Negotiating and Constructing Place: African Immigrant and Refugee Women's Experiences Seeking Reproductive Health Information, Services and Support

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Abstract

African immigrant women and refugee women face disproportionate reproductive health risks and adverse outcomes compared with the Canadian population. The diversity of African women and complexity of the migration process suggest the need for contextualized knowledge to better understand these challenges. I sought such knowledge through the use of the theoretical frameworks of place and intersectionality. These frameworks draw attention to the multi-level mixture of social relations in given contexts and how they create opportunities and oppression. The specific purpose of this research was to: a) explore how the reproductive health experiences of African immigrant and refugee women were shaped by the unique context of given places; b) consider how these women actively negotiated and constructed place in their search for reproductive health information, services, and support.

A multiple case study was used to explore the reproductive health experiences of African immigrant and refugee women in three different areas of Ottawa, Ontario. These areas provided different local contexts (e.g., history, socioeconomic profile, proximity to downtown). In each area, data was collected through interviews with African immigrant and refugee women, interviews and focus groups with reproductive health service providers, and mapping of available services. In total, 19 immigrant and refugee women and 23 service providers participated in this study.

The findings showed that African immigrant and refugee women's reproductive health experiences were much more complicated than simple interaction with neighbourhood services. Their varied social positions in Canadian society were highly relevant. In addition,

social networks based in places outside of the system (e.g., private homes, religious institutions) were environments in which they were comfortable and sought support for their reproductive health needs. Recommendations based on these findings include the need to engage communities and explore the delivery of information and services outside of the traditional places employed by the Canadian health care system.

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Chapter 1: Introduction

Statistics paint a complex and, at times seemingly contradictory, picture of immigrant and refugee health in Canada. For example, whereas newcomers as a whole are healthier on average than the Canadian-born population, their health deteriorates with increasing length of time spent in the country. In addition, refugees are not necessarily healthier on arrival depending on the circumstances they endured prior to migration. Racialized populations, low-income populations, and women are at greater risk of health declines over time than other groups of newcomers (Health Canada, 2010; Kobayashi & Prus, 2012). This complexity demonstrates the importance of understanding immigrants and refugees as extremely heterogeneous groups. It further suggests the need for studies that dig deeper into the diversity of newcomer populations to inform more nuanced programs and policies for supporting immigrant and refugee health in Canada (Kobayashi & Prus, 2012; Vang, Sigouin, Flenon, & Gagnon, 2015).

The research that I present in this dissertation works towards this aim. I seek to provide new, highly contextualized knowledge on the reproductive health experiences, needs, and challenges of African immigrant and refugee women living in Ottawa. For the purposes of this study, I use the term "African" to denote people from the entire continent of Africa. I do so not to overlook the incredible range of nations, cultures, languages, religions, ethnicities, and socioeconomic positions represented by the women who migrate from that region (Mensah & Williams, 2015; Statistics Canada, 2011a; Tettey & Puplampu, 2005). Rather, my intent is to embrace this diversity and delve into it. Such an approach allows me to explore how diversity

relates to African immigrant and refugee women's varied reproductive health experiences, as well as potential commonalities between different women. My focus also recognizes that immigrants and refugees from the African continent are an important and growing part of the Canadian population (Statistics Canada, 2011a). The experiences of African migrants to Canada are sometimes overshadowed by the larger body of North American literature on African Americans. For Black African Canadian migrants, they are sometimes also conflated with Black migrants from the Caribbean (Spitzer, 2006a). In my research, I concentrate on African migrants to Canada from francophone and anglophone countries as well as women from other African countries who speak either of these languages. The African continent has its own unique histories and contexts that play a role in shaping migration experiences, as does Canada as the destination country. For these reasons, it is valuable to explore the health of immigrants and refugees from Africa to Canada separately from the bodies of literature on African Americans and Caribbean Canadians (Spitzer, 2006a).

Reproductive health is an important issue in relation to immigrant and refugee women. Changes associated with migration may affect access to contraception, abortion, and prenatal/postpartum care (Dunn, et al., 2011; Oxman Martinez, et al., 2005; Wiebe, 2013). The migration journey may expose immigrant and refugee women to risks of sexually transmitted infections and violence (Reddit, Janakiram, Graziano, & Rashid, 2015; Vu, et al., 2014). Women may also be separated from families and communities important for reproductive health information and support (Kandasamy, Cherniak, Shah, Yudin, & Spitzer, 2014; Mehta & Gagnon, 2016). Immigrant and refugee women from Africa have greater risks of feto-infant mortality and preterm birth as compared to the destination country populations in Western

industrialized nations (Gagnon, et al., 2009). They are also disproportionately affected by HIV/AIDS in Canada (Worthington, Este, Strain, & Huffey, 2013).

Research related to African Canadian populations has grown significantly in recent years (Mensah & Williams, 2015; Muszynski, 2014; Spitzer, 2006b; Tettey & Puplampu, 2005; Veronis & McLeman, 2014). Studies focused specifically on the reproductive health of these women, however, remain relatively limited (Etowa, 2012; Etowa, Weerasinghe, & Eghan, 2010; Kapiriri, et al., 2014; Worthington, et al., 2013). Some studies on the reproductive health of African Canadian women centre their discussions primarily within health care settings. A need for increased cultural competence for clinicians and their institutions is one important finding from this work (Etowa, 2012; Etowa & Adongo, 2010). Such research is valuable and necessary. Another vital piece for immigrant and refugee women is to interrogate the role of the broader context (e.g., social, political) in helping to shape their health (Dyck, 2004; Etowa, et al., 2010; Vissandjée, Thurston, Apale, & Nahar, 2007).

Purpose and Research Questions

Through this dissertation research, I seek to provide a better understanding of the reproductive health experiences and needs of African immigrant and refugee women in the City of Ottawa. One of the main aims of this work is to make recommendations for reproductive health services and other interventions to better support the health of these women. To provide a richly contextualized analysis of the issues, I take a feminist approach to the research that prioritizes the experiential knowledge of immigrant and refugee women themselves (Reiger & Liamputtong, 2010). Within this approach, I apply a theoretical framework that draws on intersectionality and theories of place. Intersectionality is a feminist theory that

explores how social categories (e.g., gender, immigrant status, culture) influence and intersect each other to create unique experiences of oppression or opportunity for individuals and populations (McCall, 2005). Theories of place prompt us to investigate the role that the geographic areas in which we live, settings (e.g., homes, doctor's offices) where we carry out our interactions, and meanings and feelings we attach to these places play in structuring social relations (e.g., through "common sense" understandings of what is appropriate or not in a place or by granting access to some to given places while limiting the access of others) (Agnew, 1987; Cresswell, 1996).

I discuss these theories in more detail in Chapter 2. Combined, they help me examine the ways in which African immigrant and refugee women are positioned within multi-level networks of social conditions and relations that interact to structure or constrain opportunities for reproductive health. In particular, the specific interaction of these networks at given times and in given locations are explored to situate the reproductive health experiences of African immigrant and refugee women in Ottawa (Massey, 1994a). A growing body of work points to the place-dependant nature in which immigrants are admitted to a country (e.g., as seen in immigration policies) (Smith, 1993). Newcomers also experience their intersecting identities of, for example, migration status, gender, and religion in relation to the unique settlement and integration environments of different countries and cities (e.g., through labour market opportunities, housing, and discrimination) (Anthias, 2012; Ray & Preston, 2009; Vissandjée, et al., 2007). Place may also be a source of health-relevant resources and social networks. For instance, global migration flows may contribute to the establishment of immigrant and refugee communities and settlement services from which newcomers can benefit (Dyck, 2004).

In light of these findings, place emerges as a useful concept that may be applied to gain greater understanding of the reproductive health experiences and needs of African immigrant and refugee women. Following from this, the specific purpose of this research is to explore how the reproductive health experiences of African immigrant and refugee women in Ottawa are shaped by the unique context of given places. I also consider how African immigrant and refugee women actively negotiate these places and construct their own places to seek information and services, and otherwise support their reproductive health. The focus of this research is inclusive of, but not restricted to experiences within the health care system. As I discuss in more detail below, reproductive health is understood holistically as connected to other realms of women's lives and with symbolic meanings that extend beyond the physical (Ginsburg & Rapp, 1995).

The overall research question I ask is: *How do African immigrant and refugee women experience, negotiate and construct place in relation to their reproductive health and as they seek reproductive health information, services, and support in the City of Ottawa?* This research question is explored through a qualitative, multiple case study approach. Using this approach, I study African immigrant and refugee women's reproductive health experiences in three different areas of Ottawa, each comprised of two neighbourhoods: central Ottawa (Centretown and West Centretown neighbourhoods), west Ottawa (Bayshore and Whitehaven-Queensway Terrace North neighbourhoods), and southwest suburban Ottawa (Barrhaven and New Barrhaven-Stonebridge neighbourhoods).

As I discuss in Chapter 4, these three areas were purposively chosen to explore different local contexts within which African immigrant and refugee women experience their

reproductive health. They were feasible sites for recruitment, and differed in terms of their histories as newcomer-receiving areas, their socioeconomic contexts, and their proximities to the downtown core. In each of the case study areas I collected different types of data to present an in-depth and contextualized analysis of the reproductive health experiences of the women in place. These sources of data were: in-depth interviews with African immigrant and refugee women, interviews and focus groups with reproductive health service providers, and maps of reproductive health services. In Table 1, I present the sub-questions related to my overall research question and the sources of data that I use to answer each question.

Table 1. Research Sub-Questions and Related Data Sources

Research Sub-Questions	Data Source(s) to Answer the Questions
a) What aspects of place-based context (e.g., health service environment, social context) do African immigrant and refugee women in the City of Ottawa feel are important to their reproductive health (RH) and impact their comfort and/or ability to seek RH information, services, and support?	▪ Interviews with African immigrant & refugee women
b) In what ways do these women actively construct places (e.g., social networks, safe/comfortable places) that facilitate their RH and access to information, services, and support?	▪ Interviews with African immigrant & refugee women
c) What context and perspectives do maps of RH services and RH service providers present regarding African immigrant and refugee women's RH?	▪ Maps of RH services ▪ Interviews/focus groups with RH service providers
d) What does comparison of the African immigrant and refugee women's experiences across case study areas tell us about how place influences and is shaped by these women in relation to their RH?	▪ Interviews with African immigrant & refugee women ▪ Maps of RH services ▪ Interviews/focus groups with RH service providers
e) How do the perspectives presented through mapping and by RH service providers converge and/or diverge from those of the women in this study? What are the implications for the use of different types of evidence to inform interventions to support African immigrant and refugee women's RH?	▪ Interviews with African immigrant & refugee women ▪ Maps of RH services ▪ Interviews/focus groups with RH service providers

By highlighting the voices of the women and contextualizing their experiences, the findings of this research contribute to our understanding of African immigrant and refugee women's reproductive health in place. They also provide information on how the intersecting social locations of these women have an impact on their access to and opportunities for reproductive health in their day-to-day lives. This knowledge makes a contribution to efforts to recognize the diversity of immigrants and refugees in Canada and inform programs and policies responsive to their varied needs. Finally, this research adds to the body of scholarship that seeks to integrate intersectional and place-oriented lenses in health research.

Contours and Meanings of Reproductive Health

Reproductive health is a key component of overall health. Consistent with understandings of health more generally, it involves wellness beyond simply the absence of physical illness. As defined by the World Health Organization (WHO), reproductive health includes physical, mental, and social considerations throughout the life course in relation to the reproductive systems and their functions. Reproductive health, therefore: "implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and freedom to decide if, when and how often to do so" (WHO, 2010, p. 76). The scope of potential programs and services to support reproductive health includes information and education, counselling, clinical services, and social support in relation to a broad range of issues such as: sexually transmitted infections, contraception, gynaecological care, prenatal and postnatal care, breastfeeding and infant support, pregnancy termination, and sexual violence (WHO, 2006).

