;
- Feelings of desperation and lack of knowledge of available resources;
- Isolation through controlling partners; and
- Immigration status (or lack thereof) (Tsang 2001, 6-7).

In short, this study found that the majority of immigrant and refugee women were unaware of either their rights and legal entitlements under Canadian law or where to find assistance. In addition, many women feared using the legal system, while others spoke of it as discriminatory. Additional issues raised were expensive legal fees and a time-consuming, labour-intensive legal process. The report concluded with a series of over 40 recommendations for change put forward by focus-group participants and key informants. These pertained to the following areas:

- The Family Law Act around custody and access;
- Practice of law;
- Legal aid;
- Division of property/assets;
- Spousal and child support;
- Education and training for immigrant and refugee women, family lawyers, judges, counselor-advocates and community and religious/spiritual leaders;
- Information and public awareness; and
- Programs and services for woman abuse survivors (Tsang 2001, 8-9).

I would like to briefly note some other areas of community-based research being examined in the area of immigrant and refugee women and domestic violence. They include:

1. Women of colour, violence and health care – (Jiwani 2000 and 2001);

2. Handbooks/Guides for service providers:

   - Handbook to set up and assess support groups (Moussa 1994) – funded by the Ontario Ministry of Health's Wife Assault Program and the United Way of Greater Toronto;

   - Handbook for service providers working with survivors of wife assault (Rafiqu 1991) - funded by the Ministry of Citizenship;

   - Guide for the Toronto Advisory Committee on Cultural Approaches to Violence Against Women and Children (Rajan Eastcott 1992 and 1993);

   - Resource manual on best practices (Rajan Eastcott 1994c); and

3. Refugee women and cultural uprooting [Krummel (date unknown)].

Regarding research into the issue of disability and violence, this is an area of inquiry in need of greater focus. One organization leading research in this area is the Ethno Racial People with Disability Coalition of Ontario (ERDCO). ERDCO, founded by ethno-racial people with disabilities in April 1993, has striven to raise awareness of the severe difficulties endured by ethno-racial minorities with disabilities.[31] According to this organization, no studies exist that focus on the issues and barriers endured by ethno-racial women with disabilities and abuse. As a result, in 1999 ERDCO launched a research project in an effort to educate and empower ethno-racial women who were vulnerable to abuse and violence, and as a means of preventing further occurrences. Four workshops were convened, two in Toronto (cross-disability, deaf women), one in Peel Region (cross-disability), and one in Hamilton (cross-disability). At the onset, ERDCO sought to extend its research to other locations, such as Ottawa and Sudbury; however, it was unable to find partners for this expanded effort. Some of the project's findings included:

- Little information exists on the issue of violence against ethno-racial women with disabilities;

- Types of abuse include physical, sexual, emotional, psychological, medical, financial, and neglect;

- Physical and social barriers impede abused disabled/deaf women from

[31] ERDCO has more than 200 members in Metropolitan Toronto, as well as groups in Peel Region and Ottawa. See Joyette Consulting Services (Date unknown), p. 4.

accessing assistance, communication being the largest barrier for deaf women;

- Abusers include husbands, partners, children, parents, other relatives, religious and community leaders, teachers, doctors, nurses, nurses' assistants, homemakers, attendants, transportation personnel, institutions, and institutional staff; and

- Disabilities are often perceived as punishment for a sin committed by either the woman or her family (Joyette Consulting Services (Date unknown), 15-16).

According to the ERDCO study, some of the barriers confronted by abused ethno-racial women with disabilities included:

- Isolation due to language, religion, or culture;

- Perception of disability as an abnormality and/or deficiency;

- Threats of being returned to their country of origin;

- Feelings of inadequacy as mothers; and

- Acceptance of abuse (Joyette Consulting Services (Date unknown), 16).

