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THE INTERPLAY OF GENDER, MIGRATION, SOCIO-ECONOMICS, AND HEALTH

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Immigration and integration experiences interact with the determinants of health. By studying the relationship between individual immigrants' characteristics, their health, and simultaneous experiences of social factors we attempt to identify generalizable and researchable aspects of the social environment that can be changed through adjustments in policy and programs and result in better health for immigrants. We use information collected from individual and group interviews with a total of 30 immigrant women and men of various backgrounds and immigration experiences and explore the influence of employment, socio-economics, gender, social support, neighbourhood and community, and access to health care..

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INTRODUCTION

The interplay between gender, migration, socio-economics, and health has been neglected in research and in the development of policies and programs with respect to immigrant women. Explanations reduced to the level of univariate individual level measures are insufficient to guide policy (Corbin, 1994; Evans, Barer, & Marmor, 1994; King & Williams, 1995; Krieger, 1992, 1994; Krieger, Rowley, Hermann, Avery, & Phillips, 1993; Krieger, Sidney, & Coakley, 1998; Marmot & Wilkinson, 1999). Research must reflect the complexity of the determinants of health, draw upon combined methodologies, and involve the people who are intended to benefit.

This study advances our understanding of the relationship between individual immigrants' characteristics, their health, and simultaneous experiences of social factors, such as, gender, migration, and socio-economics (Krieger, 2000; Krieger & Zierler, 1995). Together, the data from the study participants form a picture of immigrant life as influenced by a number of determinants. We linked descriptions shared by immigrant women and men with multi-disciplinary theories in an attempt to identify generalizable and researchable aspects of the social environment that can be changed through adjustments in policy and resulting programs.

RELEVANT LITERATURE

Immigrants to Canada are required to be in good health upon arrival to Canada, yet individual migrant health deteriorates and continues to deteriorate with the passage of time in the country; indeed, it has been argued that the migration experience itself should be considered a determinant of health (Kinnon, 1999; Vissandjée, Leduc, Gravel, Bourdeau, & Carignan, 1998a, 1998b; Vissandjée, Mayatela, Lapointe, Dupéré, & Tourigny, 1998). The decline of migrant health and well-being is related to multi-dimensional factors including: language barriers; cultural shock; loss of socio-economic status; lack of professional accreditation or work experience; unemployment; working in unsafe or unhealthy work conditions; economic and social exclusion, including poverty, prejudice and discrimination; isolation and loss of a pre-existing support system; lack of knowledge of existing services; barriers in accessing the health system; and feelings of vulnerability due to prolonged insecurity and uncertainty (Hattar-Pollara & Meleis, 1995; McGuire, 1998; Murty, 1998; Oxman-Martinez, Abdool, & Loiselle-Léonard, 2000; Tabora & Flaskerud, 1997; Taler,

1998). These factors impact differently on women than men (Kazemipur & Halli, 2000; Kinnon, 1999).

Numerous aspects of the physical and social environment are related to the health of populations (Patrick & Wickiser, 1995). In addition to local physical conditions, quality of water, air, soil, and housing (Macintyre, Maciver, & Sooman, 1993), the availability and accessibility of resources that promote health and prevent disease are important (Green & Ottoson, 1994; Macintyre & Ellaway, 2000). "Place-based" infrastructure enables people to avail themselves of other social policies and programs (e.g., income maintenance) (Kingsley, McNeely, & Gibson, 1997, p.25). For-profit organizations (i.e., businesses) also act through individuals and collectivities, and between collectivities and the state (Showstack, Lurie, Leatherman, Fisher, & Inui, 1996; Stoesz, 1987) to influence health (e.g., workplace policies). Local community organizations (volunteer, non-profit, and non-government) promote health directly (Hawe, 1994) and serve to monitor and critique the state with the goal of improving policies and programs (Alcock & Christensen, 1995; Whaites, 1996) or bringing about fundamental social change (e.g., women's rights) (Maillé & Wängnerud, 1999). Organizations are essential to the development of collective power and shared values and ties, and provide members with experiences of power (Speer & Hughey, 1995).