Adding complexity to the above definition, ample research shows that meanings and experiences of reproductive health vary between people and societies and are infused with gendered, racialized, and classed power dynamics (Etowa, 2012; Ginsburg & Rapp, 1995; Rapp, 2011). The terms 'gendered', 'racialized', and 'classed' refer to the processes by which societies create categories of difference and attribute meanings to such perceived difference (e.g., through media portrayals and policies). These meanings may include the social roles or behaviours that that are deemed "natural" or expected depending on sex (for gender), skin colour (for 'race'), or socioeconomic position (for class) (Murji & Solomos, 2005; Weber, 2010). With respect to reproductive health, these power dynamics are demonstrated in the ways low-income, racialized, and/or immigrant and refugee women are sometimes stereotyped. For instance, they may be portrayed as irresponsibly bearing children who draw resources from the social system or in a bid to gain citizenship of a country (Huang, 2008; Mullings, 1995). Power is also evident in changing feelings towards fertility through the migration process. Childbearing may be seen by some women as a barrier to integration. Contraception, on the other hand, can be perceived as a gateway to new opportunities through the control of reproduction (Alvadj, 2007). As Dyck et al. (2001) explain, women's health has a distinct geography due to the intermingling of political and economic contexts, and social and cultural discourses in particular places. There are differences over time and space in how women's health is understood, the conditions that support health and produce illness, how these issues are responded to, and the resources women are able to draw upon as they manage their health as well as that of their families.

The examples above also suggest that the symbolic importance of reproduction extends beyond individual and family levels. In the bearing and rearing of children, women are central to the continuity of families, communities, and societies. As a result, biological reproduction is closely entwined with the reproduction of values and cultures, with women as central transmitters in that process (Anthias, 2012). For this reason women's reproduction has been, and continues to be, highly politicized and subject to interest and control far beyond individual decision-making (Ginsburg & Rapp, 1995). In the context of the material and social changes of migration, evolving roles and practices related to gender, culture, and reproduction may prove empowering in some respects for some women. These changes may also result in tension and conflict for others as they challenge established norms and/or seek acceptance within new ones (Espin, 1999). This discussion shows that the understanding of reproductive health brought to this research is a complex one. It incorporates a range of possible health issues, potentially positive and negative experiences, and interactions with social influences that shape different meanings of reproductive health in different contexts.

Researcher in Context

A further aspect of context in feminist qualitative studies is the role of the researcher. Researchers, as do all people, bring their own assumptions and perspectives to their work (Creswell, 2007). Unlike the traditional biomedical paradigm of objectivity, feminist qualitative research recognizes that the process of data collection is a mutual interaction between researcher and participants. In addition, knowledge and perspectives are viewed as subjective (Fontana & Frey, 2005). Reflecting on the researcher's position is an important part of situating a feminist qualitative study such as this one and its findings (Giacomini, 2010).

The seed of this research grew out of time I spent at a community-based organization in Ottawa that focused on providing reproductive health information and support. We worked with a diverse clientele, but I had the impression that racialized and immigrant and refugee women were underrepresented. This was not due to lack of need. Within the context of limited resources to deal with existing demand, the organization made valuable outreach efforts but was not able engage in-depth in these issues. As I crafted my PhD admission proposal, I grappled to suggest a project that would explore this further within the primarily biomedical frameworks I knew from my prior health sciences-oriented education.

Between that starting place and this writing are layered years of interdisciplinary education, research, career, and life, with all the attendant growth and personal change that comes with those experiences. Standing near the end with the benefit of these, I feel much more able to put into words my position in relation to this research. I hope that the feminist and place-oriented lenses employed in this work bring a more critical approach to my study of the reproductive health experiences of African immigrant and refugee women than I once proposed.

Even as I designed this study to explore what I felt was a community-level need, I was slightly uncomfortable undertaking the work due to awareness of my position in relation to the immigrant and refugee women with whom I would engage. That is, my privilege and power as a Canadian-born, white woman who would approach interactions with my participants as a university-based researcher. My mother is a first-generation immigrant, but from England. That country has always been among the “acceptable” source countries for immigrants and its majority culture has greatly informed Canada’s. Her history as an immigrant was certainly

present in my upbringing and remains a part of my identity. It was, however, always more of a novelty in my life than a fact imbued with struggle or hardship. Regardless, I have a profound respect for my mother and the bravery it must take to leave all that you know behind to start anew in a different country even under circumstances of relative privilege.

Consciousness of my own privilege in relation to this research and the African women represented herein is best expressed as questions: Could I or should I undertake this research? Could I, even with good intentions, carry out this work respectfully and ethically? Could I gain access to the communities with whom I wanted to work? The discomfort borne of these questions was my constant companion throughout community meetings and interviews. It remained as I engaged in analysis and writing. I was also aware that my position of privilege played into my interactions with the African women I interviewed. Despite my probing, for instance, women seemed generally reluctant to explicitly discuss racism and to label discriminatory encounters as such. Perhaps if I had not been a white woman and a Canadian-born one at that, these participants would have felt that I shared similar experiences and discussed their own with me. Aware of the power dynamic in my relationships with the women, I tried as much as possible to lessen my privilege during data collection. I met women in whichever place they were most comfortable (e.g., their homes), I strove to make my interview questions simple and relatable, and I listened to their stories with respect. During analysis, my interpretations were filtered through my own education and experiences. I tried to remain as true as possible to the women's stories but was not able to contribute insight from having lived as a racialized immigrant or refugee women myself.

The issues that I raise above are not unique to me. They have been written about in-

depth by researchers who have reflected on and who strive to improve cross-cultural research (Irvine, Roberts, & Bradbury-Jones, 2008; Liamputtong, 2008). This literature discusses the time involved in building relationships with communities, the need for patience and the ability to adapt to unforeseen situations, and the importance of ensuring that participants have access to study results. It also suggests that while "outsiders" may have difficulty negotiating and representing different languages and cultures, "insiders" may also face challenges. These include, for instance, that of an "insider" too deeply involved in a culture to perceive new avenues for questions or to identify taken-for-granted assumptions (Liamputtong, 2008).

My uncertainties have not gone away, but have been somewhat attenuated through meetings with community organizations, service providers, and African women where I was met with warmth and belief in the importance of this study. Throughout this research, I have also enjoyed ease of conversation around shared dimensions of identity beyond differences related to, for example, country of birth, religion, or culture. Some of this shared identity stemmed from being a woman. It also evolved as I progressed through pregnancy to new motherhood in the course of my data collection. The majority of my interviews with the immigrant and refugee women were conducted in their homes where they were kind enough to welcome me. Babies and kids were a frequent part of this experience. Discussing families and children was often a natural and enjoyable connection. This is not to say that access was easy, that I did not encounter occasional scepticism, or that I have not made mistakes. I now count among my privilege, however, that these women generously shared their stories with me. Having heard these, I believe even more strongly in the value of this work. While not perfect, I hope that I have done justice to the women and communities represented here.

Outline of Sections

In the chapters that follow I describe the background, approach, results, and implications of my research with African immigrant and refugee women in Ottawa. In Chapter 2, I outline my theoretical framework. This framework is rooted in feminist theories of intersectionality and theories of place from the field of geography. These complementary theories both highlight the importance of contextualizing individual-level experiences within networks of power and social relations. These networks play out at different levels within and across societies to facilitate or constrain opportunities for good health. My theoretical framework also urges consideration of the multiple diversities of African immigrant and refugee women, and how the different social positions that accompany these diversities affect their experiences of reproductive health in place.

In Chapter 3, I draw from the theoretical framework to identify and review literature salient to African immigrant and refugee women's reproductive health. Part of this approach is to set the broader context for these women's experiences. I do so through discussion of: trends and drivers of African migration to Canada, Canadian immigration policy, and settlement and integration considerations. I also examine what is known in the literature on African immigrant and refugee women's reproductive health, including how health policy interacts with immigration policy to affect the reproductive health of these women. Throughout the literature review, I attempt to 'place' African immigrant and refugee women's reproductive health experiences and draw out how this context is relevant to different African immigrant and refugee women.

Chapter 4 is devoted to the methods for the multiple case study that I used to explore

the reproductive health experiences of African immigrant and refugee women in Ottawa. This includes a broader discussion of case study approaches in qualitative research. Following this, I narrow to the specific details of the research site and participants, selection of the cases for this study, participant sampling and recruitment, data collection through in-depth interviews, focus groups, and mapping, and data management and analysis. At the end of this chapter, I also discuss trustworthiness and rigour in relation to this study and reflect on my role as a researcher.

In Chapters 5 through 7, I present my findings case by case. That is, the cases of central Ottawa, west Ottawa, and southwest suburban Ottawa are discussed in turn. Each of these chapters includes the neighbourhood context for the case and key themes that I identified from interviews with service providers and African immigrant and refugee women.

Building on the case studies, in Chapter 8 I consolidate the findings into an integrated analysis. I look across the case studies to pull out broader implications for the research questions of this study. Within this integrated analysis, I consider the results using an intersectional frame rather than a case-by-case presentation. This re-framing helps to highlight the importance of the different and intersecting social locations of diverse women to their experiences of reproductive health in place. In this chapter I also present recommendations to help support the reproductive health of African immigrant and refugee women, consider strengths and limitations of this study, and conclude with potential directions for future work.

A Note on Terminology

Prior to discussing the theoretical framework, my use of a number of terms related to migration should be clarified. "Immigrants" is used in this research to refer to voluntary

migrants to Canada who have the right to permanently reside in the country. “Refugees” refers to people who came to Canada in search of protection or for humanitarian reasons (Statistics Canada, 2016a). I use “migrant” as a general term to encompass both immigrants and refugees who have travelled from their country of birth to resettle in Canada. “Recent immigrants” and “newcomers” refer to those who came to Canada within the last five years. Finally, “foreign-born” is a term that I occasionally use as a synonym for the immigrant population to be consistent with Statistics Canada data (Statistics Canada, 2006).

Chapter 2: Theoretical Framework

From the framing of the issue to the research design and analysis, theory, whether acknowledged or not, permeates all aspects of a research endeavour (Giacomini, 2010). In this section, I discuss the theoretical framework that informs my study of African immigrant and refugee women's reproductive health experiences. This framework draws on two main bodies of theoretical work: intersectionality and theories of place. Although these theories have largely separate disciplinary roots, they also complement each other well. Both encourage highly contextualized understandings of lived experiences (Dossa & Dyck, 2011; Hankivsky, 2014). Such contextualized understanding is well-suited for this study that works with a diverse group of women, with varied reasons for moving to Canada, and different settlement stories. While it is not common practice, or always appropriate or feasible, for studies that employ an intersectional approach to integrate place into their analysis, or vice versa, there is an emerging body of research that does merge these traditions (Dossa & Dyck, 2011). Intersectionality and theories of place are also each increasingly used in the study of immigrant and refugee health and health inequities. They support the work of researchers in search of analytical frameworks to understand and explain the complex array of factors at play in these issues (Dhamoon & Hankivsky, 2011; Dyck, 2004; Hankivsky, 2012; Kobayashi, 2011; Mahler & Pessar, 2001).

Before proceeding, I would like to acknowledge that while I combined feminist theories with theories of place in the research proposal for this study, I did not explicitly include intersectionality in my theoretical framework at that stage. My trajectory through this research has been coupled with coursework and professional experiences in which I learned about and

applied intersectional approaches. I realized that, unconsciously, I had begun to think about the interviews I conducted and papers I read through the lens of intersectionality. Intersectionality both deepened and complicated my understanding of the multitude of factors beyond individual behaviours and availability of services that influence health. It is this understanding, along with theories of place, which I apply in my research.

Below, I discuss intersectionality and theories of place in turn. Building on these separate discussions, I then revisit several elements of social location raised in these frameworks ('race', gender, class, immigrant status, religion, and language) and discuss how I use the terms throughout this work. Next, I bring in health as a socially constructed concept that needs to be understood in place and in relation to intersecting social locations. I conclude the section by discussing the main implications of the theoretical framework for the design of this study.

Intersectionality

As defined by Hankivsky (2014), intersectionality is a theory that:

> promotes an understanding of human beings as shaped by the interaction of different social locations (e.g., 'race'/ethnicity, Indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected systems and structures of power (e.g., laws, policies, state governments and other political and economic unions, religious institutions, media). Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created. (p. 2)

The definition above is the result of ongoing theorizing about intersectionality that has taken place since its initial presentation in the academic literature in the 1980's (Crenshaw, 1989). Intersectionality was developed by Black feminists in the United States so as to draw attention to the ways in which existing approaches for identifying and challenging injustice

failed to adequately capture the oppressions lived by Black women (Collins, 1991; Combahee River Collective, 1978). In her foundational work, Crenshaw (1989) argued that the experiences of Black women were effectively erased by feminist theories and anti-racist politics that based their assumptions and arguments on a single dimension of identity (i.e., gender within feminist theories and 'race' within anti-racist politics). Instead, Crenshaw proposed a new analytical structure, one that recognized that "the intersectional experience is greater than the sum of racism and sexism" (p.140). That is, a much more nuanced framework was required to understand the complex ways in which multiple social locations (including and beyond 'race' and gender) influence and intersect with each other to create unique experiences of oppression or opportunity. Individuals may experience both privilege and oppression at the same time depending on their various social locations (McCall, 2005; Weber, 2010).