The report put forward a series of seven recommendations for change, including, among other things, increasing information, raising awareness, and expanding resources for women in such situations. Unfortunately, other research efforts in this area have been limited, with work largely concentrated in the production of various guides and handbooks.[32]

As the small number of retrieved items in this category suggests, domestic violence and disability and violence are areas lacking thorough analysis for immigrant women, particularly when compared to the research dealing with their health and settlement and economic integration. It is significant to stress, however, that the need is high; immigrant, refugee, and ethno-racial women in situations of violence are extremely vulnerable, a situation that becomes even more serious when disability becomes a factor. In short, there is a need for more research, specifically which is participatory and action-oriented, engaging and giving voice to women.

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[32] Examples include Rajan Eastcott (1995); Rajan (1999); Rajan (2001); The Roeher Institute and Education Wife Assault (1998).

Disability and Integration

The fifth category of community-based research involves **Disability and Integration**. I would like to note that the research retrieved in this area focuses on ethno-racial, rather than immigrant, women. The Montreal-based Multiethnic Association for the Integration of Handicapped Persons/Association multi-ethnique pour l'intégration des personnes handicapées du Québec (AMEIPH) has conducted extensive work in this area. For instance, in 1999 the organization published a report on women with disabilities from ethno-cultural communities (Penafiel 1999). The purpose of this report was to increase the understanding of service providers working with disabled women from ethno-cultural communities, as well as all other interested parties, as a means of contributing more effectively to improving the lives of women in areas including healthcare and social services, training,[33] job search, and so on. In this study, the attitudes of others, as well as the faults of a system not completely adapted to women's needs, were identified as the most significant handicaps confronting them (Penafiel 1999, 5 and 103-104). Moreover, systemic barriers that women without disabilities confront when attempting to enter and succeed in the labour market were magnified when disability became a factor, particularly the condition of solitude.

Another community-based research effort that I would like to note is one prepared for the Women's Health In Women's Hands Community Health Centre (WHIWH), a project funded by the Ontario Ministry of Citizenship, Summer Experience Program (Khan 2003). The focus of this research was on needs and issues facing young ethno-racial women with disabilities in relation to health services and information. Project objectives included:

- Improving the delivery of WHIWH's services to young women with disabilities from ethno-racial communities;
- Increasing access and decreasing barriers for young women with disabilities to services; and
- Heightening staff awareness of the young women's specific needs (Khan 2003, 4).

This study evolved in three phases. The first involved outreach to young ethno-racial women with disabilities in order to seek their participation through focus groups or telephone interviews. Phase two included fieldwork with not-for-profit, disability-related organizations, and viewing two theatrical performances, one youth- and the other disability-related. Phase three involved convening two focus groups and conducting a

[33] '…of all the barriers to job integration encountered by women with disabilities from ethnocultural communities, one of the most significant, regardless of their ethnocultural origin or disability, is the lack of adequate training' (Penafiel 1999, 87).

series of telephone interviews with young women. Barriers confronting these women included:

- Attitudes – for example, of family members, friends, co-workers, and healthcare providers among others;
- Access to information – for example, medical forms and health-related information; and
- Physical access – for example, to service locations.[34]

In sum, this report called for direct consultation with young women with disabilities from ethno-cultural communities when making decisions around improving their accessibility, because they know the true barriers they face.

Additional areas of community-based research in this area include:

- Race and disability (Chowdhury and Pathmanathan 1996) – funded by the Community Action Fund and Ontario Anti-Racism Secretariat of the Ontario Ministry of Citizenship, Culture and Recreation;
- Immigration, social services and health (Association multi-ethnique pour l'intégration des personnes handicapées [AMEIPH] 2004) – funded by Status of Women Canada;
- Benefits and supports (Doe and Rajan 2003);
- Policies and procedures manual – (Rajan Eastcott 1994a);
- Needs assessment about health care issues – (Ray 1996) – funded by the Ministry of Health, Women's Health Bureau; and
- Inclusiveness/Integration:
  - (Khedr 2003) – funded by the Ontario Ministry of Citizenship, Accessibility Directorate of Ontario, Community Accessibility Program. Partners included Toronto Public Health and WHIWH;
  - (Fawcett 2000) – funded by the Trillium Foundation; and
  - Social integration in Quebec (Bégin et al. 1993).

