Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto

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Abstract

Studies conducted in Canada and other countries with similar health care systems, such as Britain, Australia, and the Netherlands, demonstrate that refugees and refugee claimants experience barriers in accessing reproductive health care services, such as pre- and postnatal care and cervical cancer screening. These studies further indicate that the barriers that refugees and refugee claimants experience are largely due to racism and discrimination, culture, language, and/or communication. However, these studies rarely consider the broader political, economic, historical, and social contexts from which these women are attempting to access reproductive health care services. For example, they rarely consider the effects of neoliberal immigration policies and health care cut backs resulting from Canada's adoption of a neoliberal ideology that supports minimal government intervention in the economy. Many of the studies reviewed emphasise cultural barriers, that is, the researchers assume that a woman's culture is the most important determinant of their participation in reproductive health care services. When culture is viewed as the main problem attention is deflected from systemic racism and discrimination and other factors that impede access to reproductive health care services. These studies also fail to capture the unique gendered and racialised experiences of women refugees and refugee claimants and how these affect their access to reproductive health care services. To improve accessibility, most of these studies recommend culturally sensitive service delivery or increased awareness of racialised cultures among health professionals. Culturally sensitive or cross-cultural care, informed and shaped by neoliberal and multicultural policies, are popular approaches to addressing the needs of ethnic minority populations, or "multicultural others," and managing ethnic or cultural diversity within the Canadian health care system. Guided by antiracist theories and postcolonial feminist theories, this paper argues that neoliberal ideology and multicultural discourse have effectively moved attention away from racism and other systemic barriers in Canadian society and attributed the problem of unequal access primarily to the cultures of women refugees and refugee claimants. In the multicultural paradigm, the structural and material differences or inequities among populations are reduced to the issue of ethnic and cultural diversity. The discourse of diversity overlooks power differences by explaining inequities in cultural terms that construct culture, along with ethnicity and community, as static and independent of social, historical, economic, and structural forces. As such new research is required to explore whether and to what extent

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women refugees and refugee claimants underutilise reproductive health care services, such as pre- and postnatal care and cervical cancer screening, taking into account not just culture but also the social, economic, political, and historical context from which the women are seeking health care services.

Keywords: Women Refugees, Refugee Claimants, Reproductive Health, Race, Gender, Class and Barriers.

Introduction

Despite the general view that Canada's universal health care system is equally accessible to everyone living in Canada, two populations, refugees and refugee claimants, do not find this to be so. Several studies have found that although refugees, immigrants, and Canadian racial minority women have health care needs as great as or greater than other women in Canada, they utilise health care services at a significantly lower rate.[3] As Anderson and Reimer-Kirkham insisted, the marginalisation of some groups within the so-called Canadian mosaic needs to be examined in order to uncover the reasons for women refugees' and refugee claimants' underutilisation of the country's health care services.[4]

Research studies on women refugees' and refugee claimants' access to reproductive health services, such as pre- and postnatal care and cervical cancer screening services, seem to be lacking in critical feminist and antiracist perspectives, that is they fail to consider the broader political, economic, historical, and social contexts of the populations being studied. Guided by antiracist and postcolonial feminist theories, in this paper we problematise the concept of culture as it is employed in the literature on women refugees' and refugee claimants' low utilisation of pre- and postnatal care and cervical cancer screening services. Because there is a significant gap in the research on reproductive health care in Canada with respect to women refugees' and refugee claimants' access to pre- and postnatal care and cervical cancer screening, we have drawn on studies conducted in other countries with health care systems similar to Canada's, such as Britain, Australia and Netherlands. However, this paper's focus is an examination and critique of the Canadian health care system and women refugees' and refugee claimants' access to reproductive health care services.

The first section of the paper draws on the literature on racism and discrimination and the barriers women refugees and refugee claimants experience accessing pre- and postnatal care as a result, and how these women are portrayed in the context of a state policy of multiculturalism and the culturally sensitive approach to health care service delivery.

In the next section, we present examples of culturalism in the existing literature on women refugees' and refugee claimants' use of cervical cancer screening and pre- and postnatal care in which culture is framed as the main reason or their failure to access these services. Finally, we consider the relevance of antiracist and postcolonial feminist perspectives for understanding women refugees' and refugee claimants' experience of unequal access to health care and their underutilisation of pre- and postnatal care and cancer screening services. We recognise that there is a vast literature in the area of postcolonial theory outside of the

[3] Carolyn Egan and Linda Gardner, "Racism, Women's Health and Reproductive Freedom," in *Feminisms and Womanisms: A Women's Studies Reader*, ed. Althea Prince and Susan Silva-Wayne (Toronto, ON: Women's Press, 2004), 263–268.

[4] Joan M. Anderson and Sheryl Reimer-Kirkham, "Constructing Nation: The Gendering and Racializing of the Canadian Health Care System," in *Painting the Maple: Essays on Race, Gender and the Construction of Canada*, ed. Veronica Strong-Boag et al. (Vancouver, BC: University of British Columbia Press, 1998), 242–261.

medical and public health fields, however, for the purposes of this paper we have restricted our considerations to literature coming out of the health care fields.
According to the 1951 United Nations Convention:

> A refugee ... is someone who is unable or unwilling to return to his or her country of origin because of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion.[5]

In Canada, refugee claimants are temporary residents who have requested protection upon or after arrival in Canada by making a refugee claim.[6] A refugee claimant receives Canada's protection if he or she is found to be a Convention refugee as defined by the United Nations 1951 Geneva Convention relating to the status of refugees and its 1967 Protocol, or a person in danger of torture as defined in the United Nations Convention Against Torture.[7] This paper focuses on women refugees and refugee claimants as these statuses are defined by the government of Canada.