African immigrant and refugee women can be understood to be positioned variously in relation to 'race', gender, class, migration status and religion, for example. These intersecting positions help shape their health (Viruell-Fuentesa, Mirandab, & Abdulrahimc, 2012; Vissandjée, et al., 2007) . Explaining how such multiple and complex interactions function to affect lived experience has been a central focus for those interested in intersectional approaches. A number of authors have attempted to explain this complexity through the use of metaphors and analogies. For instance, Crenshaw (1989) describes the mutual operation of oppression and privilege as akin to traffic at an intersection. Vehicles may travel one way or another and accidents are sometimes difficult to attribute to a single driver or cause. Weber (2010), on the other hand, makes reference to the compound eyes of a fly. They put together a

single, highly-detailed image from information captured by an array of visual receptors. This image includes even partially shadowed objects often missed by human eyes.

What are often partially shadowed in the everyday workings of society are the power relationships that create and support systems of advantage and disadvantage. These systems vary by historical and geographical context. The power relationships operate simultaneously at levels that flow from the micro level of individuals to the macro ones of community and society (Browne, Smye, & Varcoe, 2007; Weber, 2010). It follows that a more complete understanding of the reproductive health experiences of African immigrant and refugee women should be contextualized within the broader forces that structure their lives, such as health and immigration policies (Viruell-Fuentesa, et al., 2012; Vissandjée, et al., 2007).

Theories of Place

As described above, intersectionality emphasizes the importance of context to understanding how power shapes inequalities in society. Geographic context is recognized as one element that influences the operation of power. Place is sometimes included in the application of intersectionality alongside other intersecting social categories (Weber, 2010). Despite this, it is still relatively rare for studies that use an intersectional approach to integrate a fully theorized concept of place.

Place has received increased attention in studies of population health and health inequities as researchers have sought to better understand the broad factors that influence the health of individuals and populations (Cummins, Curtis, Diez-Roux, & Macintyre, 2007). In these fields, the notion of place has focused predominantly on neighbourhoods and the built environment. For example, researchers have looked for patterns of inequalities that may be

attributable to place-based characteristics, or investigated how the built environment may structure access to health-promoting behaviours and resources (e.g., healthy home environments, safe sidewalks and parks for outdoor activity, grocery stores that sell healthy food) (Bernard, et al., 2007; Gelormino, Melis, Marietta, & Costa, 2015; Wasfi, Dasgupta, Orpana, & Ross, 2016).

Place is not a new concept, however, and within the field of geography it has a long history. This history includes a theoretical evolution away from views of places as fixed, physically-defined areas within whose boundaries various features of the landscape or characteristics of populations or cultures are described (Jackson, 1989). In general terms, place is now defined as spaces invested with meaning (Cresswell, 2004). Whereas space is something abstract, less specific, and undifferentiated, as people live in spaces, name them, and develop feelings towards them, they become places (Tuan, 1977).

Agnew (1987) outlines a theory of place that acknowledges its multi-faceted nature. He describes three fundamental elements of place: (1) *Location* – the geographic area, which is constituted as a result of broader economic and social processes; (2) *Locale* – the smaller settings where social relations occur and which help to shape behaviours and beliefs; (3) *Sense of Place* - the subjective feelings that people attach to a place. Importantly, these three processes interact. The social relations associated with locale cannot be separated from the larger global processes (i.e., social, political, economic) that structure location and the meanings and feelings denoted by 'sense of place'.

Massey (1994b) builds on this conceptualization of place in a manner that is particularly relevant for research involving immigrant and refugee women. With reference to the increased

movement of people and goods associated with globalization, she describes places as particular sets of social relations that come together at a given moment in time. This notion of time is important to theories of place partially in terms of the "space-time compression" of technology. Such compression speeds up the ability of people to move and communicate between places and, thus, stretches out their presence and interactions (Massey, 1994b). Understandings and experiences of social locations, such as gender, migration status, and culture, also vary in time and between places. As a result, immigrant and refugee women may feel shifting pulls on their identities and experiences of power, privilege and oppression as they navigate their lives in Canada and stay connected with families and friends in their countries of birth (Anthias, 2012). Time and place also interact in the ways in which different people are granted access to or otherwise occupy places at different times. Bass (2014) describes how the cleaning jobs that low-income, racialized, immigrant women in France disproportionately undertake are generally carried out at night so that they do not disturb the higher-income, predominantly white office workers who occupy the space during the day.

These examples demonstrate the ways in which places are experienced differently depending on one's position in relation to multi-scale networks and flows of social relations. Massey (1994b) describes the power a person has over these forces and flows as their position in the "power geometry". She states:

> Different social groups have distinct relationships to this anyway differentiated mobility: some people are more in charge of it than others; some initiate flows and movement, others don't; some are more on the receiving-end of it than others; some are effectively imprisoned by it. (p. 149)

It follows from this theorizing, that place is not just an entity but a revealing lens through which to see and understand the world (Agnew, 1987; Cresswell, 2004). While people

do not always take note of place, places can subtly shape behaviour, support difference, delineate what is appropriate, and exclude those who are not welcome. Cresswell (1996) illustrates this with an example of Black youth in the United States who are attacked by white residents. Their presence in a predominantly white area of town is assumed to indicate intent to cause mischief. In addition to being racialized, place can be gendered. This is shown, for instance, through the traditional denotation of the domestic sphere as "women's place" (Massey, 1994c, p. 201). The less physical manifestations of place are also examined by scholars. Smith (1993) analyses how the process of nation-building can be supported by immigration policies which outline who is a desirable citizen and who is not. Jackson (1989, p. 2) describes "maps of meaning" whereby people attach value and significance to their world in order to make sense of it and support their preferred perspective.

These examples show that place is as an essential force in social life (Gieryn, 2000). Importantly, however, places do not simply act on passive individuals. They are also sites of conflict as people actively negotiate their constitution and influence on their lives and in doing so, reshape places themselves (Cresswell, 1996; Massey, 1994b).

Social Location: Defining Key Concepts

Intersectionality and theories of place both help to shed light on the operation of multiple levels of systems of power. They also draw attention to the unique positioning of individuals within these systems of power based on their multiple social locations, such as 'race', ethnicity, gender, and class. In this study, I take my understanding of the terms 'race', ethnicity, gender, and class, and their relevance to African immigrant and refugee women's health, from these theoretical bases. That is, I understand them to be social constructs rather

than fixed, objective characteristics of a homogeneous group of people. Their particular meanings, representations, and experiences are rooted in specific historical, political, spatial, and social contexts, and vary across time and space as these contexts change (Anderson, 1987; Dyck, 2004; Mahler & Pessar, 2001; Weber, 2010). Although they are social constructs, 'race', ethnicity, gender, and class do nevertheless have grounding in reality. They are notions created to support ideas of difference and are often deeply and sometimes invisibly embedded in social institutions and society more broadly. When used as a basis for inequitable allocation of power or resources, these socially constructed notions can have very real consequences for access and opportunity (Weber, 2010).

The three intersecting social locations of 'race', gender and class are often the focus for studies that use an intersectional approach (Jordan-Zachery, 2007). In my research with African immigrant and refugee women, religion and language are other social locations of potential importance (Reimer-Kirkham, 2011; Spitzer, 2006a). As with the terms discussed above, religion, even within a given faith, is not seen as a constant. From the specific practices and beliefs associated within a given religion, to the meanings attributed to religiosity by adherents of that faith and those witnessing it, religion (even the practice of the same religion) is also contextually specific and varies across time and space (Reimer-Kirkham, 2011). In addition, as highlighted by Reimer-Kirkham (2011), religion is increasingly used to imply more than simply attachment to a given faith. It is also employed to indicate difference, and "when imbricated with culture, ethnicity, and race, implicitly infers colonial images of the racialized Other and positions those who are not white Christians on the margins" (p. 115).

Competency in an official language is considered in the points system used to assess the applications of voluntary immigrants to Canada (CIC, 2015). Language proficiency, therefore, partially structures who is admitted to Canada and who is not. Even for immigrants and refugees for whom English or French is a primary language, as well as for those who are learning, language discrimination may form the basis for social exclusion, bias perceptions of education level, and act to restrict access to meaningful employment. In particular, discrimination based on accent may intersect with racism and legacies of colonialism to create such marginalization (Creese, 2010).

Finally, while the terms 'immigrant' and 'refugee' have official definitions that I touched on in Chapter 1 they are recognized to encompass greater complexity. That is, they are a shorthand for extremely heterogeneous groups of people from diverse backgrounds, with a range of socioeconomic positions and ethnicities, and a diverse set of identities and experiences (Thurston, Meadows, Este, & Eisener, 2006). How the terms 'immigrant' and 'refugee' are understood in a given context is influenced by structural forces, such as policies that limit who may or may not enter a country and what rights and opportunities immigrants and refugees have once they arrive. Similar to the social construction of religion, the notion of 'immigrant' is closely entwined with racialized, classed, and gendered discourses (Abu-Laban, 1998). These discourses often work to discriminate against certain groups of immigrants and refugees and mask the considerable diversity among them (Vissandjée, Desmeules, Cao, Abdool, & Kazanjian, 2004).

Health in the Context of Social Location and Place

I discussed the contours and meanings of reproductive health in Chapter 1, but it is nevertheless valuable to re-engage with the notion of health here. This allows me to further elaborate on its conceptualization in relation to my theoretical framework. More specifically, health is a social construct, with uses and meanings that vary by place in light of different historical, social, and cultural contexts. Places contain certain sets of cultural attitudes towards health, and act as arenas in which health is played out at various times in relation to different populations (Kerner, Bailey, Mountz, Miyares, & Wright, 2001). Ethnographic work with Chinese and Somali newcomers in Canada, for instance, has revealed interpretations of social support that vary in light of the homeland cultures and experiences of these groups. Chinese immigrants tend to define social support in relation to government responsibilities, while Somali immigrants refer to informal social networks of families and friends. The implications of these findings are that, in the face of disrupted social networks through the migration process, Somali immigrants may struggle more than Chinese immigrants. The Chinese immigrants are more prone to look to the Canadian formal sector for support (Stewart, et al., 2008). Insufficient supports provided to immigrants and refugees can negatively impact health directly as well as limit their access to health services. Over time, however, conceptualizations of social support shifted as immigrants engaged with their new communities and broader society (Stewart, et al., 2010).

Such individual- and group-level experiences of immigrants and refugees are further set within the broader political economy of health in different places. That is, the policies of nation-states that determine the distribution of economic, health, and other resources. These

policies are created, and are most easily influenced, by those who have the power to shape the political systems (Raphael, 2015). The result is that resources are often not distributed equitably, to the detriment of those whose social locations put them at the most disadvantage (Shahidi, 2011). Of particular note are the ways in which macro-level processes (e.g., neoliberal globalisation) entwine with meso-level policies and services (e.g., the push to situate health care services increasingly in the private rather than public sphere), and translate to health-related effects for migrant populations (e.g., the stress and physical strain associated with low-wage, precarious caregiving work). These pathways play out along gendered and racialized lines, rooted in the legacy of colonialism. As a result, racialized migrant women are often stratified into the lowest social roles and labour market positions and suffer the health consequences thereof (Spitzer, 2016).

In Canada, its history as a liberal welfare state influences the country's approach to social and health policy. Interference with the free market is generally kept to a minimum and the corporate and business sectors have a relatively strong voice. The result is lower spending on social programs (e.g., housing, employment, early childhood education) than in the social democracies of some European countries (Raphael, 2015). Strong public services are important to the settlement and integration of immigrant and refugee populations, including their longer-term economic success and good health. Racialized newcomer populations and those who speak neither English or French are particularly susceptible to the cutbacks in social services that have characterized recent decades in Canada (Shahidi, 2011). In one illustration, Spitzer (2004), provides evidence of the impact of health care reform on the childbirth experiences of visible minority women. Cutbacks and staff reductions in hospitals created an environment in

which nursing staff tended to avoid interactions with these women. Based on their reading of these women's bodies, the nurses assumed there would be language or cultural challenges that would create more time consuming encounters. In turn, these women felt ignored, invisible, and discriminated against during a time of vulnerability and need.