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[34] 'For young ethno-racial women with disabilities, physical barriers, as well as informational barriers, coincide with people's attitudes' (Khan 2003, 13).

The issue of disability and integration as it impacts immigrant women has received some research attention, particularly in Quebec. Nevertheless, it, along with issues of domestic violence and disability and violence, are areas in need of further attention, particularly in relation to women living in the City of Toronto.

Seniors, Seniors and Disability, and Elder Abuse

The last category that I would like to comment on is **Seniors, Seniors and Disability and Elder Abuse**. It is significant to here note that very few items were retrieved in this area. Moreover, as in the category 'Homelessness and Housing,' items collected were not specific to immigrant women; rather some referred to all women, and others to immigrant men and women. I would like to focus on the latter, viz. seniors from ethno-cultural communities.

According to the Roeher Institute, 36 per cent of Canadians between 65 and 74 years of age claim an ethnic origin. Their integration depends on various circumstances including:

- Social and cultural factors;
- Family and interpersonal relationships; and
- Living arrangements/conditions [The Roeher Institute (date unknown)].

Moreover, effective integration is further complicated for ethno-cultural seniors with disabilities, as they are confronted with additional barriers such as:

- Unsupported financial needs;
- Heightened vulnerability to abuse;
- No access to services and supports;
- Insufficient programming and training; and
- Discrepancies in generic seniors and disability-specific services [The Roeher Institute (date unknown)].

In March 1998, the Rexdale Women's Centre[35] in northwest Toronto, launched the *Ethno-Cultural Seniors Advocacy Project* (ECSAP), a multi-faceted project funded by the Department of Canadian Heritage, Multiculturalism Programme. This program allows

[35] The Rexdale Women's Centre is a United Way agency.

service providers to work with, support, and develop the advocacy capabilities of ethno-cultural seniors in order to improve their access to recreation and preventative health services in Rexdale (Hutchinson 2001). The project, which ran from March 1998 until August 2001, was divided into three distinct, yet interrelated, phases:

1. Identify and assist in eliminating barriers preventing ethno-cultural seniors from accessing recreation and preventative health services;

2. Foster and increase the capacity of ethno-cultural seniors to implement positive changes within their communities, and encourage their advocacy efforts;[36] and

3. Facilitate collaborative relationships between ethno-cultural seniors and service and government agencies as a means to address identified access issues (Hutchinson 2001, 10).

ECSAP commenced by securing project staff who were sensitive to diversity issues, particularly those pertaining to age and ethnicity. The project then began outreach to various ethnic groups in order to organize a series of community soundings as forums where ethno-cultural seniors could both speak and be heard. Approximately 40 consultations were convened over a five-month period. Based on these findings, the Project Coordinator[37] met with potential community partners to discuss the seniors' concerns, and foster prospective relationships as a means of resolving issues raised (Hutchinson 2001, 17-19).

The ECSAP study found that seniors from ethno-cultural communities confronted a series of barriers in accessing recreation and health preventative services. These barriers included, among others, accessibility to and the cost of public transportation, language, physical mobility, isolation and cultural differences. It is significant to note, however, that some of these barriers were more pertinent to/challenging for women than men. For instance, transportation was particularly difficult for women, as many had never used public transportation in their home country. In addition, language and culture were the most frightening issues for women, as opposed to men. Regarding the former, the study found more women were unable to read or write in their own language than men; the latter more commonly had been better educated in their home country. Moreover, women possessed little confidence and would only attend programs if they had trust in the

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[36] Between April 1999 and March 2000, the project assisted eight ethno-cultural seniors groups to develop advocacy skills. These groups include seniors from Somali, Ghanaian, Sri Lankan, Italian, Spanish, Punjabi, West Indian and Pakistani descents; they formed ECSAP. Within this group, a smaller working group, namely, the Rexdale Ethno-Cultural Seniors (RECS), was formed, including two representatives from each ethnic group. RECS has and continues to be extremely active in lobbying for improved preventative health and recreation services. See Hutchinson 2001, 11.