Another aspect of local environments that are increasingly shown to be related to health outcomes pertains to the organisation of social life, the patterns of social relationships, and the distribution of power that form the "social". Social cohesion, social capital, public participation, gender, and discrimination based on race or sex are all concepts used to describe the organisation of social life (Amaratunga, Stanton, & Clow, 2002). Recent literature reviews have provided ample evidence that local environments can be described according to these concepts and that the local organisation of life captured by these concepts is related to population health outcomes (Berkman & Kawachi, 2000; Hawe & Shiell, 2000; Link & Phelan, 1995; Lorber, 1994). Discrimination on race or sex, for example, reflects local patterns of social relationships and access to resources that affect people's health (Hawe, 1998; Kazemipur & Halli, 2000; Krieger, 2000; Krieger et al., 1993; Potvin & Frohlich, 1998). In the same vein, income inequality (Wilkinson, 1992, 1996, 1999), social capital, and social cohesion are related to a variety of health outcomes (Kawachi & Berkman, 2000). Relative income, as well as absolute personal income, appears to be related to health (Kennedy, Kawachi, Glass, & Prothrow-Stith, 1998).

In the ideal community, family members and neighbours provide social support,

assistance with activities of daily living, and collective action to those in need of help or in times of crisis. These types of care, however, are not provided on a continuous basis without reciprocation (Levine, 1999; Lloyd & Gilchrist, 1994), and in reality, are sometimes not provided at all (Campbell & Campbell, 1996; Frazer & Lacey, 1993; Pinn & Chunko, 1997). The home and family are important sites for health promotion (Soubhi & Potvin, 2000).

Immigrants' employment experiences are influenced by a number of factors that others take for granted. They are often more vulnerable to being fired and they may have a greater lack of knowledge of either their or their employer's rights and responsibilities than do long-term residents in the same types of jobs (Neysmith & Aronson, 1997; Thurston & McGrath, 1993; Thurston & Verhoef, 2003). They would therefore be less likely to refuse unsafe work or to work more slowly, change procedures, or otherwise contradict demands of production. Immigrant women face additional challenges because they may experience sexism as well as racism in job assignments and treatment of their occupational health concerns (Drummond & Lee, 1981; Gannagé, 1999; Neysmith & Aronson , 1997; Taler, 1998).

In addition to the lack of acknowledgement of the physical and social factors that may influence the health of immigrants, health research and policy development are often victim to what Razack (1998) refers to as culturalization, that is, cultural differences identified as explanations of, rather than signposts for, the occurrence of social oppression (Nazroo, 1998). The assumption underlying culturalization is cultural inferiority, and the solutions proposed usually involve efforts to improve individual level integration and adaptation to the dominant culture without paying attention to the barriers erected by that culture. Differences among immigrant and host country populations in health status or health service utilization, for instance, are often described as cultural differences, with a lack of regard for the social structures that prevent full participation of people with beliefs, norms, or activities that differ from those of a dominant population (Bollini & Siem, 1995). The issue of who established the norm against which others are judged and what purpose the norm serves remains unexamined (Sherwin, 1998); the idea that others have culture is perpetuated.

It is clear that the interactions among determinants of immigrants' health are complex and, as yet, little understood. It is important to understand the role of the social status characteristics of immigrants, the migration experience, economics, and gender as

determinants of health (Amaratunga et al., 2002; Kinnon, 1999; Krieger et al., 1993) and to address the impact of individual, family, and social level variables on health (Leventhal & Brooks-Gunn, 2000).

METHODS

This qualitative research used approaches from ethnography (Agar, 1986), having people describe their lives and health and well-being in their own words, and grounded theory (Strauss & Corbin, 1998), looking for collective meaning in data collection and analysis. We therefore employed a mixed-methods design, including observational, ethnographic, and participatory methods, and conducted data collection in three parts.

Individual interviews with immigrant women were completed between 2002 and 2003, and 11 women were interviewed in this part of the study. The goal of these interviews was to obtain information from immigrant women regarding the influence of migratory experiences, gender roles, socio-economics, access to information, and social support on their self-perceived health. These data were collected as part of the requirements for a Master of Science degree in Community Health Sciences successfully completed in June 2003 (Graham, 2003).

Women who had recently immigrated to Canada (< 5 years) and who were living in the inner city of Calgary were invited to participate. Recruitment was done through immigrant service agencies, English as a Second Language (ESL) courses, and health clinics in the inner city. Although the sample was relatively homogenous (i.e., all women, all recently immigrated to Canada, all living in the inner city), we attempted to identify women from different countries of origin with a variety of social status characteristics (e.g., children or not, employed or not). Data were collected in one-on-one ethnographic style interviews using an interview guide combined with a short demographics questionnaire. Interviews usually took place in the participant's home, lasted between one-and-a-half and two-and-a-half hours, and were audio-recorded with permission.