Implications for Research Design

There are a number of implications of this theoretical framework for the design of my research. The primary implication is that my investigation of the reproductive health experiences of African immigrant and refugee women must be framed within an understanding of the multiple social locations they inhabit. It must also include the broader social processes that operate at multiple levels to facilitate or constrain the women's opportunities for health.

One of the recurring critiques of intersectionality is that it is difficult to translate the theory's tenets into concrete research methods. This is particularly the case for the simultaneous operation of multiple axes of privilege and oppression (Bowleg, 2012). While some researchers are developing quantitative approaches with this aim (Cairney, et al., 2014; Veenstra, 2011), qualitative approaches are viewed as particularly well-suited to intersectional analysis. This is because of their ability to deeply investigate lived experiences in a contextualized manner (Jordan-Zachery, 2007; McCall, 2005). Qualitative approaches have also been essential in geography. In this field, they provide the rich description and understanding necessary to investigate social relations at play in a given place. Qualitative methods are also well-suited to gaining in-depth knowledge to consider how the lives of individuals are shaped through both local and global processes (Dossa & Dyck, 2011; Dyck, 2004).

A final implication following from my theoretical framework is that the voices of African

immigrant and refugee women should be central to this work. Only through speaking with women themselves and by valuing their stories can understanding be gained about their lived experiences of reproductive health in a new country. By prioritizing diverse women's voices, this research also follows in the tradition of feminist research that highlights the perspectives of women who have been historically marginalized or who may not be in a position to participate in mainstream venues for influencing policy and practice (Browne, et al., 2007; Morrow & Hankivsky, 2007) .

Chapter 3: Literature Review

Flowing from the theoretical framework, in this research I seek to situate local reproductive health experiences of African immigrant and refugee women in Ottawa within an understanding of the broader context that affects these experiences. The literature review that follows contributes to this endeavour and has two purposes. First, I identify global, national, and community-level factors that help shape the diverse social positions African immigrant and refugee women inhabit, the places in which they live and experience their health, and their daily engagements with others in these places. As Massey (1994a, p. 5) emphasizes, places, as particular sets of social interactions in "envelopes of space-time", do not exist in isolation. They are constituted, in part by norms, values, policies and processes operating at multiple different scales throughout and between societies. For the purposes of this research, I provide an overview of the trends in and the drivers of African migration to Canada and the immigration policy context over time that has shaped African migration to Canada. I also briefly consider settlement and integration issues with an eye to their relevance to the health of African immigrant and refugee women.

Second, I review literature on African immigrant and refugee women's reproductive health. The purpose of this review is to provide background information on the health policy context, what is known regarding key reproductive health issues and challenges facing these populations, and to identify gaps in the literature. Throughout the literature review I use the broad term "African", but recognize the vast diversity of nations, cultures, languages, religions, ethnicities, and socioeconomic statuses represented by the women who migrate from that

continent. Wherever possible in my review, I highlight the relevance of the multiple social positions of African immigrant and refugee women to the issues discussed.

African Migration to Canada – Trends and Drivers

Canada's population includes almost seven million people born in other countries. This number represents approximately 20% of the total population and is expected to grow to about 11.1 million people by the year 2031 (Statistics Canada, 2011a, 2016a). African immigrants and refugees were largely excluded from moving to Canada prior to the 1970s due to immigration policies imbued with racialized biases (Smith, 1993). This bias is discussed in more detail in the next section. Coupled with policy changes, the last 50 years have seen a striking change in the source regions and cultural diversity of the foreign-born population. In 1971, Europe and the United States accounted for approximately 70% of recent immigrants to Canada and only 12% of immigrant women were visible minorities (Statistics Canada, 2007, 2016a). By 2011, these numbers had shifted so that 60% of immigrant women were visible minorities. Asia had become the top source region comprising almost 57% of the recent immigrant population (Statistics Canada, 2011a, 2016a).

Whereas in 2011 immigrants from the African continent constituted just 7% of the total foreign-born population of Canada, this proportion increases to 12.5% when looking at recent immigrants (i.e., those who arrived from 2006 to 2011) (Statistics Canada, 2011a). These numbers are consistent with a general trend of a growing population of African immigrants and refugees in Canada (Tettey & Puplampu, 2005). These immigrants and refugees bring with them some of the incredible wealth of linguistic, religious, cultural, and socioeconomic diversity encompassed within the African continent. Fifty-three countries are represented among the

places of birth of recent African immigrants and refugees to Canada, with Algeria, Morocco, Nigeria, Egypt and Ethiopia as the top source countries (Statistics Canada, 2011b). There are clear distinctions between the locations in Canada where newcomers from English-speaking African countries (e.g., Nigeria, Egypt) settle as compared to those from countries in which French is a common language (e.g., Algeria, Morocco). Four provinces accept the majority of African immigrant and refugees to Canada: Ontario, Quebec, British Columbia, and Alberta (Lindsay, 2001). Quebec receives 81% of Canada's French-speaking newcomers, within which Africans represent a large and growing share. Among the minority of French-speakers who do not settle in Quebec, most (70%) tend to tend to settle in Ontario (Houle, Pereira, & Corbeil, 2014).

Along with an overall diversification of immigrants and refugees to Canada, in the last 100 years the number of female migrants also increased. Women comprise approximately 49% of the total African foreign-born population in Canada, and approximately 52% of recent immigrants and refugees from Africa (Statistics Canada, 2011a, 2016a). The term "feminization of migration" is used to describe, in part, internationally changing patterns of female migration. Women are migrating independently more frequently and many do so to provide support to families back home. Particularly for poorer, racialized women, this income is often earned by meeting the demand in richer countries for unstable, poorly compensated, and sometimes dangerous occupations in caregiving, domestic labour, and the sex trade (Paiewonsky, 2007).

Beyond changing migration flows, the "feminization of migration" also refers to a bounty of research in the last few decades that injects a gender lens into migration studies (Anderson, 1987; Paiewonsky, 2007; Spitzer, 2006a, 2011a; Vissandjée, et al., 2007). This

scholarship seeks to rectify a prior focus of the field on men and their experiences. Through the inclusion of the voices and experiences of women, migration is re-framed as a complex, gendered process and one in which women are active agents rather than passive accessories to male decision-making (Mahler & Pessar, 2001; Spitzer, 2006a). The power and mobility that women have in relation to migration is necessarily related to their various social positions. As discussed later in this chapter, migration category of entry is one particularly salient element of this. Women who are primary applicants have more independence than those whose submissions for entry to Canada place them as reliant on others (e.g., as the spouse of the primary economic immigrant or as a migrant sponsored by family members) (Bierman, Ahmad, & Mawani, 2009; Oxman Martinez, et al., 2005).

Issues of agency and power are particularly relevant to changes that have taken place with respect to how the drivers of international migration are understood. A classic conceptualization of these drivers is a push-pull model. This model posits that a decision to migrate is influenced by a blend of conditions in the source country that may 'push' one to leave, while simultaneously being 'pulled' by factors in the destination country (Lee, 1966). Among the diverse factors that may encourage Africans to leave the continent are insufficient economic opportunities, political instability, violence and conflict, and environmental disasters. These compelling factors enmesh with perceived conditions in Western industrialized nations like Canada, such as educational and career prospects, and protection for political and human rights (Tettey & Puplampu, 2005; Veronis & McLeman, 2014).

The push-pull model has been criticized, however, for leading to overly simplistic and static lists of factors involved in migration decisions (Anthias, 2012; Walton-Roberts, 2015).

These lists tend to present migration in terms of an individual-level weighing of costs and benefits. This neglects the structural nature of influences such as labour markets, policies, and power inequalities. Such "invisible elements" are time and place-dependent, and are embedded in state, community, and family levels of social relations (Haas, 2011; Vissandjée, et al., 2007). Migration is a dynamic process that involves complex chains of decisions, the known realities of life in the home country and imagined dreams of a future elsewhere. It is also affected by potential constraints on the ability and choice to migrate that are experienced differently by people in varied social locations (Anthias, 2012; Haas, 2011).

For the diverse group of women who migrate from different countries and social contexts in Africa, one implication of this line of reasoning is that we must: "pay attention to how different nations are hierarchically positioned and how actors themselves are positioned through these global dimensions of power" (Anthias, 2012, p. 103). African immigrant and refugee women in all of their diverse national, cultural, religious, socioeconomic, and racialized positions have different experiences of education, violence, trauma, employment, discrimination, and power in a continent deeply affected by the ongoing legacies of colonialism and historically peripheralized economies (Spitzer, 2006a; Tettey & Puplampu, 2005). These histories are further set within the context of an increasingly interconnected world. Economic development and social transformation within Africa may increase the desires and abilities of some African women to pursue educational and career opportunities beyond the continent (Flahaux & Haas, 2016).

Migrant women have unique vulnerabilities due to gendered norms that traditionally limit their access to power and resources. The body of work on gender and migration also

shows that women can be a powerful force within families and social networks. Decision-making regarding migration often occurs at these family and community levels, rather than at the individual (often male) level as earlier models of migration suggested (Anthias, 2012). This is, of course, situated within the recognition that sometimes those at the most disadvantage lack the resources necessary to facilitate the international migration process (Veronis & McLeman, 2014), and that who is able to migrate to Canada is partially shaped by Canadian immigration policies.

Canadian Immigration Policy

In the section that follows, I present a brief history of Canada's immigration policy up to and including the period of data collection for this study (i.e., until early 2014). Continued shifts in Canadian immigration policy after that point are discussed in the concluding chapter of this work. There are two main reasons why it is important to set African immigrant and refugee women's reproductive health experiences within an understanding of both historical and current immigration policy context. First, immigration policy lays out rules governing who is admitted into the country and delineates different categories of admittance. The category of entry into which immigrant and refugee women fall, depending on their reasons for migrating, influences their autonomy, security, and rights and privileges once in Canada (Wayland, 2006). Secondly, as Smith (1993) explains, nations are more than "lines on a map". Immigration policies, due to their social and economic selectivity: "may be regarded as one expression of a political idea of who is, or could be, eligible to receive the entitlements of residence and citizenship" (p. 50). Canada takes pride in narratives related to its history as an immigrant-receiving society and legislation upholding multiculturalism (Smith, 1993). Examining Canadian

immigration policy provides a more nuanced understanding of the society and the attitudes which help to shape the realities and health of different African immigrant and refugee women.

Historically, Canada's immigration policy was designed to spur the economic and population growth of the nation while upholding racialized ideals of what constituted a desirable citizen. Until the 1960s, subjective wording was used to establish a preference for primarily white immigrants from Western Europe and the United States. Meanwhile, people were excluded who were "deemed unsuitable due to their peculiar customs", "because of their probable inability to be readily assimilated", or who would "alter the character" of the Canadian population" (Hawkins, 1991, p. 17; Smith, 1993, p. 62). A racialized hierarchy of preferred immigrants effectively excluded significant numbers of Africans from migrating to Canada. Scattered pockets of African settlement in Canada existed, but these were largely due to African Americans who escaped slavery during the nineteenth century. Without a legacy of widespread slavery of its own, the roots of Black African populations in Canada are very different from those of African Americans in the United States (Spitzer, 2006a).

The diversification of Canada's immigrant population began in 1962 as entry criteria related to education and training replaced the prior emphasis on country of origin and ethnicity. This was followed by policy changes in 1967 and 1976 to attempt to further de-racialize the selection process. A points system was instituted to rank applicants across a number of categories such as education, age, and financial resources (Knowles, 2007; Smith, 1993). The points system – albeit revised over the years - remains foundational to immigration policy in Canada today. Presently, immigrants to Canada are admitted through one of three broad categories: economic immigrants (who are chosen for their skills and potential economic

contributions, and which may also include their spouses and dependants); family class immigrants (who are sponsored by other family members or relatives); and, refugee class (who enter on humanitarian grounds). This category includes Convention Refugees, who are selected at Canadian visa offices abroad. It also includes refugee claimants who apply for refugee status after they land in Canada (Statistics Canada, 2016a). Outside of these categories are non-status migrants whose refugee claims were denied, who overstay their student or work visas, or who are trafficked or smuggled into the country (Wayland, 2006). According to statistics from 2011, the economic stream is the largest category of admittance for recent immigrant women (whether as principal applicants or as spouses or dependants). Women from Africa are much more likely than those from Europe, the United States, or Asia and the Middle East to have landed as refugees (Statistics Canada, 2016a).