Racism and Discrimination: Pre- and Postnatal Care

Canada is an immigrant-receiving country and has an official multiculturalism policy that was implemented in 1971 in an attempt to alleviate the colonial practices of racial discrimination.[8] However, racism is still embedded in Canadian institutions. According to Prendergast, some scholars, such as Bannerji and Jacobs, have identified racist institutional practices as the perpetuation of old colonial practices designed to preserve racial inequality.[9]

Traditionally, "'race' was constructed in relation to biological origin and physical appearance,"[10] and although the assumptions underlying this construction have been disproved, mainstream society continues to divide individuals into groups based upon physical characteristics.[11] Race is socially constructed, formed in and by the processes of social and political struggle, and tends to shape everyday relations and unequal power relationships in society.[12] Bannerji supported this understanding of "race," arguing that "racism is after all a concrete social formation and race cannot be independent of other social relations of power and ruling which organise the society, such as those of gender and class."[13] Ahmad pointed out that "racialization assumes that race is the primary, natural and neutral means of categorization and that the groups are distinct also in behavioural characteristics, which result

[5] United Nations High Commissioner for Refugees (UNHCR), *Convention and Protocol Relating to the Status of Refugees*, accessed December 2, 2016, http://www.unhcr.org/3b66c2aa10.html, 3.
[6] Canadian Council for Refugees, *Talking about Refugees and Immigrants: A Glossary of Terms*, accessed December 2, 2016, http://ccrweb.ca/sites/ccrweb.ca/files/static-files/glossary.PDF.
[7] Ibid.
[8] N. Prendergast, "Deconstructing Hybrid Spaces: Internationally Educated Nurses of Colour in Canada," in *"Righting" Humanity in Our Time?* M. Jacobs and L. A. Visano, L. A., eds. (Concord, ON: APF Press, 2015), 282–306.
[9] Ibid.
[10] Sheryl Reimer-Kirkham and Joan M. Anderson, "Post-Colonial Nursing Scholarship: From Epistemology to Method," *Advance in Nursing Scien*ce 25, no. 1 (2002): 1–17.
[11] Ibid.
[12] Ibid.
[13] Himani Bannerji, *The Dark Side of the Nation: Essays on Multiculturalism, Nationalism and Gender* (Toronto, ON: Canadian Scholars Press, 2000), 128.

from their 'race.'"[14] Anderson further argued that rather than categorizing people by race one should examine how racial categories are constructed and used in everyday life to divide people and interpret their behaviour.[15] Although racialising processes can affect anyone, they are most harmful in the context of unequal power relations in which some racialised individuals are constructed as subordinate, inferior, or needy. Assumptions of this kind, when acted upon, have dire implications for women refugees' and refugee claimants' access to reproductive health care services.

Several studies have suggested that refugee women avoid reproductive health care services as a result of prior experiences of disrespect, prejudice, and racial stereotyping by health care providers. In a Canadian study with 432 Somali women refugees (individuals who had applied for temporary residence) and immigrants (individuals who had received permanent residence), 87.5% reported hurtful comments made by their caregivers related to their having undergone female genital mutilation (FGM).[16] They reported verbal expressions of shock and an attitude of disgust on the part of health care providers, which they perceived as a lack of respect. In some instances, colleagues were invited by providers to look at the women's private parts without first seeking their permission, which was perceived as both a lack of respect for the woman and a lack of respect for her privacy. Similarly, Reitmanova and Gustafson explored discrimination against immigrant Muslim women accessing maternity care in St. John's, Newfoundland.[17] These women were subjected to remarks that were insulting, insensitive, stereotypical, and embarrassing when they asked providers to respect their religious or cultural beliefs and needs, for example, their preference for female providers, and/or need for privacy and to remain clothed. Although some women refugees subscribe to Western medical models for pre- and postnatal care they might still prefer female health care providers. That respecting this preference is not considered reasonable accommodation by many health care providers is an example of racism and discriminatory practices in health care services that create barriers for women refugees and refugee claimants.

Discriminatory practices and disrespect towards refugee women due to the fact they have experienced FGM or based on their religious beliefs is a violation of section 17 of the Canadian Medical Association Code of Ethics, which states that "health care professionals are ethically bound not to discriminate in providing medical services against any patient on such grounds as race, gender, marital status, religion, age, medical disability, sexual orientation or socioeconomic status."[18] This Code of Ethics is designed to safeguard refugees and other marginalised populations against discriminatory treatment by health care providers. Studies reviewed indicate that this goal has not been completely realised; this may be attributable to the neoliberal cut- backs in health care spending that has resulted in an increase of health care providers' workload. However, clinical guidelines for the care of women and adolescents affected by female genital mutilation have been written and put into practice.[19]

As indicated in the introduction of this paper, the literature we reviewed included studies conducted in countries with similar health care systems. A study conducted by Small et al. in

[14] Waqer Ahmad, *'Race' and Health in Contemporary Britain* (Buckingham, UK: Open University Press, 1993), 18.
[15] Joan M. Anderson, "Reflections on the Social Determinants of Women's Health. Exploring Intersections: Does Racialization Matter?" *Canadian Journal of Nursing Research* 38, no. 1 (2006): 7–14.
[16] Beverley Chalmers and Kowser Omer Hashi, "432 Somali Women's Birth Experiences in Canada after Earlier Female Genital Mutilation," *Birth* 27, no. 4 (2000): 227–234.
[17] Sylvia Reitmanova and Diana L. Gustafson, "'They can't understand it': Maternity Health and Care Needs of Immigrant Muslim women in St. John's, Newfoundland." *Journal of Maternal Child Health* 12 (2008): 101–111.
[18] Canadian Medical Association, *Canadian Medical Association Code of Ethics* (Update 2004), accessed December 2, 2016, http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf.
[19] L. Perron et al., *Clinical Practice Guidelines: Female Genital Cutting*, no. 299(November 2013), accessed February 24, 2017. https://sogc.org/wp-content/uploads/2013/10/gui299CPG1311E.pdf.

Melbourne, Australia, with Vietnamese and Turkish women, explored the women's experiences of obstetrical services and found that the women were less concerned that service providers know about their cultural practices than they were about the lack of kindness and support and the prejudices affecting the care they received.[20] Studies conducted in the UK have also found that refugee women often associate mainstream maternity services with a lack of sympathy, racism, and racial stereotyping, which affects their participation in pre- and postnatal services.[21] These studies demonstrate some of the barriers to equitable health care access for women refugees and refugee claimants.

A few studies have explored the racism embedded in the broader practices, structures, and policies related to immigration and health care that shape women refugees' and refugee claimants' access to reproductive health care services. For instance, a study conducted in Canada with South Asian and Vietnamese women documented racist views among nursing staff that included views regarding "peculiar body odours" and "inadequate mother-infant bonding" among some ethnocultural groups arising from dealing with individuals who do not fit their preconceptions of how a patient in the Canadian health care system ought to present herself.[22] This study also exposed broader systemic and institutional factors shaping practitioners' attitudes and behaviours. For example, health care reform and cutbacks, stemming from Canada's public services' adaptation to neoliberal market forces, have resulted in increased workloads and staff and supply shortages, which in turn have given rise to a tendency in nurses to ignore patients assumed to be problematic and more costly in terms of time and energy. These patients were visible minorities seen as problematic due to linguistic and cultural barriers.[23] Thus, health care restructuring may have particularly adverse effects on women refugees and refugee claimants, especially those who face language and communication barriers and are isolated and without the support of extended family. This results in increased marginalisation and racialisation of these women as the "other."