Ten individual interviews with immigrant men were completed in the spring of 2004. The goal of these interviews was to understand the role of gender and how the immigration experiences might affect the health of women and men differently. Participants were recruited through snowball sampling from the research assistant's community network; friends and acquaintances connected him to most of the participants, although some

participants were recruited through community functions. Interviews were conducted in a location selected by the participants, using the same interview guide that was used for the women. Interviews were audio-recorded with permission.

Data were collected through group interviews with immigrant women at the Calgary Mennonite Centre for Newcomers (CMCN) Collective Kitchens Catering between June 2003 and March 2004. The data gathered from these group interviews were intended to complement the data collected in the individual interviews. Five group interviews were held, scheduled approximately a month apart, and each focused on one theme: 1) Introductions; 2) What keeps you healthy?; 3) Employment, economics, and health; 4) How is being a woman different?; and, 5) A review of what was said and possible ways of reporting the findings to other immigrant women. Participants were asked open-ended questions derived from the original individual interview guide. Group interviews were held at the Collective Kitchens Catering site following cooking sessions so that it would be easier for women to participate. The same participants were invited to each group interview, but due to scheduling conflicts, not all were present at each. Five participants on average attended each group interview.

Participants had varying levels of capacity with English and often acted as interpreters for each other. Without consent from the entire group to audio-record the group interviews, all information reported was extracted from detailed field notes and debriefing sessions (audio-recorded and transcribed) between the group facilitator and the note-taker.

This study received approval from the University of Calgary Conjoint Medical Research Ethics Board and from the Calgary Health Region Adult Research Committee.

Data Analysis

Standard approaches to qualitative data analysis were used. We used QSR N6© software to assist in qualitative analysis as it facilitates shared analysis among researchers (Gijsbers van Wijk, Huisman, & Kolk, 1999). We employed thematic analysis using memoing and coding (Crabtree & Miller, 1999; Strauss & Corbin, 1998) and immersion and crystallization (Borkan, 1999) on both the individual and group interviews. The Research Coordinator completed initial analysis of the project as a whole using the research questions as a guide.

A template developed by research team members guided secondary analysis to identify and explore predominant themes. We connected and legitimatised our analysis (Miller & Crabtree, 1999) through reviewing of the transcripts and identified themes. Research team members interpreted the data, searched for disconfirming evidence, and utilized thick description (Meadows & Morse, 2001) to ensure within-project validation. Revisiting the relevant literature assisted in assuring transferability and credibility. We ensured validity by situating the study in the literature, bracketing, and methodological cohesion (Meadows & Morse, 2001; Patton, 1987).

PARTICIPANT DESCRIPTIONS

Immigrant Women Participants

Participants (n=11) in the individual interviews with immigrant women were originally from nine different countries: Belarus, China, India, Iraq, Mauritius, Romania, Suriname, USA, and Yemen, primarily from urban settings. The amount of time lived in Canada ranged from four weeks to four years, with six women having immigrated within the previous year. Nine of the women had landed immigrant status, one came as a refugee (and received landed immigrant status), and another was in Canada on a work permit. The women ranged in age from 29 to 48, with a mean age of 37.2 years. Ten of the women were married, only one was single. None of the participants lived alone, although one woman lived only with her young daughter. Eight of the women had children, who ranged in age from 3.5 to 20, with the average age being 10.5 years. Three of the women spoke English at home but only one spoke English as a first language. All of the participants were highly educated; none of the participants had less than a few years of post-secondary education, six had a bachelor degree, and three had a master's degree. Only one of the women had not worked for pay before coming to Canada. Five of the women had not worked for pay since being in Canada.

Immigrant Men Participants

In the individual interviews with immigrant men, there were ten participants. Their time lived in Canada ranged from two to thirteen years. Countries of birth included Afghanistan, Algeria, Caribbean, China, Ethiopia, Ghana, Nigeria, and Somalia. Many (n=7) had lived in other countries before coming to Canada. Six men identified themselves as "Landed

Immigrants," and four were Canadian citizens. Participants ranged from 29 to 47 years old (mean = 37.8 years). Seven of the men were married. Of the married men, five had children, ranging in number from one to five and ranging in age from 4 months to 11 years old (average = 4.8 years). All participants had at least some university, two held college certificates, two held bachelor degrees, three held master's degrees, and one held a doctorate degree. Eight of the participants were currently working, some while taking university courses.