The category of admittance through which migrant women enter Canada influences their independence, their access to services, and their vulnerability to exploitation and abuse (Vissandjée, et al., 2007; Wayland, 2006). The way in which Canadian immigration policy acts to structure rights and privileges is gendered, such that immigrant women are disadvantaged compared with men. One example of this gendered bias lies within the points system itself. By emphasizing characteristics such as education, financial resources, and literacy and language abilities, it favours resources to which male applicants have greater access. Globally, women have less financial autonomy than men and are less likely to have formal educational opportunities. This is especially pertinent given the increase in the number of women immigrating to Canada from developing countries where opportunities for women may be more limited (Vissandjée, et al., 2007).

As a result of the gendered nature of the points system, more women are admitted in categories where their residency status is not secure or is dependant on the sponsorship and support of another family member (Oxman Martinez, et al., 2005). There is greater gender parity in the refugee class, but women still significantly outnumber men as spouses or dependants in the economic and family classes (Statistics Canada, 2016a). In addition, even when women and men have comparable levels of education and work experience, male members of two-parent families are more likely to be admitted as independent status immigrants. This is reflective of gendered norms that position men as traditional heads of household (Vissandjée, et al., 2004).

Oxman-Martinez (2005) discusses how the dependent status of many immigrant women decreases the power they have in relationships and creates insecurity and stress. This insecurity and stress can have a direct effect on health. Indirectly, dependency and fear of being deported may decrease the likelihood of women to report violence or abuse. Dependant status also creates a situation of financial control in which women may feel obligated to work excessively long hours in multiple jobs. Overwork may create fatigue and strain, and limit the time available to access health care services.

Settlement and Integration

Just as the policy context has implications for African immigrant and refugee women's reproductive health, so do their broader settlement and integration experiences. Settlement and integration in a new country are long-term processes that may span generations. Immigrants and refugees and the people, institutions, cultures, values and political and economic contexts of their new homes interact to shape integration in the following realms:

labour market, educational, linguistic, residential, and civic/political (Ray, 2002). These diverse realms of integration are all relevant to a perspective of health that moves away from a biomedical focus on health behaviours and health care settings, to the complex mix of socially-determined conditions (e.g., housing, employment) that facilitate or constrain opportunities for good health (WHO, 2008).

The process of integration, and the ways in which the effects of this process flow down to affect health, are influenced by: the interactions between immigrant and refugees' past experiences (e.g., of health, of trauma), stressors encountered in the migration process, the presence or absence of accessible resources and opportunities in society, and the supports and protective strategies that they and their broader families and communities have for resettlement. Social position, such as age, gender, education level, migration category, and language fluency, also intersect in relation to the above considerations to affect how settlement is experienced by different immigrants and refugees (Beiser, 2005; Vissandjée, et al., 2007). Upon entry, for instance, female immigrants are less likely than males to be able to communicate in one of the official languages of Canada's bureaucracy, school systems, and health care practitioners (Statistics Canada, 2016a). These women may have limited time to undertake language training due to their increased likelihood to shoulder the burden of domestic and child-rearing responsibilities while potentially also looking for work outside the home (Thurston, et al., 2006). In another example, refugees may lack official identity documents. This can add hardship and stress to the settlement process as they face restrictions on their ability to apply for permanent residence, challenges in registering for educational

opportunities, and limitations on their ability to sponsor loved ones who may remain in danger back in their country of birth (Spitzer, 2006b).

The examples above speak to some of the changes and challenges associated with the settlement process. They also hint at its broader complexity and sometimes less visible elements. As Anthias (2012) discusses, migration does not merely involve movement between physical places. It also involves "dislocation and relocation" of one's social, political, and economic locations, which are time- and place-dependant (p.103). To illustrate, she uses the example of a Ghanaian immigrant who lives in the United Kingdom. This person may encounter shifting experiences of privilege and oppression while carrying out their job, socializing with the Ghanaian diaspora, or visiting family and friends back in Ghana. Anthias (2012) further critiques research and discourse that present immigrants and refugees as undifferentiated groups who seek integration into equally undifferentiated host societies. Such work tends to problematize immigrants and refugees while implying that the host society is devoid of tension, conflict, diversity, and a role in the success of settlement and integration.

In grappling with diverse meanings, values, and practices in different places in Canadian society, Spitzer (2006a) finds that African-Canadian women may choose to emphasize certain elements of their identities to facilitate entry to new social networks. In their home countries, women associated themselves precisely in relation to their specific birth country or cultural group. In place- and time-dependent ways in Canada, these women would sometimes seek out broader affiliations based on being "African", "Black", or "Francophone". Newer arrivals to the country, for instance, were more likely to find an established community of shared ethnic identity than women who migrated in the 1970s. These earlier migrants tended to leverage

broader social categories (e.g., African, Black) to make connections. Social support is an essential part of the integration of newcomers, who face increased need related to the loss and disruption of previous networks as well as the stress, changes, and challenges of settlement. Research has shown that the presence of good social support facilitates settlement and integration as well as being beneficial to health and access to heath services. Immigrants and refugees in Canada, however, can be faced with considerable unmet support needs (Stewart, et al., 2008; Stewart, et al., 2010).

Although African women display agency as they use diverse identities to seek out support networks, Spitzer (2006a) also cautions that they remain constrained by broader social forces that limit the subject positions with which they may choose to engage. Processes of discrimination and exclusion work to position racialized immigrant women in ways that limit their access to resources and opportunities. These processes construct and label some groups of immigrants and refugees as unable to adapt to the culture, lazy or having a bad attitude, requiring too much of the system, and best suited to certain kinds of work or positions in society (Anderson, 2006; Grosfuguel, Oso, & Christou, 2015). Such discrimination is evident is statistics that show, for example, that African Canadians face increased marginalization in income and employment, and that Black women in Canada are disproportionately represented in the service sector and low-end manufacturing (Abdi, 2005; Yesufu, 2005). A focus on "Canadian experience" in hiring has been described as a means of excluding newcomer populations (Bhuyan, Jeyapal, Ku, Sakamoto, & Chou, 2016). Well-documented are experiences of discrimination when seeking meaningful employment and the psychosocial and health effects of related de-skilling and declines in socioeconomic status (Branker, 2016). Immigrant

and refugee women may also experience discrimination and exclusion from within their own communities and not just from broader society. This was one finding from the work of Mensah, Williams, and Aryee (2013) with African communities in Toronto, Canada. These researchers found that some African migrant men coped with their loss of social status once in Canada by carrying out "compensatory patriarchy". That is, they sought power in African churches in roles from which women were excluded from participating.

Reproductive Health of African Immigrant and Refugee Women

Having discussed broader contextual factors that help to structure the places and experiences of African immigrant and refugee women in Canada, I now turn my attention more specifically to the literatures on health and reproductive health. Within this section, I first discuss the interaction of immigration policy and health policy in Canada. Following this, I briefly review literature on the reproductive health needs and challenges of African immigrant and refugee women.

Interaction of Health and Immigration Policies

The reproductive health of African immigrant and refugee women is set within a policy context whereby the immigration category in which women are admitted to the country interacts with the health policy environment. Together, these policies influence the likelihood that women will be admitted with pre-existing health conditions, as well as the availability and extent of health care coverage they receive once in Canada. The type of health coverage available for different categories of migrants varies. This complexity can make it difficult for both newcomers and service providers to understand the system and can negatively impact the

access of immigrants and refugees to appropriate health care (Ontario Medical Association, 2011).

All immigrants and refugees to Canada are required to undergo a medical examination (CIC, 2014). This examination includes mandatory HIV testing, a policy particularly salient to women from HIV-endemic regions of Africa. Inconsistencies with respect to pre- and post-test counselling and the human rights implications of mandatory HIV testing have been the subject of recent examination (Bisaillon, 2010, 2012). Potential reasons for excluding applicants for medical reasons are based either on a concern for public health or safety, or due to an expectation of "excessive demand on health or social services" (CIC, 2002). The spouses/partners of the principal applicant and eligible refugees cannot be excluded based on the criterion of excessive demand (Government of Canada, 2001). Women outnumber men in the first of these categories and are approximately on par with men among refugees (Statistics Canada, 2016a). This increases the likelihood that female newcomers to Canada may have greater health needs than men upon arrival. In addition, the changes and instability of migration may disrupt access to contraception and prenatal care, and refugee women may have experienced trauma, conflict, or disaster situations that heightened their vulnerability to sexually transmitted infections and sexual violence (Vu, et al., 2014).

For those who enter Canada through the voluntary immigrant categories, health care shifts from a federal to provincial responsibility once they have arrived. In Ontario, the Canadian province within which this study is set, there is a three-month waiting period before immigrants can access the publicly funded health insurance system (OHIP). Babies born to women in Ontario during this three-month waiting period are covered by OHIP; however, the

mothers themselves are not (OMHLTC, 2011). In addition to potentially dissuading women from seeking appropriate prenatal care, this wait time may prove expensive if women experience pregnancy complications or deliver before OHIP coverage begins. The potential to delay preventative care or incur large personal expense for required medications are also issues for reproductive health more generally (e.g., for contraception, and testing and treatment for sexually transmitted infections) (Goel, Bloch, & Caulford, 2013; Ontario Medical Association, 2011). Ontario's community health care centres and midwifery clinics operate under different funding models and may help to address some of these barriers for women not covered by OHIP. These institutions provide basic primary care as well as prenatal care, but long waiting lists for these services may still act to restrict access (Ontario Medical Association, 2011).

Immediate health care coverage for refugee claimants, on the other hand, is supported by Canada's federal government through the Interim Federal Health Program. The program was designed to provide emergency and essential care (including contraception, prenatal care, and some medications) to refugee claimants while they wait for their claims to be processed (Ontario Medical Association, 2011). In 2012, mid-way through the data collection period for this study, changes to Interim Federal Health were made. These changes created different tiers of health coverage for refugee claimants based on their country of origin. Initial announcements of significantly reduced coverage for most claimants were met with organized protest from health professionals. This led to partial revision of the proposed modifications to the program. During the time of data collection for my study, one of the primary impacts of the changes was confusion among refugees and service providers about the details of the new

policy. Cases of refugees who were refused care by walk-in clinics in light of the complexity and confusion were also documented (Harris & Zuberi, 2015).

Migrant women who fall outside of the official categories of immigrant or refugee either have private health coverage or no coverage at all. These women include those in the country on visas (e.g., student or work) or non-status immigrants who have overstayed visas, have refugee claims that were denied, or who may have been trafficked into the country. Women are over-represented among non-status immigrants, and their precarious position and lack of legal documentation may make them hesitant to approach the health system (Oxman Martinez, et al., 2005).

Reproductive Health Needs and Challenges

In comparison to the overall body of work on the reproductive health of migrants, studies focused specifically on African immigrant and refugee populations are relatively small in number. Those focused on the reproductive health of African immigrants and refugees in the Canadian context are even more limited. For the reasons detailed earlier in this chapter and in the theoretical framework of this study, it is important to draw insight from literature that is situated within an understanding of the historical, political, and social environment of Canada. This broader national context shapes the places in which the women in my study experienced their reproductive health.

Despite the relatively small volume of literature, a number of studies provide insight into reproductive health issues for which African immigrant and refugee women face inequities. In a population-based study on maternal morbidity, for instance, sub-Saharan African immigrant women had higher rates of serious complications, such as severe preeclampsia, as

compared to women born in Canada (Urquia, et al., 2015). In a meta-analysis that included Canadian populations, both North African and sub-Saharan African women were found to have a greater risk of feto-infant mortality than locally born populations, and women from sub-Saharan Africa were also at greater risk of preterm birth (Gagnon, et al., 2009). Female African refugees in Canada have also been found to have higher rates of HIV, delays in accessing prenatal care, higher rates of low-birth weight infants, and an increased likelihood of homelessness and social isolation during pregnancy as compared to pregnant women who are not refugees (Kandasamy, et al., 2014). On the other hand, some studies suggest that African immigrants to Canada, and particularly African refugees, are more likely than both the Canadian-born population and other migrants to initiate and maintain breastfeeding (Dennis, Gagnon, Van Hulst, Dougherty, & Wahoush, 2013).