[37] Saadia Akram-Pall is the Project Coordinator.

organizers.[38] As a result of this study, the Rexdale Women's Centre, in collaboration with other partners, currently provide a series of activities for seniors. Some are gender specific, while others are mixed. In addition, the Centre periodically convenes ethnically-mixed events such as picnics and tree-planting days. These have been well received by participants.

I will close the discussion of this category with one comment on elder abuse. Seniors, both those with and without disabilities, are vulnerable to abuse, particularly in circumstances of high stress and poverty, circumstances often faced by newcomer families. Despite this fact, with the exception of one study, I did not come across any research specific to elder abuse in ethno-cultural communities.[39] The study to which I am here referring is one on elder abuse in the Punjabi community conducted by the Punjabi Community Health Centre and seniors' organizations serving the Punjabi elders in the Region of Peel, and funded by the Ontario Trillium Foundation.[40] Research commenced in autumn 2001, and findings were presented in a report to the community on 6 March 2004 (Mutta et al. 2004, 4). Specific research objectives included understanding the nature of abuse as well as factors contributing towards it, such as caregivers' personal problems, social and environmental conditions, access to and availability of services, and cultural factors fostering abuse (Mutta et al. 2004, 2-3 and 6). In short, researchers sought to determine whether or not senior abuse existed within the Punjabi community. They ultimately determined that it did (Mutta et al. 2004, 2). The research methodology for this was both quantitative and qualitative, the former involving the development and distribution of a questionnaire to 500 seniors, and the latter stemming from focus groups and random conversations with seniors.[41] Each data set was analyzed separately and a series of recommendations was put forward. For instance, the questionnaires highlighted a total of 44 findings. It is significant to here note that 70 per cent of persons surveyed were male and 30 per cent female. All of the survey participants were members of seniors groups in Peel Region. The small percentage of women participants may indicate that females were not accessing these groups or their services for reasons such as residential confinement or forced babysitting. Moreover, this figure may imply that women were at greater risk of abuse, particularly since the population ratio reveals that females outnumber

[38] Seniors aged 55 years and older attend these programs. However, there are a greater number of men than women between 80 and 85 years who participate. (Personal Interview with S. Akram-Pall, ECSAP Project Coordinator, 26 February 2004).

[39] For instance, according to Mutta et al. 2004, 7, research on South Asian elder abuse in North America is practically non-existent.

[40] According to the 2001 Census, the Punjabi community is the largest ethnic community in the Region of Peel, with the Punjabi language the second most spoken mother tongue following English. Nevertheless, research on elder abuse within this community is non-existent (Mutta et al. 2004, 5).

[41] The research team randomly initiated conversations in public places, such as bus stops, subway stations and grocery stores, with at least twenty Punjabi seniors. Researchers wanted to listen to the seniors' 'stories' with hopes of revealing any possible signs of elder abuse. Analysis of these stories highlighted the existence of forms of elder abuse; yet seniors did not identify it as such. See Mutta et al. 2004.

males in these age cohorts.[42] Findings based on the focus groups included the identification of nine types of abuse,[43] revelation that the term 'elder abuse' remains unclear to elders, highlighting of four factors contributing to abuse, and resource development and outreach as suggested by research participants (Mutta et al. 2004, 11-12). Findings based on personal stories revealed a variety of themes including, among other things, feelings of worthlessness, isolation, loneliness, and despair, as well as longings for fruitful relationships, spiritual fulfillment, and respect (Mutta et al. 2004, 10). Seniors' recommendations included:

- Raising awareness of elder abuse through various means such as media, art, and the development of an advocacy group;
- Elaboration of inter-generational programming;
- Addressing seniors' needs in four specific areas viz. support to caregivers, social and environment, access to services, and cultural factors fostering abuse; and
- Development of resources – for example, video cassettes, DVDs.