Similar studies examining barriers to health care access experienced by refugees in Canada have found that some health care providers are unwilling to accept refugees as patients even when they are seeking new clients;[24] this population is perceived to be challenging due to complex health needs, linguistic barriers, and complicated insurance coverage that can delay payment for services delivered.[25] These are examples of how the prevailing systemic institutional values driven by neoliberalism, neocolonialism, efficiency, objectivity, and technocracy produce, perhaps unintentionally, discrimination and inequitable access.

Some women refugees tend to present very late in their pregnancy for prenatal care due to fears arising from their uncertain immigration status and legal restrictions affecting their access to health care; this is particularly the case for rejected asylum seekers as they lack health

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[20] Ronda Small et al., "Mothers in a Country: The Role of Culture and Communication in Vietnamese, Turkish and Filipino Women's Experiences of Giving Birth in Australia," *Women's Health* 28, no. 3 (1999): 77–101.

[21] For example, Kate Harper Bulman and Christine McCourt, "Somali Refugee Women's Experiences of Maternity Care in West London: A Case Study," *Critical Public Health* 12, no. 4 (2002): 365–378 and Jenny McLeish, *Mothers in Exile: Maternity Experiences of Asylum Seekers in England* (2002), accessed December 2, 2016, http://www.maternityaction.org.uk/wp-content/uploads/2013/09/mothersinexile.pdf.

[22] Denise L. Spitzer, "In Visible Bodies: Minority Women, Nurses, Time, and the New Economy of Care," *Medical Anthropology Quarterly* 18, no. 4 (2004): 490–508.

[23] Ibid.

[24] See Maria McKeary and Bruce Newbold, "Barriers to Care: The Challenges for Canadian Refugees and Their Health Care Providers." *Journal of Refugee Studies* 23, no. 4 (2010): 523–545 and Grace Pollock et al., "Discrimination in the Doctor's Office: Immigrants and Refugee Experiences," *Critical Social Work* 13, no. 2 (2012): 61–79.

[25] McKeary and Newbold, "Barriers to Care."

insurance coverage.[26] As mentioned earlier in this paper, Canada has a publicly funded universal health care system that is expected to provide equal access to services to Canadians and immigrants, however refugees and refugee claimants are covered through a different system, the Interim Federal Health Program (IFHP). In the province of Ontario, they only become eligible for provincial health coverage when they are given permanent resident status.[27] Further, not all refugees are eligible for IFHP coverage. For example, refugee claimants who have withdrawn their claim, and claimants who are considered by the Immigration and Refugee Board (IRB) to have abandoned their claim are not covered, neither are refugee claimants who had failed to submit their initial Basis of Claim (BOC) information form outlining claim details of their claim are ineligible to be referred to the IRB.[28]

Because of these barriers, as well a lack of awareness of their coverage and other factors, it is common for refugee women, and particularly refugee claimants, within these categories to underutilise pre- and postnatal care because they have no health insurance. Similar to refugee women in the Netherlands, when medical complications that could be easily dealt with early in pregnancy are left untreated this may lead to more serious complications for refugee women in Canada for both the mother and the fetus, requiring increased levels of medical intervention and treatment.[29] Refugees and refugee claimants who are not covered by provincial public health plans are advised by health care providers or health care administration staff to purchase private insurance or pay out-of-pocket for health services. Refugees who are ineligible for IFHP coverage may be unable to purchase private health insurance, thus are deterred from accessing health care services as a result of both institutional and financial barriers.

Many studies have suggested that there is a need to provide culturally sensitive pre- and postnatal services to improve access to reproductive health care for women refugees and refugee claimants.[30] Culturally sensitive or cross-cultural care training is provided to service providers to help them to recognise how the client's culture and their own culture affect their relationships with clients.[31] However, this training is informed and shaped by the state institution of biomedicine and multicultural policy, a popular approach to addressing the needs of populations of the "multicultural other," and managing diversity in the Canadian health care system. Biomedicine, as Ahmad argued, "depoliticizes and individualizes ill health, treats the afflicted in isolation from their social, economic and citizenship context and thus legitimates structural inequalities and supports the status quo."[32]

Similarly, the discourse of culturally sensitive care tends to focus on the cultural or ethnic identity of the individual, and ignores inequities in Canadian society grounded in race, gender, class, age, sexual orientation, and ability. The structural and material differences among

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[26] Nina Ascoly, Ineke Van Halsema, and Loes Keysers, "Refugee Women, Pregnancy and Reproductive Health Care in the Netherlands." *Journal of Refugee Studies* 14, no. 4 (2001): 371–393 and Anna Gaudion, Jenny McLeish, and Claire Homeyard, "Access to Maternity Care for 'Failed' Asylum Seekers," *International Journal of Migration, Health and Social Care* 2, no. 2 (2006): 15–21.

[27] Government of Canada, Interim Federal Health Program: Summary of coverage, accessed February 25, 2017, http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp.

[28] Government of Canada, "Notice – Changes to the Interim Federal Health Program" (2016), accessed December 2, 2016, http://www.cic.gc.ca/english/department/media/notices/2016-04-11.asp.

[29] Ascoly, Van Halsema, and Keysers, "Refugee Women, Pregnancy and Reproductive Health Care in the Netherlands."

[30] See Kate Harper Bulman and Christine McCourt, "Somali Refugee Women's Experiences of Maternity Care in West London;" Mary Carolan and Loris Cassar, "Antenatal Care Perceptions of Pregnant African Women Attending Maternity Services in Melbourne, Australia," *Midwifery Journal* 26, no. 2 (2010): 189–201; Chalmers and Hashi, "432 Somali women's birth experiences in Canada;" and McLeish, "Mothers in Exile."

[31] College of Nurses of Ontario, *Practice Guideline: Culturally Sensitive Care* (2009), accessed February 17, 2017, http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf.