Although comparative studies of populations are useful for identifying inequities, they are not as adept as some other research methods at exploring diversity within populations and unpacking the "why" questions that underlie such inequities. Qualitative research studies help to surface the array of influences, within and outside of the health care system that influences African immigrant and refugee women's reproductive health. In research on HIV/AIDS service needs, gendered norms around condom use and infidelity, social isolation, loss of social status, religious beliefs, stigma and discrimination, and the racialization of HIV as a 'Black disease' by the mainstream media have all been identified as playing a role in risk of infection, and influencing the likelihood of seeking testing and support (ACCHO, 2006; Worthington, et al., 2013). The complex mix of factors that influences reproductive health was also surfaced in a recent study with Zimbabwean and Sudanese refugees in Canada who were new parents.

Interviews and focus groups identified feelings of isolation and stress among the parents, compounded by challenges in accessing health and social services due to language barriers, discrimination, a disjointed system of government services, and culturally insensitive policies (Stewart, Makwarimba, et al., 2015). The diversity of African women in relation to potential needs is highlighted in work conducted with African women in Nova Scotia. These women negotiated their own cultures as well as those of Canadian society and service providers throughout their experiences of childbirth and maternal health (Etowa, 2012; Etowa, et al., 2010).

Interventions to increase cultural competence among health and other service providers recur as recommendations in the literature on the reproductive health needs of African women (Etowa, 2012; Etowa & Adongo, 2010; Stewart, Dennis, et al., 2015). As Thurston et al. (2006) highlight, however, attention to the need for cultural competence in care should be careful not to neglect broader social and political factors that influence migrant women's health risks and outcomes. Cultural differences should not be viewed as single explanations for health inequities, but rather as potential indicators of complex forms of social oppression that influence the health of particular cultural groups. Policies based on culturalist explanations should be coupled with efforts aimed at addressing the upstream factors that shape opportunities for good health.

In addition to a need for improved cultural competence among health care providers, studies on the reproductive health of African immigrant and refugee women support further examination of factors and interventions outside of the health care system. Such action could take the form of, for instance, education, employment, and social support programs (Stewart,

Dennis, et al., 2015; Stewart, Makwarimba, et al., 2015). As Bollini et al. (2009) find in their cross-country comparison of pregnancy outcomes in immigrant women, women consistently fare better in countries with strong integration policies than in those that provide fewer supports for their immigrant populations.

Summary and Gaps

The literature points to the importance of considering the reproductive health needs and challenges of diverse African immigrant and refugee women within the broader context of their lives, immigration experiences, and upstream influences on health and access to services. Immigration history, policy and health policy interact to shape the Canadian society in which African immigrant and refugee women enter. These women are positioned variously with respect to nationality, religion, country, migration category, ethnicity, and socioeconomic status. All of these interrelated factors affect how African immigrant and refugee women experience their health, their places within Canadian society, and the support and resources to which they have access.

While the existing literature is helpful to inform our understanding of place and immigrant women's reproductive health, a number of knowledge gaps remain. First, while this literature review highlights the complexity of issues that may influence African immigrant and refugee women's reproductive health, there are still relatively few Canadian studies that seek to engage these women specifically and which employ research methods to explore these issues in depth. Given the incredible diversity of women from Africa who settle in Canada, many more studies are needed to do justice to these populations and these issues. Second, within this body of work we also lack specific analysis of the ways in which African immigrant

and refugee women experience reproductive health with respect to place-based context. As previously discussed, the lens of place can be particularly useful to bring context into the study of health inequities. In this case, such a lens would help us to examine how African immigrant and refugee women are positioned within multi-level networks of social conditions and relations that interact at given times in specific locations to structure or constrain opportunities for reproductive health (Massey, 1994b). A place analysis would be inclusive of health care settings, but would also help to draw attention to places outside of these settings that are important to the reproductive health of African immigrant and refugee women. Finally, further analysis of the diversity of African immigrant and refugee women in Canada in relation to their reproductive health is needed to explore how reproductive health issues and challenges may vary as their social positions in place do as well.

Table 2. Summary of Findings and Knowledge Gaps from the Literature

Key Issues	Main Findings	Knowledge Gaps
The role of place	Places help to structure opportunities, behaviours, and beliefs Lived experience in place varies by social location Policies, norms, and values at different levels help to shape place itself	Relatively little literature on African immigrant and refugee women in the unique Canadian context, and outside of the top immigrant-receiving cities Little is known about the aspects of place-based context relevant to the reproductive health (RH) of African women in Canada
Trends in African migration to Canada	African migration to Canada has increased in the last few decades African women are diverse and have different degrees of power and vulnerability in migration decisions	Diversity of women from Africa argues for the need for more studies on the effect of their varied positions on their RH needs
Canadian immigration policy	Canada's immigration policy is gendered and, historically, racialized Migration category affects autonomy, access to services, and vulnerability	Increased consideration needed of how migration policy positions African women within places to influence RH opportunities and challenges

Settlement & integration	Settlement and integration are long-term processes that affect a number of social determinants of health Settlement and access to resources is influenced by social position (e.g., linguistic abilities) and place (e.g., established cultural communities) Racialized migrant women face particular challenges in relation to access and opportunities	In the unique context of smaller Canadian metropolises, relatively few studies on how African women's settlement experiences affect their RH Need for increased consideration of how African women's diverse social positions affect their settlement and RH in different local contexts
African immigrant and refugee women's RH	Health and migration policy interact to affect likelihood of pre-existing health conditions and health care access Depending on their migration journey, women are exposed to risks of sexual violence and disrupted RH care African immigrant and refugee women are at increased risk of a number of adverse outcomes (e.g., preeclampsia, pre-term birth) Greater likelihood of positive outcomes are also reported (e.g., initiation of breastfeeding) Complex factors play into RH outcomes (e.g., language barriers, social support) Cultural competence in health care services is a central recommendation to improve African women's RH	Relatively few Canadian studies present African women's own voices with respect to RH needs and challenges Lack of analyses that contextualize African women's RH experiences within complex place-based context Little examination of how African women may actively leverage elements of place to support their RH Fewer recommendations to address structural factors outside of health care settings

Chapter 4: Methods

As discussed in Chapter 1, in this research I ask: *How do African immigrant and refugee women experience, negotiate and construct place in relation to their reproductive health and as they seek reproductive health information, services, and support in the City of Ottawa?* I seek a richly contextualized analysis of the issue by drawing insight from the theoretical framework and literature review, as well as through the feminist methodological approach, multiple case study design, and qualitative methods used in this research project. The overall aim of this analysis is to provide new knowledge on the reproductive health experiences, needs, and challenges of African immigrant and refugee women living in Ottawa. Such knowledge allows me to make recommendations in the conclusion of this work for reproductive health services and other interventions to better support these women.

Prior to focusing on the research design and methods used in this study, in this current chapter I first briefly discuss feminist methodologies. That is, the approaches to research that helped to guide the choice of design and methods and the ways in which these were applied. While not a single, discrete methodology, feminist approaches to qualitative research share a number of key features which inform the design of my study (Giacomini, 2010). These features coalesced out of the combined efforts of feminist researchers across disciplines to challenge the historical omission of diverse women's needs, knowledges, and bodies in research (as evidenced, for example, by the past exclusion of women from clinical trials on the assumption that results for men could unproblematically be applied to women) (Reiger & Liamputtong, 2010). Hesse-Biber, Leavy and Yaiser (2004) describe the commonalities among feminist

methodologies as a focus on: challenging the ways in which the knowledge of some is created, respected and distributed in preference to the knowledge of others, drawing on women's own experiences, critically examining "universal truths" and taken-for-granted assumptions, bringing attention to issues of difference and the operation of power to support such difference and oppression, and undertaking research with the aim of informing broader social change.

I chose to draw upon feminist methodologies as these ideas align well with my theoretical framework and literature review. In particular, the findings which suggest that the study of African immigrant and refugee women's reproductive health should be situated within an understanding of their own views as well as the ways in which their diverse social positions in different contexts help structure the resources at their disposal, access to services, and day-to-day interactions with the health system and broader community (Etowa, 2012; Higginbottom, et al., 2013; Oxman Martinez, et al., 2005; Viruell-Fuentesa, et al., 2012). Further, a feminist methodological approach is well-suited to guiding attention to the diversity of African immigrant and refugee women engaged in my work, respecting the contribution of all participants in this research, aiming to make useful recommendations for change, and being attentive to and reflective about potential sensitivities and challenges involved in undertaking cross-cultural research on a complex and value-laden topic such as reproductive health (Liamputtong, 2008; Reiger & Liamputtong, 2010).

Research Design

Within a feminist methodological approach, I undertook a multiple case study research design that centred on three different geographic areas in the City of Ottawa (central area, west area, southwest suburban area). The reproductive health experiences of African

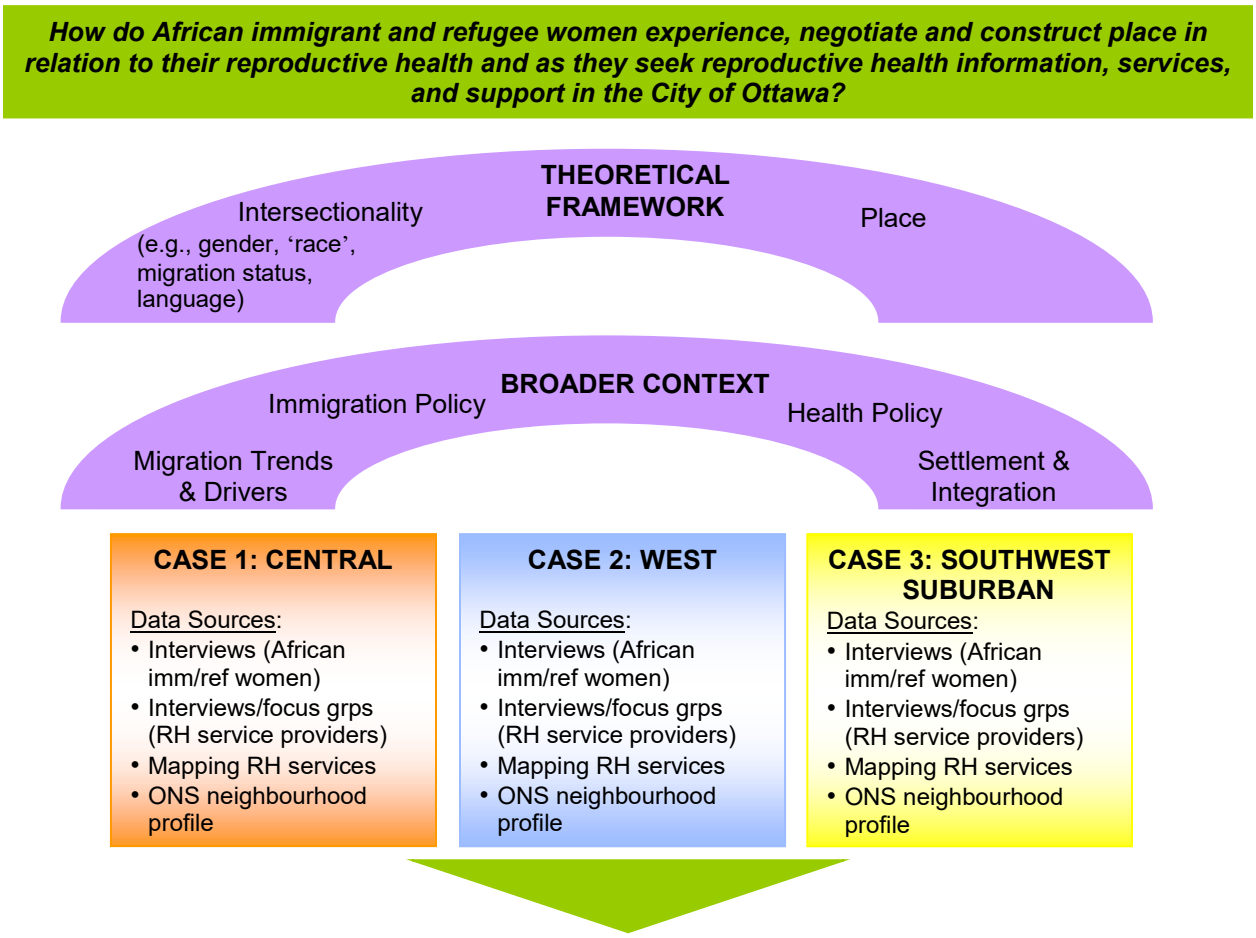
immigrant and refugee women who lived in those areas were the focus of my work. Case study is a qualitative research design. It involves the in-depth exploration of an issue by collecting experiential knowledge contextualized through the use of multiple sources of information (Stake, 2005, 2006). I chose this design because the rich detail and multiple data sources associated with case study can help paint a picture of how people and groups interact with and build meaning in and through place (Herbert, 2010; Sutherns, 2001). Multiple case study is a particularly useful strategy because it facilitates the examination of how and why there are differences between different contexts and can bring forward processes that stretch across these contexts (Herbert, 2010). As Stake (2005) argues, however, it is still important to approach comparison between cases cautiously. This is due to the potential to shift the focus to generalities rather than the complex characteristics that make a particular case unique.