Group Interviews

Nine women, representing various ethnic backgrounds and immigration experiences, participated in the first group interview on June 16, 2003. These women were invited to participate in the continuing group interviews that began November 2003, and three of the original nine participated in subsequent group interviews. Four other women joined the group interviews at various times. Only one woman participated in all of the group interviews. Data were therefore collected from a total of 13 women who participated in at least one group interview.

The participants represented various stages of the migration process, with time in Canada ranging from under 8 weeks to over 25 years. Countries of birth included Afghanistan, China, Sudan, Lebanon, and Palestine. Many had lived in other countries before coming to Canada. Six women identified themselves as "Landed Immigrants," two had refugee status, and one identified herself as an "Independent." Participants ranged from 22 to 49 years old. All were married except two of the younger participants. Married women had between one to four children, ranging in age from 3 to 27 years. Two mothers had children born in Canada; the others had immigrated with school-aged children. All of the women were employed with Collective Kitchens Catering. A few were working part-time in other employment or attending community college in addition to their work in the kitchens. Two women had left Collective Kitchens Catering during the course of the study because they had found full-time work.

KEY FINDINGS

Employment and Socio-Economics

Immigrants' experiences in securing professional, or at least economically secure, employment are perhaps the most pervasive theme in all of the interviews. Regardless of the research question or sex of the participant, responses most often referred back to how finding adequate work and income influenced every aspect of their lives.

Immigrant women and men expected to find professional employment, but their expectations were not immediately realized and often not realized in the long-term. The first few experiences of looking for professional work were not usually what recent immigrants expected:

> Cause I heard about Canada is, ah, they have like, ah, you can work, there's some good wages, the good life but when I came here I found everything difference. [Male03]

> In the first place I came with an expectation to utilize my education and to contribute to society but I think I am when I came to Calgary I realized that what I had didn't mean anything in terms of my education. Those things didn't mean anything to the society.… [Male09]

Most participants came to Canada believing that they would not have difficulty in finding professional employment. Those immigrants who held advanced university degrees thought that they would find related employment or at the very least, educational opportunities. Most saw the experience of moving to Canada as initially optimistic and hopeful but were soon discouraged by the lack of suitable or professional employment opportunities:

> …I think about that I should work…I, I deserve to have a nice job in fact I understand the situation with that. You don't mix. I just accept it. I just unlikely to get a job offer. That's what I understand. I mean here is expectation I would have a wonderful life, but in real life we always not really match your expectations. I accept that…. [Female07]

> It's a very depressing experience…. You know I feel I could be doing so much more, have so much more to offer and yet I'm not given the opportunity to flourish and blossom so, um, in this environment as I know I can and should, so I feel that sort of wasting time basically and, um, it's a very depressing…. [Male05]

There were few differences between women and men in expressions of disappointment over loss of professional identity and income.

Participants often described frustration and difficulty understanding the systems or processes involved with finding work in Canada. They did not, in general, talk directly about discrimination by prospective employers. However, running through most of the interviews was the expression of frustration in utilizing the recommended strategies (such as taking

English language courses, upgrading skills, and making a Canadian-style resume) and still not finding employment, despite being highly educated and experienced. For most immigrants, potential employers did not value previous education, skills, and experience. While most recognized that training and better English would improve their chances of employment, there was also an understanding that the greatest limits to employment were not personal, but rather systemic barriers to employment for all immigrants:

> I know it's not just me, it's the system, it's what we have to go through to have a life in Canada as immigrants. [FemaleFG02]

> Ah, but they [Canadians] can move around the system better than me. I have to stick to those like hold on to a, to the straw that I have, you know, like a drowning man where these guys have boats, (chuckle) they could move about. Um, the, the, the, the system makes it more flexible for them to exist. …It just doesn't compute and I know I'm not the only one. It's, it's an immigration thing…. You know it's, it's, it's, it's, it's, it's an impediment in this society. [Male 05, emphasis added]

Immigrant women described their employment experiences either in terms of having to work survival jobs or in terms of having to work outside the home, for the first time for some, because of their husbands' lack of employment. Many of them worked in jobs far below their qualifications simply to get by financially. These "survival jobs," as more than one participant termed them, are low-waged positions often in service industries, manufacturing (often offered to their husbands), and cleaning services. These jobs are necessary for earning money but are often detrimental to immigrants' mental and physical health. Employment experiences bring new challenges to gender roles and expectations.

Although an important part of living, being employed is more than just earning money. Being employed plays an important role in terms of who one is, self-worth and self-esteem, and in providing a sense of normality. For women in the group interviews, employment brought a sense of independence, provided interactions with other people, and allowed many to feel as though they could contribute to the fundamental needs of their family.