[32] Ahmad, *'Race' and Health in Contemporary Britain*, 12.

populations are reduced within the multicultural paradigm to the issue of cultural diversity. Bannerji insisted that through the discourse of community and cultural diversity inscribed in the official formulations and implementation of multiculturalism, notions of cultures and life practices of ethnic minority women are created and circulated within institutions and among providers of education, health, and other social services in efforts to deal with diversity and grapple with the challenges of providing cross-cultural services.[33] Razack also asserted that while health care providers try to ensure cross-cultural service delivery by raising awareness about behavior differences and cues that indicate a person's cultural identity, majority group members know very little about the impact of racism and neocolonialism on the lives of the racialised women they serve, such as women refugee and refugee claimants.[34] Culturally sensitive care is informed by simplistic notions of culture and community engraved in multicultural policy and constructs women refugees and refugee claimants as a homogenous group; refugees as a group are diverse with respect to ethnicity, language, sexual orientation, race, and political experience. Some refugee women experience privilege based on their social locations or identities. Culturally sensitive care overlooks the differences in this population and the complex and diverse social realities of these women. While there is a new emphasis on cultural competence, which is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes that enable professionals to work effectively in cross-cultural situations to increase the quality of health care, [35] integrating this into practice is moving at a slow pace.

Postcolonial scholars[36] have argued that the concept of cultural sensitivity, defined as knowledge about communal practices, beliefs, and meanings of other cultures is inadequate to change discriminatory practices in health care services. Anderson et al. suggest that the concept of culture must take into account the unequal relations of power that are the legacy of colonial past and neocolonial present, and how the cultures of the West have redefined local meanings, and dictated social structures, including health care delivery.[37]

Gender, Race, and Culture in Women Refugees' and Refugee Claimants' Access to Cervical Cancer Screening and Pre- and Postnatal Care

As Ruzek, Olesen, and Clarke claimed, feminist models of health research place women at the center of analysis and emphasise how gender as well as other social roles and rules affect women's health.[38] However, they confessed that such models have not always adequately addressed the health issues of women whose life circumstances vary by race, class, or a variety of other factors, such as location, immigration status, and identity. Reimer-Kirkham further noted that the health care and nursing literature in Canada has been largely silent on

[33] Bannerji, *The Dark Side of the Nation*.
[34] Sherene Razack, "What Is to Be Gained by Looking White People in the Eyes? Culture, Race and Gender in Cases of Sexual Violence," *Journal of Feminism and the Law* 19, no. 4 (1994): 894–923.
[35] T. L. Cross, et al., *Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed* (March 1989), accessed February 25, 2017, http://files.eric.ed.gov/fulltext/ED330171.pdf.
[36] For example, Sheryl Reimer-Kirkham et al., "Rethinking Cultural Safety While Waiting to Do Fieldwork: Methodological Implications for Nursing," *Journal of Nursing & Health* 25, no. 3 (2002): 222–232.
[37] Joan Anderson, et al., "'Rewriting' Cultural Safety within the Postcolonial and Postnational Feminist Project: Toward New Epistemologies of Healing," *Advances in Nursing Science* 26, no. 3 (2005): 196–214.
[38] Sheryl Burt Ruzek, Virginia L. Olesen, and Adele E. Clarke, "Social, Biomedical, and Feminist Models of Women's Health," in *Women's Health: Complexities and Differences*, ed. Sheryl Burt Ruzek, Virginia L. Olesen, and Adele E. Clarke (Columbus: Ohio University Press, 1997), 11–28.

inequities in health, marginalising health practices, racialization, and racism.[39] Instead, there has been a pervasive focus on culture as an influence on health and illness in an effort to account for differences in health outcomes. In the existing literature, studies on cervical cancer screening among women refugees and immigrants are based on epidemiological data and quantitative methods that do not capture the lived experiences and personal perspectives of these women. These studies often view women refugees' and refugee claimants' failure to access cervical cancer screening through a culturalist lens, which results in a lack of focus on racism and other systemic barriers in Canadian society. For these reasons, the culture of these women is viewed as the most crucial barrier to their access to cancer screening services. Jiwani argued that a culturalist framework:

> Pathologizes immigrant women of colour from different ethnic backgrounds. At the backdrop of systematic and everyday racism, the focus on culture quickly becomes one of implicitly or explicitly comparing a backward, traditional, and oppressive cultural system to the modern, progressive, and egalitarian culture of the West. Such an approach again results in the production of cultural prescriptions or a culturally sensitive approach that further reifies stereotypic representations of some ethnic groups.[40]

Dyck used two major models to analyze the health status and health care access issues of minority immigrant groups: one focuses on culture and the other focuses on the political economy and the marginalisation of immigrants.[41] Feminist antiracist health researchers, such as Anderson, Dossa, and Jiwani, have studied the impact of the structural relations of power on the health of immigrant women.[42][43] Anderson and Reimer-Kirkham and Jiwani, among others, have used antiracist and postcolonial feminist approaches to examine how the history of colonisation and systemic racism in Canada affects immigrants' and Aboriginal women's access to health care and the quality of care they receive.[44] Antiracist scholars, such as Ahmad (1993) and Jiwani (2001), have provided important critiques of Western biomedicine as a racialised and patriarchal system of dominance.[45] Several antiracist scholars have argued that culturally sensitive approaches often result in stereotypic assumptions and erroneous generalisations about marginalised people while keeping the unequal relations of power unchanged.[46]

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[39] Sheryl Reimer-Kirkham, "The Politics of Belonging and Intercultural Health Care," *Western Journal of Nursing Research* 25, no. 7 (2003): 762–780.

[40] Yasmin Jiwani, *Intersecting Inequalities: Immigrant Women of Colour, Violence and Health Care* (Vancouver, BC: Feminist Research Education Development and Action (FREDA) Centre, 2001), 161.

[41] Isabel Dyck, "Immigration, Place and Health: South Asian Women's Accounts of Health, Illness and Everyday Life" (No. 04–05), *Research on Immigration and Integration in the Metropolis: Working paper series* (Vancouver, BC: Vancouver Centre of Excellence, 2004), accessed December 2, 2016, http://mbc.metropolis.net/assets/uploads/files/wp/2004/WP04-05.pdf.