In sum, this work is of the utmost importance, for it addresses a concern often not spoken, one that exists in multiple communities and that is in need of greater research.

In conclusion, community-based research on immigrant women is vast in both depth and scope. Despite challenges, including limited funds, community organizations are targeting issues confronted by people in the community, and seeking their voice and direct participation in the development and implementation of action-oriented research. Moreover, community organizations are increasing their collaboration with academic and research institutions, particularly as the latter embrace a participatory-action-oriented approach. Nevertheless, these research efforts generally have been confined to a few areas; namely, health, economic/labour market participation, training, and settlement. Less community-based research has been directed to issues of housing, homelessness, domestic violence, disability and violence, disability and integration, seniors, seniors and disability and elder abuse. It is important to note that these areas of inquiry are extremely delicate, often taboo within a given culture, with many issues not openly spoken within the communities themselves. Nonetheless, the issues remain important, and the need for research and action imperative.

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[42] One of the seven recommendations based on the survey results were that needs of Punjabi senior women be further researched and explored. See Mutta et al. 2004, 17 and 53.

[43] These included: physical, financial, psychological/emotional, exploitation, neglect, abandonment, psychosocial, system and property. Financial, psychological/emotional exploitation and neglect were identified as the most frequent, followed by physical, psychosocial and system abuse, and abandonment and property abuse. See Mutta et al. 2004, 11.

Appendix: Study Contributors

Community/Non-Profit Organizations

1. Working Women Community Centre
2. Education Wife Assault
3. Sistering: A Woman's Place
4. MicroSkills
5. Canadian Centre for Women's Education and Development
6. COSTI Immigrant Services
7. YWCA of Greater Toronto
8. The Roeher Institute
9. Rexdale Women's Centre
10. Punjabi Community Health Centre
11. Across Boundaries: An Ethnoracial Mental Health Centre
12. Community Social Planning Council of Toronto
13. Women's Health in Women's Hands Community Health Centre
14. Access Alliance Multicultural Community Health Centre
15. Ethno Racial People with Disability Coalition of Ontario (ERDCO)
16. Centre for Equality Rights in Accommodation (CERA)
17. Multi-Ethnic Association for the Integration of Persons with Disabilities (AMEIPH)
18. London Sexual Assault Centre

Government Departments

1. Status of Women Canada
2. Canadian Heritage
3. Citizenship Immigration Canada

Provincial organizations

1. Ontario Women's Health Network
2. Office des personnes handicapées du Québec
3. Provincial Coalition of Rape Crisis Centre

Public Hospitals

1. Culture, Community and Health Studies Program, Centre for Addiction and Mental Health

Consultants

1. Doris Rajan
2. Punam Khosla
3. Margaret Oldfield and Doug Hart (University of Toronto)

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CERIS

The Joint Centre of Excellence for Research on Immigration and Settlement - Toronto (CERIS) is one of five Canadian Metropolis centres dedicated to ensuring that scientific expertise contributes to the improvement of migration and diversity policy.

CERIS is a collaboration of Ryerson University, York University, and the University of Toronto, as well as the Ontario Council of Agencies Serving Immigrants, the United Way of Greater Toronto, and the Community Social Planning Council of Toronto.

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The Metropolis Project

Launched in 1996, the Metropolis Project strives to improve policies for managing migration and diversity by focusing scholarly attention on critical issues. All project initiatives involve policymakers, researchers, and members of non-governmental organizations.

Metropolis Project goals are to:

- **Enhance academic research capacity;**
- **Focus academic research on critical policy issues and policy options;**
- **Develop ways to facilitate the use of research in decision-making.**

The Canadian and international components of the Metropolis Project encourage and facilitate communication between interested stakeholders at the annual national and international conferences and at topical workshops, seminars, and roundtables organized by project members.

For more information about the Metropolis Project visit the Metropolis web sites at:
http://canada.metropolis.net
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