Consistent with my theoretical framework and feminist methodological approach, I placed priority within the case study on the perspectives of African immigrant and refugee women. I also sought to situate their reproductive health experiences within a critical understanding of the broader structural processes that shaped the challenges and opportunities they faced. In each of the three case study areas, I collected data towards these aims using the following methods: semi-structured interviews with African immigrant and refugee women, focus groups and semi-structured interviews with reproductive health service providers, and mapping of the reproductive health service environment. I also took field notes throughout the course of my research and have contextualized the primary data within the detailed neighbourhood profiles available through the Ottawa Neighbourhood Study (Ottawa Neighbourhood Study, 2011).

When I designed the research to focus on cases by geographic area, I was influenced by the theoretical notion of place as described in Chapter 2. Within the concept of place, however, I prioritized the element of location. That is, I believed that the neighbourhoods of residence of the African women with whom I spoke would be very salient to their reproductive health. Experiences that drew on elements of the social construction of place would, I assumed, fall fairly neatly within this overall framing. This design decision was largely due to the influence of emerging work in the field of population health on neighbourhoods and health (for example, the Ottawa Neighbourhood Study (Ottawa Neighbourhood Study, 2010)). As I progressed through data collection and analysis, it became increasingly apparent that many of my findings were not aggregated around a neighbourhood frame of place. The intersecting social locations of the women rose to the fore, as did the ways in which they engaged with place on a different scale and in different ways than through a predominant grounding in neighbourhood. These changes to my theoretical understanding of African immigrant and refugee women's reproductive health are issues that I revisit when I present the findings and analyses of the case studies.

Figure 1 (below) illustrates the overall research design and data sources of this study. In the sections that follow, I describe the methods in more detail. First, I discuss the City of Ottawa as the research site as well as the study participants. Next, I present the rationale for selecting the three Ottawa areas that comprise the cases. I then discuss participant sampling and recruitment, and data collection. In the final three sections, I focus on data management and analysis, trustworthiness and rigour, and reflect on my role as a researcher.

Figure 1. Overview of the Multiple Case Study Design and Data Sources



Notes: RH = Reproductive Health; ONS = Ottawa Neighbourhood Study

Research Site and Participants

This research was conducted in the City of Ottawa in Ontario, Canada. Ottawa was chosen due to feasibility and because it is home to significant numbers of immigrants and refugees, including an established and growing population of people born in Africa (City of Ottawa, 2002; Statistics Canada, 2011c). While Canada's largest urban centres (Toronto, Montreal, Vancouver) attract the majority of newcomers to the country (Statistics Canada, 2015a), smaller cities that are home to immigrant and refugee communities are still worthy of study. Smaller communities have received less research attention than Canada's largest metropolitan areas, but every city provides a unique context that helps to shape the different settlement and health experiences of immigrants and refugees. Important factors may include, for instance, the availability of settlement services, the presence or absence of communities of shared cultures, and public attitudes towards the integration of newcomers (Dyck, 2004; Esses, Hamilton, Bennett-AbuAyyash, & Burstein, 2010). In Ottawa's case, its location at the Ontario-Quebec border and policy of English-French bilingualism also contribute to the city's distinct character and the lives of newcomers (e.g., through interactions with both anglophone and francophone communities, and the ability to cross the border to take advantage of opportunities) (City of Ottawa, 2001; Veronis, 2015).

The voices of African immigrant and refugee women living in Ottawa are central to my research. In 2011, immigrants comprised over one fifth of Ottawa's population. This number included approximately 25,000 immigrants from the continent of Africa, over half of whom were women. The following five countries were the top source regions from Africa: Somalia, Egypt, Democratic Republic of Congo, Ethiopia, and Nigeria (Statistics Canada, 2015b, 2016a).

For recent immigrants the picture was slightly different, with the following as the top African source countries: Egypt, Democratic Republic of Congo, Burundi, Somalia, and Morocco (Statistics Canada, 2016b). As discussed in Chapter 1, my research included participants from the entire continent of Africa and recognized the great diversity of women represented within this group. Exploration of this diversity was built into the design of the research to help reveal how reproductive health experiences in place were influenced by the multiple and different social locations of African immigrant and refugee women.

A second group of participants in this study was reproductive health service providers. This category encompassed a wide variety of service providers engaged in the full range of reproductive health education, prevention, treatment, and support activities from overall reproductive wellness, to contraception, conception, and birth. Examples of reproductive health service providers included midwives, physicians, nurses, pharmacists, doulas, and community outreach workers. For the purposes of this study, I engaged those with resources physically situated in at least one of the three case study areas in Ottawa. I also included those whose activity zones included at least one of the target areas. This decision was made because reproductive health service providers may be active in, and knowledgeable about, a given area without being permanently based within its boundaries.

Selection of the Cases

The cases that were compared in this study were the reproductive health experiences of African immigrant and refugee women in three different Ottawa areas: central, west, and southwest suburban. At the beginning of data collection, these areas were defined in relation to one neighbourhood each (West Centretown, Bayshore, and Barrhaven, respectively).

Recruitment challenges led me to expand the boundaries of the areas in 2011 to increase the population of potentially eligible participants. The revised neighbourhoods contained in each case study area were as follows: central (Centretown, West Centretown), west (Bayshore, Whitehaven-Queensway Terrace North), and southwest suburban (Barrhaven, New Barrhaven-Stonebridge). Figure 2 (below) shows the locations and boundaries of these areas on a map of Ottawa. The boundaries of each neighbourhood were defined as per the Ottawa Neighbourhood Study (Ottawa Neighbourhood Study, 2011).

Figure 2. Locations and Boundaries of Case Study Areas in Ottawa, Ontario

The three areas were chosen to represent different local contexts within which African immigrants and refugees experienced their reproductive health in Ottawa. Stake (2006) states that the cases in a multiple case study should be chosen with an eye to diversity across contexts, as well as to their relevance to the key issue under study and the opportunity they provide to learn about the complexity of this issue. The considerations below were taken into account when I selected the cases for this study. I have provided descriptive details for each case in the results chapters.

a) *Immigrant and refugee populations*: All the areas selected had significant immigrant and refugee populations, making them sites of feasible recruitment. The absolute number of African immigrants and refugees, and the percentage of the population that they represented varied between the case study areas. This may be significant because a strong localized group of immigrants, particularly from similar cultural groups, can provide a base of support to assist in the settlement process, help create social networks for the sharing of health information, and facilitate access to health-related resources (Dyck, 2004). Strong cultural groups from the home country may also be relevant due to their potential to exert pressure to maintain more traditional gendered values and roles for women that are not necessarily supportive of their broader health and reproductive health (Lynam, Browne, Reimer Kirkham, & Anderson, 2007; Oelke & Vollman, 2007).

b) *History:* The history with respect to immigration in Ottawa varied by case study area. The central area was an established immigrant receiving area, the west end was a relatively newer immigrant enclave, and the southwest suburban area did not have a

long history of settled immigrant and refugee communities (Ottawa Neighbourhood Study, 2011). Research shows that the geography of newcomer settlement in Canada has shifted in some locations, as immigrants and refugees look beyond the urban core to employment opportunities and more affordable housing in the suburban areas of cities (Murdie, 2008). History as an immigrant receiving area may be relevant to reproductive health experiences in light of the presence of established cultural groups as mentioned above. An area with a strong history of welcoming immigrant and refugee populations may also have a base of targeted health services and outreach programs, established community leaders, and social advocacy groups to assist newcomers.

c) *Socioeconomic context:* The areas chosen presented different socioeconomic contexts. Socioeconomic status is a fundamental social determinant of health and may influence, for instance, the financial resources women have to pay for reproductive health services (e.g., contraception) or the control they have over work hours and time away from work to seek reproductive health care (Oxman Martinez, et al., 2005; WHO, 2008). Neighbourhood socioeconomic context has also been shown to play a role in health through perceived safety, housing quality, social capital, and the service environment (e.g., health, food, transportation) (Bernard, et al., 2007; CIHI, 2006; Rose, Germain, & Ferreira, 2006; Ross, Tremblay, & Graham, 2004).

d) *Proximity to the downtown core:* The three areas varied in their proximity to the downtown core (see Figure 2, above). For centralized reproductive health services, this may be relevant in terms of the distance, time necessary, and mode of transportation (e.g., on foot, public transportation, car) required for access. In the results chapters of

this dissertation, I include maps that I prepared which show the reproductive health services available within each case study area.

e) *Access to African immigrant and refugee populations*: Each area had associated community organizations that worked with immigrant and refugee populations. This facilitated access to potential participants. I, my supervisor, or my thesis committee members had relationships with some of these organizations that were built upon during the recruitment process.

Participant Sampling and Recruitment

In the early stages of my PhD, as I engaged primarily in coursework and comprehensive examinations, I began to make contacts with community organizations who worked with immigrant and refugee populations in Ottawa. This led to individual meetings and participation in community gatherings during which I was able to discuss and receive feedback on my proposed research, become more familiar with the African communities in Ottawa, and explore potential avenues of recruitment. I began recruitment in the Fall of 2010 after the University of Ottawa Research Ethics Board approved the study and its methods. Following a 12-month maternity leave, I completed my data collection in early 2014.

African Immigrant and Refugee Women

African immigrant and refugee women were sampled purposively by case study area using a snowball recruitment method. That is, I used a number of eligibility criteria to define the population of interest and welcomed new contacts who flowed from those I met and/or interviewed (Green & Thorogood, 2009). At the beginning of my study, I used the following

eligibility criteria: female immigrant or refugee, self-identified as African, settled in Canada within the last 10 years, between the ages of 18 and 45, resident of one of the three case study areas, English or French-speaking. Women who had lived in Canada 10 years or less were originally targeted because this population faces increased challenges related to reproductive health. These challenges include lack of awareness of services, language barriers, potential delays in health insurance, and an increased risk of poverty that affects stress, free time, and the ability to access health services (Beiser, 2005; McKeary & Newbold, 2010).

Recruitment was initially slow. This was not unexpected due to my newness in being engaged with immigrant and refugee communities in Ottawa, the potential sensitivity of the topic of reproductive health, and the settlement process for newcomers that may limit time or desire to participate in research. To increase the pool of potential participants, I received ethics approval for a number of changes to the eligibility criteria. As discussed in the previous section, the case study areas were expanded in 2011 to include two neighbourhoods each. Limitations around length of time in Canada were dropped in 2013. I also found that, as my recruitment progressed, women above the stated maximum age of 45 identified with my research topic. Given their interest in my work and my continued need for participants, I welcomed these older women into my study.

I used a number of recruitment strategies, one of which was to provide community organizations with flyers to circulate to potential participants. Originally, I used the term "reproductive health" on these flyers and included a picture of the African continent. In response to feedback during the recruitment process and discussion of recruitment challenges with my supervisor and thesis committee, I received ethics approval to instead use the

language of "women's health" and include images of diverse women (Appendix 1). I brought these flyers with me as I continued to make new contacts with community organizations that worked with African immigrant and refugee women and engaged in activities where I might meet interested participants (e.g., presentations at language classes for newcomers, participation in community celebrations). I additionally requested circulation of the materials electronically through as many listservs as possible. Finally, as recruitment continued to progress but slowly, I hired two "community liaisons" who were themselves a part of Ottawa's African communities. These women were essential in helping me to complete my recruitment. They used their networks to engage potentially interested women and assure them of my legitimacy in conducting this work.