[42] Joan M. Anderson, "Gender, 'Race', Poverty, Health and Discourses of Health Reform in the Context of Globalization: A Postcolonial Feminist Perspective in Policy Research." *Nursing Inquiry* 7, no. 4 (2000), 220 – 229; Parin Dossa, *The Politics and Poetics of Migration: Narratives of Iranian Women from the Diaspora* (Toronto, ON: Canadian Scholars Press, 2004); and Yasmin Jiwani, *Discourse of Denial: Mediations of Race, Gender and Violence* (Vancouver, BC: University of British Columbia Press, 2006).

[43] Feminist antiracist health researchers place women at the center of their research and analysis.

[44] Anderson and Reimer-Kirkham, "Constructing Nation" and Jiwani, *Intersecting Inequalities* and *Discourse of Denial*.

[45] Ahmad, *'Race' and Health in Contemporary Britain* and Jiwani, *Intersecting Inequalities*.

[46] For example, Ahmad, *'Race' and Health in Contemporary Britain*; Anderson and Reimer-Kirkham, "Constructing Nation;" Lorraine Culley, "Transcending Transculturalism? Race, Ethnicity and Health-

Although there are several critical studies of immigrant women in the areas of mental health,[47] violence against women,[48] chronic illnesses, and general health status,[49] other areas of health, such as cervical cancer screening and pre- and postnatal care, tend to be ignored. Critical attention has not been extended to these areas of preventive health care. Most quantitative and qualitative studies that focus on cervical cancer screening and women immigrants and refugees take a culturalist approach, that is, they explain the differences in the rates of cervical cancer screening among these women in terms of their cultural origins.[50] In the broader literature on women refugees' and refugee claimants' access to pre- and postnatal care, there is a general recognition that cultural beliefs and practices are important in childbearing and that most women continue with their traditional practices when they immigrate to Western countries.[51] These cultural beliefs and practices are viewed as barriers to these women's access to pre- and postnatal care services.

Culture in these studies is deemed the sole determinant of health practices, abstracted from the broader social, economic, historical, political, and structural factors affecting these women's lives. Culture in this context is viewed as fixed in a "timeless and unchangeable vacuum outside of patriarchy, racism, imperialism and colonialism."[52] Another study that looked at barriers to effective uptake of breast and cervical screening services among Black minority ethnic groups living in Britain overemphasised the importance of culture and advocates culturally sensitive care.[53] It is widely recognised that beliefs about health care differ across cultural groups; Thomas et al.'s study suggests that it is essential for health professionals to be educated in cultural beliefs and customs, communication skills, and racial awareness of the populations they serve.[54]

Care," *Journal of Nursing Inquiry* 13, no. 2 (2006): 144–153; and Razack, "What Is to Be Gained by Looking White People in the Eyes?"

[47] For example, Dossa, *The Politics and Poetics of Migration*; Sepali Guruge and Nazilla Khanlou, "Intersectionalities of Influence: Researching the Health of Immigrant and Refugee Women," *Canadian Journal of Nursing Research* 36, no. 3 (2004): 32–47; Sepali Guruge and Enid Collins, *Working with Immigrant Women: Issues and Strategies for Mental Health Professionals* (Toronto, ON: Centre for Addiction and Mental Health, 2008).

[48] For example, Vijay Agnew, *In Search for a Safe Place: Abused Women and Culturally Sensitive Services* (Toronto, ON: University of Toronto Press, 1998); and Jiwani, *Intersecting Inequalities and Discourse of Denial*.

[49] For example, Joan Anderson, Connie Blue, and Annie Lau, "Women's Perspectives on Chronic Illness: Ethnicity, Ideology and Restructuring of Life." *Journal of Social Science and Medicine* 33, no. 2 (1991): 101–113; Joan M. Anderson, "Gender, 'Race,' Poverty, Health and Discourses of Health Reform"; Dyck, "Methodology on the Line;" and "Immigration, Place and Health."

[50] For example, Abha Gupta, Ashesh Kumar, and Donna E. Stewart, "Cervical Cancer Screening among South Asian Women in Canada: The Role of Education and Acculturation," *Health Care for Women International*, 23 (2002): 123–134; James Ted McDonald and Steven Kennedy, "Cervical Cancer Screening by Immigrant and Minority Women in Canada," *Journal of Immigrant Minority Health* 9 (2007): 323–334; and Kelly J. Woltman and K. Bruce Newbold, "Immigrant Women and Cervical Cancer Screening Uptake: A Multilevel Analysis," *Canadian Journal of Public Health* 98, no. 6 (2007): 470–475.

[51] For example, Carolan and Cassar, "Antenatal Care Perceptions of Pregnant African Women;" Chalmers and Hashi, "432 Somali Women's Birth Experiences in Canada;" Gina Higginbottom et al., "'I Have to Do What I Believe': Sudanese Women's Beliefs and Resistance to Hegemonic Practices at Home and During Experiences of Maternity Care in Canada," *BioMed Central Pregnancy and Childbirth* 13, no. 51 (2013): 1–10; and Helen Stapleton et al., "Women from Refugee Backgrounds and Their Experiences of Attending a Specialist Antenatal Clinic: Narratives from an Australian Setting," *Women and Birth* 26, no. 4 (2013): 260–266.

[52] Razack, "What Is to Be Gained by Looking White People in the Eyes?" 896.

[53] Veronica Nicky Thomas, Tariq Saleem, and Rachel Abraham, "Barriers to Effective Uptake of Cancer Screening among Black and Minority Ethnic Groups," *International Journal of Palliative Nursing* 11, no. 11 (2005): 562–571.

[54] Ibid.

This exemplifies the essentialisation of culture, the assumption that every culture has an essence that defines it and that every cultural group is homogenous. It also focuses on differences between or across what are assumed to be internally coherent groups based on gender, class, age, ability, sexuality, and other dimensions and maintains the "idea of consistent and coherent cultural groups with defined set of beliefs and health behaviours."[55] In another example, Woltman and Newbold studied immigrant women, particularly women from Asia. Their cultural origin has been used to explain low rates of cervical cancer screening in this population.[56] The essentialisation of culture, a common feature of culturally sensitive care, also emphasises the importance of information and awareness, rather than the removal of the structural inequities of gender, racialisation, and poverty.

A woman's ethnicity was taken by Woltman and Newbold to be predictive of her use of cervical cancer screening.[57] We argue that rather than focusing on culture as a barrier for cervical cancer screening among women refugees and refugee claimants the solution is to promote information addressing their cultural beliefs and misconceptions, and awareness of the availability of cervical cancer screening services in these populations.