Gender and Identity

Immigrants are often forced to negotiate between the roles learned in their country of origin and the new roles expected of them in Canada. Negotiating and adapting to new expectations in daily activities, responsibilities, and changes in family decision-making processes were part of the adaptation process:

> Before in my country we have our work we ah divide it two, for both. My husband and my, my work. But now, different situation. [Female08]

This participant was describing that there had been greater sharing of workload before the couple moved to Canada.

The process of adapting to new roles often resulted in immigrant women putting higher expectations on themselves while assuming the burdens of home and employment labour, studying English or retraining, and being responsible for their family's health and happiness. For immigrant women, especially those who were employed for the first time, their new roles as 'breadwinners' in the family and as 'cultural brokers' led to increased responsibility in making more family decisions than before. Being responsible for making more decisions was seen as a positive, empowering thing but also created tensions between spouses and with other family members.

Immigrant men tied gender identity (their idea of being "a man") to their socio-economic status. When asked, many emphasized that being "a man" meant to take care of one's family and to be the breadwinner. Thus, their identity was directly related to their role in the family. However, all emphasized throughout the interviews that they work for less than they expected and thus their role has diminished:

> …but the difference in particular…is that here I cannot be guaranteed there is like job and that causes a, a lot of, um, pressure, is [untold] pressure on the man, or on me. [Male09]

Social Support Networks and Other Coping Strategies

Despite the added stress, guilt, and frustration of the migration experience, immigrants demonstrated agency and resiliency, enabling them to develop effective coping strategies. Participants spoke about different attitudes and behaviours that helped them cope with the challenges of migrating to Canada. They were successfully coping with these adverse circumstances, thereby showing great resilience.

Several studies point to the potential for female immigrants in particular to be very isolated (e.g., Meadows, Thurston, & Melton, 2001; Oxman-Martinez et al., 2000; Simich, Beiser, Stewart, & Mwakarimba, 2005). Contradictory to the literature, the findings of this study indicate that the female participants had excellent skills for developing social support networks. Network-building skills enabled immigrants to increase their power in terms of

accessing services and information. Social support network building was a powerful tool used by the participants to facilitate acculturation and settlement post migration.

Neighbourhood and Community

In keeping with their dreams of a better life, many participants wanted to move to a nicer house when they had more money, but this was weighted against moving away from the social network they had established where they currently lived. Both male and female participants phrased this "better life" in terms of owning their own home instead of renting, not necessarily moving away from their current neighbourhood.

Immigrant women identified many salient aspects of community important to their health and well-being. Some aspects of community having a positive effect on their health were geographically bound, such as green-spaces and accessible services. Participants also emphasized less place-bound healthy features of their "community", such as developing friendships or relationships with certain neighbours, co-workers, and other recent immigrants; being able to communicate; exploring their independence; and beginning to understand popular Canadian norms and mores. Many participants developed a sense of community by joining groups and forming relationships that were not tied to a particular area of the city. A sense of belonging was important to most immigrants:

> As a human being, as a living person, you need to have a sense of belonging. [Male04]

Access to Health Care

Because of Canada's universal health care, immigrants have access to health care regardless of their incomes. Policies in Alberta provide for immediate access to a health care number. In addition, settlement and service agencies assist immigrants in obtaining a number. Access to health care is therefore possible. Participants described difficulty, however, in finding a doctor who was accepting new patients and frustration with getting appointments in a short time period. Some did not go to, or send their families to, the doctor when they had only minor ailments, preferring to self-treat than pay for expensive prescriptions:

> Why go to the doctor or emergency clinic to wait for hours to see a doctor for a very short time only to be prescribed medication that you can't afford anyway? [Female FG02]

Immigrant women preferred having a female doctor from the same culture but

resigned themselves to accepting any doctor with whom they could make an appointment. Frustration with wait times and preferring female doctors are similar to concerns expressed by their Canadian-born counterparts. Having friends and/or contacts that can refer you to a "good" doctor was seen as important. For instance, group interview participants expressed concern that some immigrant women might not have the advantage of connections to an organization such as the Calgary Mennonite Centre for Newcomers that would assist them in finding appropriate medical care. They believed that access would be very limited for those women.

DISCUSSION

Without being prompted, participants identified many of the determinants of population health as described by Health Canada: income and social status; social and support networks; education and literacy; employment and working conditions; social environments; physical environments; personal health practices and coping skills; health services; gender; and culture (Health Canada, 2003). They also discussed how the migration experience was a determinant of their health.