A culturalist explanation of the barriers to cancer screening faced by refugees and ethnic minority immigrant women such as this fails to take into account factors from the broader context of their lives, such as racial discrimination in health care, social factors, education, economic status, immigration and settlement issues, and other challenges faced by non-White women. The very absence of the notion of racialisation, and the centeredness of the term *culture* in the literature perpetuates the culturalisation of racism.[58] Within such discourse, culture is viewed as the barrier to equitable and effective health care service delivery and refugees and immigrant women as a challenge creating special problems or requiring special attention and solutions from health care providers.

Language and Communication

Studies by many researchers have demonstrated a relationship between language barriers and access to reproductive care.[59] The literature in Canada and other countries recognises that women refugees' and refugee claimants' lack of proficiency in the new country's dominant language, such as English or French in Canada, is a crucial roadblock to reproductive health care services accessibility.[60] For example, Woloshin et al.'s study, based on the responses of 22,448 women aged 18–74 years who had completed the 1990 Ontario Health Survey, found that refugee and immigrant women who do not speak English at home are less likely to access cervical cancer screening services than women who speak English at home because of communication barriers.[61] Other studies have found that refugee and immigrant women who

[55] Culley, "Transcending Transculturalism?" 150.
[56] Woltman and Newbold, "Immigrant Women and Cervical Cancer Screening Uptake."
[57] Ibid.
[58] Razack, "What Is to Be Gained by Looking White People in the Eyes?"
[59] For example, Eva Grunfeld, "Cervical Cancer: Screening Hard to Reach Groups," *Canadian Medical Association* 157, no. 5 (1997): 543–545; Helen Stapleton et al., "Women from Refugee Backgrounds and Their Experiences of Attending a Specialist Antenatal Clinic;" Woloshin et al., "Is Language a Barrier to the Use of Preventive Services?"
[60] For example, Ascoly et al. "Refugee Women, Pregnancy and Reproductive Health Care in the Netherlands;" Carolan and Cassar, "Antenatal Care Perceptions of Pregnant African Women Attending Maternity Services in Melbourne, Australia;" Lisa A. Merry et al., "Refugee Claimant Women and Barriers to Health and Social Services Post-Birth." *Canadian Public Health Association* 102, no. 4 (2011): 286–290; and Steven Woloshin et al., "Is Language a Barrier to the Use of Preventive Services?" *Journal of General Internal Medicine* 12, no. 8 (1997): 472–477.
[61] Woloshin et al., "Is language a barrier to the use of preventive services?"

do not speak the dominant language of their new country do not know of the existence of pre- and postnatal classes or preventive services, such as the Pap smear for cancer screening, due to language barriers.[62] While it is common for countries to have an official language or languages, in a country such as Canada that receives large numbers of refugees, it must be recognised that language barriers serve as an impediment to refugee women's reproductive care.

Informed by Bannerji's analysis of multiculturalism and Razack's critique of cross-cultural service delivery, we argue that by constructing culture as fixed and cultural/ethnic identities as immutable while simultaneously erasing the diverse backgrounds of women refugees and refugee claimants, the discourse of multiculturalism and culturally sensitive care homogenises these women as the multicultural other who belong to the margins of Canadian society.[63] Multicultural discourse has effectively obscured racism and other systemic barriers in the Canadian health care system, and attributed the problem of health inequalities and inequitable health care access to the cultures of women refugees and refugee claimants.

Feminist Antiracist and Postcolonial Scholarship and Women Refugees' and Refugee Claimants' Experiences of Health Inequities

Feminist researchers and theorists emphasise the importance of examining and understanding women's health within the broader social, economic, cultural, and political contexts of their lives. According to Bannerji's insightful critique of state multicultural policy, multiculturalism constructs women refugees and refugee claimants as creators of "ethnic cultures" while constructing White women as mothers of the nation and bearers of Canadian culture and identity.[64] These constructions show us how the lives and experiences of women refugees and refugee claimants are organised along the lines of gender, race, class, and immigration status. This can also be useful for understanding how their health is affected by the broader socioeconomic and political contexts. The culturalist view of health inequities decontextualises the health and health care practices of women refugees and refugee claimants from the broader political, economic, historical, and social contexts and the existing structural inequalities of the Canadian society. For example, the dominant understanding of women refugees' and refugee claimants' access to pre- and postnatal care and cervical cancer screening services fails to locate their health care practices within the context of their gendered experiences of migration, relocation, everyday racism, and the racializing practices and culture of biomedicine.

Antiracist perspectives can deflect attention away from the narrow focus on the individual and culture, and illuminate health inequities produced by racialised practices that sustain structural and material inequities within and beyond the health care system. Feminist postcolonial theories bring to the forefront issues of race, but also expand understanding of how this socially constructed category intersects with gender, culture, and class to structure human relationships within particular historical and neocolonial contexts.[65]

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[62] See Ascoly et al., "Refugee Women, Pregnancy and Reproductive Health Care in the Netherlands;" and Aisha K. Lofters et al., "Predictors of Low Cervical Cancer Screening among Immigrant Women in Ontario, Canada" (2011), accessed December 2, 2016, http://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-11-20.

[63] Bannerji, *The Dark Side of the Nation* and Razack, "What Is to Be Gained by Looking White People in the Eyes?"

[64] Bannerji, *The Dark Side of the Nation.*

[65] Annette Browne, Victoria L. Smye, and Colleen Varcoe, "Postcolonial-Feminist Theoretical Perspectives and Women's Health," in *Women's Health in Canada: Critical Perspectives on Theory and Policy*, ed. Marina Morrow, Olena Hankivsky, and Colleen Varcoe (Toronto, ON: University of Toronto Press, 2007), 124–142.

From postcolonial and antiracist, feminist perspectives we can seriously interrogate the notion of culture, ethnicity, and community as pre-given or natural constructs, challenge the multicultural and neoliberal approaches to health care, and examine how gender, race, and class intersect to shape women refugees' and refugee claimants' access to health care services. Anderson asserted that a postcolonial feminist perspective provides tools for analyzing how the intersecting social relations of power shape the experience and meaning of health and illness of immigrant women of color in the diaspora, and organise their ability to manage episodes of illness.[66] Anderson has put forward the idea of a postcolonial feminist epistemology, grounded in voices from the subaltern and the recognition of their historical positioning, to construct knowledge for practice and praxis. Supporting Anderson's view, we believe equity and justice in health care can be achieved through integrating the voices and perspectives of women refugees and refugee claimants into relevant policies. This can be achieved through qualitative research that includes the perspectives of other immigrant and racialised women as well as those of women refugees and refugee claimants on their access to health care services and their positioning within the intersecting forces of race, gender, age, and class, while also being sensitive to the experiences of migration above and beyond recognition of cultural diversity.

This paper critiques and challenges the cultural essentialist model of health research, it does not, however, reject the notion of culture and its influence on health. As Culley argued:

> Abandoning the notion of fixed and homogenous cultures does not mean rejecting cultural processes as one set of influences on health and health behaviors or rejecting the importance of ethnic identification in specific contexts. It rather means that we cannot read off health status, health beliefs and behaviors from an individual's designated ethnic status.[67]

In conclusion, the dominant strategies, guided by the ideologies and policies of multiculturalism, intended to address health inequities by providing culturally sensitive care for particular marginalised groups, are neither adequate nor effective. Such approaches, as Varcoe argued, must be replaced with antiracist and critical feminist perspectives and strategies that take into account the entire context in which women refugees and refugee claimants find themselves during and after migration, as women, as refugees, and at this time, as people of color in a White-majority society. Only from this perspective can we adequately address the fundamental social inequities these women experience and provide services in ways that take into account the experiences of women refugees and refugee claimants and their effects on the women and their families and communities.[68]

[66] Anderson, "Toward a Post-Colonial Feminist Methodology in Nursing Research."
[67] Culley, "Transcending Transculturalism," 150.
[68] Varcoe, Colleen, "Inequality, Violence and Women's Health," in *Health, Illness, and Health Care in Canada* (4th ed.), ed. B. Singh Bolaria and Harley D. Dickson (Toronto, ON: Nelson Education, 2008), 259–282.

References

Agnew, Vijay. *In Search for a Safe Place: Abused Women and Culturally Sensitive Services*. Toronto, ON: University of Toronto Press, 1998.

Ahmad, Waqer. *'Race' and Health in Contemporary Britain.* Buckingham, UK: Open University Press, 1993.

Anderson, Joan M. "Gender, 'Race', Poverty, Health and Discourses of Health Reform in the Context of Globalization: A Postcolonial Feminist Perspective in Policy Research." *Nursing Inquiry* 7, no. 4 (2000): 220–229.

_____. "Toward a Post-Colonial Feminist Methodology in Nursing Research: Exploring the Convergence of Post-Colonial and Black Feminist Scholarship." *Nurse Research* 9, no. 3 (2002): 7–27.

_____. "Reflections on the Social Determinants of Women's Health. Exploring Intersections: Does Racialization Matter?" *Canadian Journal of Nursing Research* 38, no. 1 (2006): 7–14.

Anderson, Joan, JoAnn Perry, Connie Blue, Annette Browne, Angela Henderson, Koushambi Basu Khan, Sherryl Reimer-Kirkham, Judith Lynam, Pat Semeniuk, and Vicki Smye. "'Rewriting' Cultural Safety within the Postcolonial and Postnational Feminist Project: Toward New Epistemologies of Healing." *Advances in Nursing Science* 26, no. 3 (2005): 196–214.

Bannerji, Himani. *The Dark Side of the Nation: Essays on Multiculturalism, Nationalism and Gender*. Toronto, ON: Canadian Scholars Press, 2000.

College of Nurses of Ontario. *Practice Guideline: Culturally Sensitive Care,* 2009. Accessed February 17, 2017. http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf.

Cross, T. L., B. J. Bazron, K. W. Dennis, M. R. Isaacs, and Portland Research and Training Centre. *Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*, 1989. Accessed February 25, 2017. http://files.eric.ed.gov/fulltext/ED330171.pdf.

Dossa, Parin. *The Politics and Poetics of Migration: Narratives of Iranian Women from the Diaspora*. Toronto, ON: Canadian Scholars Press, 2004.

Dyck, Isabel. "Methodology on the Line: Constructing Meanings about 'Cultural Difference' in Health Care Research." In *Painting the Maple: 'Race', Gender and the Construction of Canada*, edited by Veronica Strong-Boag, Joan Anderson, Sherrill Grace, and Avigail Eisenberg, 19–36. Vancouver, BC: UBC Press, 1998.

_____. "Immigration, Place and Health: South Asian Women's Accounts of Health, Illness and Everyday Life" (No. 04–05). *Research on Immigration and Integration in the Metropolis: Working paper series.* Vancouver, BC: Vancouver Centre of Excellence, 2004, accessed December 2, 2016, http://mbc.metropolis.net/assets/uploads/files/wp/2004/WP04-05.pdf.

Egan, Carolyn, and Linda Gardner. "Racism, Women's Health and Reproductive Freedom." In *Feminisms and Womanisms: A Women's Studies Reader,* edited by Althea Prince and Susan Silva-Wayne, 263–268. Toronto, ON: Women's Press, 2004.

Gaudion, Anna, Jenny McLeish, and Claire Homeyard. "Access to Maternity Care for 'Failed' Asylum Seekers." *International Journal of Migration, Health and Social Care* 2, no. 2 (2006): 15–21.

Government of Canada. (2017). *Interim Federal Program. Summary of coverage,* accessed February 25, 2017, http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp

Government of Canada. (2016). *Notice – Changes to the Interim Federal Health Program,* accessed December 2, 2016, http://www.cic.gc.ca/english/department/media/notices/2016-04-11.asp.

Grunfeld, Eva. "Cervical Cancer: Screening Hard to Reach Groups." *Canadian Medical Association* 157, no. 5 (1997): 543–545.

Gupta, Abha, Ashesh Kumar, and Donna E. Stewart. "Cervical Cancer Screening among South Asian Women in Canada: The Role of Education and Acculturation." *Health Care for Women International* 23 (2002): 123–134.

Guruge, Sepali, and Enid Collins. *Working with Immigrant Women: Issues and Strategies for Mental Health Professionals.* Toronto, ON: Centre for Addiction and Mental Health, 2008.

Guruge, Sepali, and Nazilla Khanlou. "Intersectionalities of Influence: Researching the Health of Immigrant and Refugee Women." *Canadian Journal of Nursing Research* 36, no. 3 (2004): 32–47.