A review of the relevant literature on health of immigrants suggested that under-utilization and barriers to accessing health services was a serious problem for recent immigrants, particularly women (Ballem, 1998; Despard, 1998; Kinnon, 1999). None of the literature, however, spoke of the personal characteristics of recent immigrants that would facilitate overcoming barriers to access. The participants in this study did not have trouble accessing primary health care, in part because social support networks increased access, as did local immigrant service organizations, and in part because of psychological responses to their situation. Even though they may not have arrived in Canada with appropriate schemas (Thurston & Vissandjée, 2004), participants quickly developed ways to process, group, and analyze new information within the new context. It is, however, important to place utilization of personal resources within context. The Alberta government provides for immediate access to publicly funded health care.

Participants (especially the women from individual and group interviews) used coping strategies to deal with the challenges of moving to Canada. Examples of strategies included obtaining additional training, improving language skills, maintaining a hopeful attitude, and asking people for assistance. In studying health risks and barriers to services it is easy to

overlook the strengths and coping mechanisms as demonstrated by these study participants. The strategies participants used for successfully dealing with the challenges arising during and after the migration process, particularly the development of a range of social support networks, could be facilitated among future immigrant women who move to the inner city of Calgary (Graham & Thurston, 2005).

CONCLUSION

While important contributions regarding the inequalities in health among certain populations of immigrants to Canada have been made, it is important also to focus on the coping strategies, resilience, and resistance strategies developed by these populations so that they are not viewed as helpless victims. Victimizing recent immigrants results in viewing them as passive rather than active, contributing to stereotypes, and reinforcing certain societal structures that discriminate against immigrants. We have highlighted the coping strategies of recent immigrants to increase the likelihood of a positive dialogue around health challenges that includes immigrants in both identifying problems and devising feasible, realistic solutions. To avoid culturalization as described by Razack (1998), it is important to understand that many Canadians have complaints about waiting times, access to specialists, poor communication with health providers, and so on. Our results support Krieger's (2000) conceptualization of discrimination as an experience that is multi-faceted and enmeshed within other determinants of population health. Discrimination, racism, sexism and other sources of inequity may not often be discussed as distinct experiences, but they are revealed in the descriptions of experiences and aspirations of immigrants.

The finding of enduring effects of migration has methodological implications for studies that define "immigrant" as being in Canada for less than 5 years. Much has been written about integration and adaptation, and as Thurston and Vissandjée (2004) have stated, the migration process varies by more than time and is very heterogeneous. This study shows that some immigrants quickly develop social support networks including people beyond a specific ethno-cultural community and continue to provide social support to other immigrants over many years. Others may feel like outsiders for years. Contrasting and comparing the insights of a variety of immigrants may help test and expand popular models explaining access to health services and to health.

Gender plays an important role in the health of immigrant populations. It intersects

with and changes the migration experience, employment opportunities, identity formation, and many other factors. In some cases, new immigrants experience Canadian norms and practices as promoting less equality for men and women than in their country of origin. In other cases, opportunities for women to be involved in society are far greater and empowering. As has been stated many times in the health and social policy literature, gender analysis of theories, frameworks, programs and policies is essential if they are to perform optimally for women and men, girls and boys.

The relationship between immigration experiences and the health of immigrant women is revealed in individual characteristics and simultaneous experiences of social factors, such as, socio-economics, gender, community, and social support networks. With this recognition, we have begun work to identify generalizable and researchable aspects of the social environment that can be changed through adjustments in policy and programs with the aim of improved health for immigrant women and ultimately all people.

POLICY RELEVANCE

This research reinforces the value of engaging health policy makers and health care providers in understanding and discussing cultural competence, that is, deconstructing how norms, beliefs and practices shape and are shaped by individuals. This is in clear opposition to trying to be "sensitive" to cultural differences (e.g., religious or normative practices of a particular group of people), a process that assumes some majority "culture" is normative. Training and organizational change programs would be more likely to prevent inequity if moved towards cultural competence, understanding how everyone has culture, and how stereotypes and discrimination are manifested in health care systems.

Cultural competence will result in less 'blaming of the victim', that is, attributing the impact of the social environment to individual choices. The results of this study also point towards the value of recognizing all immigrants (recent to long-term) as actively, and often successfully, coping with a number of challenges. This also alters how immigrants as a population are viewed. Given the opportunity, immigrants can provide valuable input into analyzing policy issues and identifying possible solutions, in short, they can participate in policy development. Civil society plays an important role in providing opportunities for such input.

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