Higginbottom, Gina, Jalal Safipour, Zubia Mumtaz, Yvonne Chiu, Patricia Paton, and Jennifer Pillay. "'I Have to Do What I Believe': Sudanese Women's Beliefs and Resistance to Hegemonic Practices at Home and During Experiences of Maternity Care in Canada." *BioMed Central Pregnancy and Childbirth* 13, no. 51 (2013): 1–10.

Jiwani, Yasmin. *Intersecting Inequalities: Immigrant Women of Colour, Violence and Health Care*. Vancouver, BC: Feminist Research Education Development and Action (FREDA) Centre, 2001.

_____. *Discourse of Denial: Mediations of Race, Gender and Violence.* Vancouver, BC: UBC Press, 2006.

Lofters, Aisha K., Rahim Moineddin, Stephen W. Hwang, and Richard H. Glazier. "Predictors of Low Cervical Cancer Screening among Immigrant Women in Ontario, Canada." *BMC Women's Health* (2011): accessed December 2, 2016, http://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-11-20.

McDonald, James Ted, and Steven Kennedy. "Cervical Cancer Screening by Immigrant and Minority Women in Canada." *Journal of Immigrant Minority Health* 9 (2007): 323–334.

McKeary, Maria, & Bruce Newbold. "Barriers to Care: The Challenges for Canadian Refugees and Their Health Care Providers." *Journal of Refugee Studies* 23, no. 4 (2010): 523–545.

McLeish, Jenny. *Mothers in Exile: Maternity Experiences of Asylum Seekers in England*. Maternity Alliance (2002): accessed December 2, 2016, http://www.maternityaction.org.uk/wp-content/uploads/2013/09/mothersinexile.pdf

Merry, Lisa A., Anita Gagnon, Nahid Kalim, and Stephanie S. Bouris. "Refugee Claimant Women and Barriers to Health and Social Services Post-Birth." *Canadian Public Health Association* 102, no. 4 (2011): 286–290.

Perron, L., V. Senikas, M. Burnett, and V. Davis. *Clinical Practice Guidelines: Female Genital Cutting,* 2013. Accessed February 24, 2017. https://sogc.org/wp-content/uploads/2013/10/gui299CPG1311E.pdf.

Pollock, Grace K., Bruce Newbold, Ginette Lafreniere, and Sara Edge. "Discrimination in the Doctor's Office: Immigrants and Refugee Experiences." *Critical Social Work* 13, no. 2 (2012): 61–79.

Prendergast, N. (2015). "Deconstructing Hybrid Spaces: Internationally Educated Nurses of Colour in Canada." In *"Righting" Humanity in Our Time?* Edited by M. Jacobs and L. A. Visano, 282–306. Concord, ON: APF Press, 2015.

Razack, Sherene. "What Is to Be Gained by Looking White People in the Eyes? Culture, Race and Gender in Cases of Sexual Violence." *Journal of Feminism and the Law* 19, no. 4 (1994): 894–923.

_____. *Looking White People in the Eyes: Gender, Race and Culture in Courtrooms and Classrooms*. Toronto, ON: University of Toronto Press, 1998.

Reimer-Kirkham, Sheryl. "The Politics of Belonging and Intercultural Health Care." *Western Journal of Nursing Research* 25, no. 7 (2003): 762–780.

Reimer-Kirkham, Sheryl, and Joan M. Anderson. "Post-Colonial Nursing Scholarship: From Epistemology to Method." *Advances in Nursing Scien*ce 25, no. 1 (2002): 1–17.

Reimer-Kirkham, Sheryl, Vicki Smye, Sannie Tang, Joan Anderson, Connie Blue, Annette Browne, Ruth Coles, Isabel Dyck, Angela Henderson, M. Judith Lynman, JoAnn Perry, Pat Semeniuk, and Leah Shapera. "Rethinking Cultural Safety While Waiting to Do Fieldwork: Methodological Implications for Nursing." *Journal of Nursing & Health* 25, no. 3 (2002): 222–232.

Reitmanova, Sylvia, and Diana L. Gustafson. "'They can't understand it': Maternity Health and Care Needs of Immigrant Muslim Women in St. John's, Newfoundland." *Journal of Maternal Child Health* 12 (2008): 101–111.

Ruzek, Sheryl Burt, Virginia L. Olesen, and Adele E. Clarke. "Social, Biomedical, and Feminist Models of Women's Health." In *Women's Health: Complexities and Differences*, edited by Sheryl Burt Ruzek, Virginia L. Olesen, and Adele E. Clarke, 11–28. Columbus: Ohio University Press, 1997.

Small, Ronda, Pranee Liamputtong Rice, Jane Yelland, and Judith Lumley. "Mothers in a Country: The Role of Culture and Communication in Vietnamese, Turkish and Filipino Women's Experiences of Giving Birth in Australia." *Women's Health* 28, no. 3 (1999): 77–101.

Spitzer, Denise L. "In Visible Bodies: Minority Women, Nurses, Time, and the New Economy of Care." *Medical Anthropology Quarterly* 18, no. 4 (2004): 490–508.

Stapleton, Helen, Rebecca Murphy, Ignacio Correa-Velez, Michelle Steel, and Sue Kildea. "Women from Refugee Backgrounds and Their Experiences of Attending a Specialist Antenatal Clinic: Narratives from an Australian Setting." *Women and Birth* 26, no. 4 (2013): 260–266.

Thomas, Veronica Nicky, Tariq Saleem, and Rachel Abraham. "Barriers to Effective Uptake of Cancer Screening among Black and Minority Ethnic Groups." *International Journal of Palliative Nursing* 11, no. 11 (2005): 562–571.

UNHCR (The UN Refugee Agency). *Convention and Protocol Relating to the Status of Refugees* United Nations (2010): accessed December 2, 2016, http://www.unhcr.org/3b66c2aa10.html.

Varcoe, Colleen. "Inequality, Violence and Women's Health." In *Health, Illness, and Health Care in Canada* (4th ed.), edited by B. Singh Bolaria and Harley D. Dickson, 259–282. Toronto, ON: Nelson Education, 2008.

Woloshin, Steven, Lisa M. Schwartz, Steven J. Katz, and H. Gilbert Welch. "Is Language a Barrier to the Use of Preventive Services?" *Journal of General Internal Medicine* 12, no. 8 (1997): 472–477.

Woltman, Kelly J., and K. Bruce Newbold. "Immigrant Women and Cervical Cancer Screening Uptake: A Multilevel Analysis." *Canadian Journal of Public Health* 98, no. 6 (2007): 470–475.