In total, 19 immigrant (n=10) and refugee (n=9) women were recruited (central: six participants; west: seven participants; southwest suburban: six participants). These women represented 12 different countries from the continent of Africa. In Table 3 (below), I summarize the demographics of the participants by case study area.

Table 3. Demographic Summary of African Immigrant and Refugee Women (n=19)

DEMOGRAPHICS	CASE STUDY AREA		
	Central (n=6)	**West (n=7)**	**Southwest Suburban (n=6)**
Immigration Category	Immigrant (n=1) Refugee (n=5)	Immigrant (n=5) Refugee (n=2)	Immigrant (n=4) Refugee (n=2)
Interview Language	English (n=2) French (n=4)	English (n=5) French (n=2)	English (n=5) French (n=1)
Source Country	Burundi (n=1) Djibouti (n=1) DR Congo (n=3) Tanzania (n=1)	DR Congo (n=1) Ethiopia (n=1) Libya (n=3) Somalia (n=1) Zimbabwe (n=1)	DR Congo (n=1) Ghana (n=1) Kenya (n=2) Nigeria (n=1) Zambia (n=1)

Years in Canada	0-5 yrs (n=3) 6-10 yrs (n=1) 10-15 yrs (n=1) >15 yrs (n=1)	0-5 yrs (n=4) 6-10 yrs (n=3)	6-10 yrs (n=2) 10-15 yrs (n=3) >15 yrs (n=1)
Highest Level of Education	≤ High School (n=4) Trade School (n=1) College/Univ. (n=1)	Trade School (n=1) College/Univ. (n=6)	≤ High School (n=1) Trade School (n=1) College/Univ. (n=4)
Age	21-30 y.o. (n=1) 31-40 y.o. (n=1) 41-50 y.o. (n=2) 51-60 y.o. (n=2)	21-30 y.o. (n=3) 31-40 y.o. (n=3) 41-50 y.o. (n=1)	31-40 y.o. (n=2) 41-50 y.o. (n=4)
Religious Affiliation	Christian (n=5) Muslim (n=1)	Christian (n=2) Muslim (n=4) None/Not Stated (n=1)	Christian (n=6)

Reproductive Health Service Providers

Using a snowball recruitment method, I also sampled reproductive health service providers purposively by case study area. In addition to the existing ethics approval from the University of Ottawa, I sought and received approval from Ottawa Public Health in 2013 to recruit members of their staff. Eligibility criteria were as follows: self-identified as reproductive health service provider, activity area included at least one of the three case study areas of interest, spoke English or French. My primary method of recruitment was to contact service providers directly with whom I had existing relationships, had met in the course of my engagement with community organizations, or who were referred through these contacts or contacts of my supervisor and committee members. I also circulated flyers (Appendix 2) electronically through the listservs of professional networks. Throughout recruitment, I targeted the diversity of professions who provide services related to reproductive health. In total, 23 service providers participated in this study, some of whom had experiences working with populations in more than one of the case study areas. These participants included:

community health and/or social workers (n=8), a doula (n=1), midwives (n=2), nurses (n=7), a pharmacist (n=1), and physicians (n=4). In Table 4, I summarize the demographics of reproductive health service providers who participated in this study, and the case study areas in which they were active.

Table 4. Demographic Summary of Reproductive Health Service Providers (n=23)

PROFESSION [and gender]	CASE STUDY AREA(S)*		
	Central (n=16)	West (n=13)	Southwest Suburban (n=9)
Community Health &/or Social Worker (n=8) [7 females, 1 male]	n=4	n=5	n=5
Doula (n=1) [1 female]	n=1	n=1	n=1
Midwife (n=2) [2 females]	n=2	n=2	-
Nurse (n=7) [6 females, 1 male]	n=5	n=3	n=3
Pharmacist (n=1) [1 female]	n=1	-	-
Physician (n=4) [4 females]	n=3	n=2	-

*Note: Some service providers were active in more than one case study area.

Data Collection Strategies

To gain in-depth information about the reproductive health experiences of African immigrant and refugee women and the places in which they occurred, I used a number of collection strategies. I describe these strategies in more detail below.

Interviews with Immigrant and Refugee Women

I conducted semi-structured interviews with African immigrant and refugee women recruited from each of the three case study areas. In keeping with my approach to this

research, the interviews were conducted as semi-structured conversations so that participants had the opportunity to shape the discussion and communicate what they believed was important (Speer, 2002). I entered each interview with a guide (Appendix 3) that laid out open-ended questions relevant to my research topic. As the conversation progressed, I followed the flow of the discussion, probed to explore potential new areas of interest, and/or gently encouraged the return to the issues of the study as needed (Kelly, 2010).

I strived for a narrative style of interviewing in which I encouraged participants to share stories about their experiences. During our conversations, I explored the context of these stories within their broader lives rather than as fragmented pieces (Riessman, 2012). In practice, I found that the extent to which detailed storytelling occurred varied between interviews. This depended on the participant and their predisposition to speak in such a way, as well as my ability to establish a rapport and draw out stories. As Fontana and Frey (2005) discuss, qualitative interviews are not a neutral undertaking. Rather, they are a process of collaborative engagement between two people situated within historical, political, and social contexts. As I sought to build rapport, I was aware of my position of relative power in the interaction as a Canadian-born researcher. I attempted to partially mitigate this by encouraging the women to meet me at a place where they would be most comfortable. Often this place was their home.

All interviews were conducted by me in English or French (my second language). I had obtained ethics approval to use the support of an interpreter for interviews in French. During recruitment, however, I found that privacy was a very strong concern for women and that they preferred to interact with me alone. My first interview in French occurred by mistake, as I took

advantage of the immediate availability of a participant and then realized that she preferred French over the language in which we had been introduced (English). That experience gave me the confidence that I could engage in further interviews in French on my own. This allowed me to ease potential privacy concerns related to the presence of an interpreter and adapt quickly to the availability of participants.

Prior to beginning each interview, I reviewed an informed consent form (Appendix 4) with the participants and asked them to complete a brief demographic questionnaire (Appendix 5). As English or French was not always the first language of the women and reproductive health was a potentially sensitive topic, I took special care to explain the contents and answer questions. In addition, I assured the participants of their power to redirect, pause, or stop the interview at any time. I also gave the option to provide consent verbally on the digital recording instead of by signing the written form, though none of the participants took advantage of this option. Digital recording of the interviews was easiest from my perspective as a researcher, but was optional. Three of the 19 women who participated asked that I not record their interviews. In these cases, I took detailed handwritten notes during the interview and supplemented with additional notes immediately after the interview.

Feedback that I received from community organizations indicated that interviews of an hour in length would likely be perceived as manageable by the women. Any longer was felt to appear too daunting or difficult to schedule into their lives. I prepared for hour-long interviews but was almost always flexible to allow for more time in case of need. Most interviews did last approximately an hour, while some ranged closer to two hours. There were also a few interviews that were conducted back-to-back at a community organization that hosted a drop-

in. Under the pressure of others waiting their turn, these interviews were closer to 40 minutes each. Each interview participant received $30 in compensation for their time and contribution.

Focus Groups and Interviews with Service Providers

To supplement and contextualize the experiences shared by African immigrant and refugee women, I conducted focus groups and interviews with reproductive health service providers. Focus groups alone were originally planned to allow the service providers to engage each other around shared or divergent perspectives and experiences based on their differing professional roles (e.g., nurse, midwife, physician). Due to time constraints expressed by service providers, this format was expanded to include the option of an individual interview instead. I conducted one focus group in the central case study area with three participants, one joint interview with two participants who worked together in the west area, and the remainder of my engagements with service providers were through individual interviews. The focus group was conducted at the University of Ottawa, while the interviews were conducted at either the workplace of the service providers or another location of their choice (e.g., coffee shop).

At the beginning of each focus group or interview, I reviewed and asked the participants to sign the informed consent form (Appendix 6) and complete a brief demographic questionnaire (Appendix 7). I used a semi-structured format with a guide to focus our discussion on key topics (Appendix 8), but was open to exploring new areas of interest that emerged in our discussions. A large portion of these conversations focused on information about the programs provided by the service providers and their perspectives on reproductive health challenges and needs of African immigrant and refugee women. I also sought to gain their insight into the broader communities in which they provided their services. As a final

piece of our discussion, I provided service providers with a draft map of the reproductive health service environment in the area (discussed below). I used this map to engage in a discussion about the accuracy of the representation, the ease of access of the listed services, and additional needs to support the reproductive health of African immigrant and refugee women. The focus group and interviews were all conducted in English and were digitally recorded. Participants were provided with $30 compensation for their participation in the research.

Mapping

To contribute to the understanding of the reproductive health context, I prepared a map of the reproductive health services in each area. I followed a number of steps to carry out this process, which began in 2010 and was revisited in 2012 for the new neighbourhoods added to each case study area.

As a first step to creating the maps, I made an Excel database for each area that listed reproductive health services and their contact information. The WHO definition of reproductive health that I discussed in Chapter 1 served as a guide for which services to include in the database (WHO, 2006, 2010). This encompassed clinical services in the realms of sexually transmitted infections, contraception, gynaecological care, prenatal and postnatal care, breastfeeding and infant support, pregnancy termination, and sexual violence. Consistent with the definition, I also identified education, counselling, and social support services in these domains. Examples of services included: community health centres, medical clinics and physician offices, hospitals, midwifery practices, abortion clinics, pharmacies, and community organizations working in the area of reproductive health. I drew on publicly available resources, such as organizational websites and phone and community directories. I verified the

information collected in the database through phone calls and by driving through each case study area.

The lead investigators of the Ottawa Neighbourhood Study generously shared KML files with me that denoted the boundaries of each neighbourhood in the case study areas. I imported these into Google Maps and saved them as maps that I could edit. On each map, I marked the location of the reproductive health services I had identified and created a Word document to append that summarized the services. It was these materials that I used in my focus group and interviews with service providers, as discussed above.

When carrying out analysis in 2015 and 2016, I updated the information on the reproductive health service maps with new searches. At this time, I also revised the maps based on feedback from the focus group and interviews with service providers. The original maps, along with the updated versions are presented in the results section for each case.

Field Notes

Field notes in qualitative research provide a means to reflect on data collection experiences, document the ongoing evolution of thinking related to the issue under study, and make note of implications of particular interactions or environments for analysis (Green & Thorogood, 2009). I created field notes after every meeting with a participant or community organization, as well as during my journey through each case area during the mapping process. While I sometimes wrote notes by hand, I often found it easiest to document my thoughts verbally using my digital recorder and later transcribe them. Notes that I took by hand during interviews themselves were less frequently reflective. Rather, these served as prompts for a line of questioning and a back-up in case the digital recorder did not work.

Through my field notes prepared after meetings with participants, I captured on-the-spot impressions about the interview or focus group, key themes that surfaced, and their potential meanings. I also reflected on the environment (e.g., the area, the interview site, other people around such as children) and my feelings in relation to this environment and to the interview in general. For the most part, I integrated my field notes into the results and analysis of each case. This allowed me to present the findings in as much depth as possible. I also drew on the reflections captured in these notes during the integrated analysis across cases and as I considered conclusions, recommendations, and future directions for research. Later in this current chapter, I provide a section on Role of the Researcher in which I reflect on my position in relation to this research as well as a few special situations that occurred during data collection that I captured in my notes.

Data Management and Analysis

The data from interviews and focus groups were transcribed by myself or by one of two professional transcribers who signed confidentiality agreements to work on this project. Both of these transcribers had previously worked on qualitative health research projects in cross-cultural settings. One of them was fluently bilingual in English and French. Following every transcription, I re-read the entire document while I listened to the original recording. This served as a verification of accuracy and a way to continue to immerse myself in the data as I began to consider emerging themes. I transcribed notes from the interviews where I did not use a recorder, and also created a single Word document out of my collected handwritten field notes. In all transcripts, fieldnotes, and throughout this dissertation, the names of participants were replaced by pseudonyms chosen by me to protect their identities.

To manage the data generated from the interviews and focus groups, I imported transcripts into QSR NVivo 10. I used separate folders for each of the three cases and their relevant sources of data (transcripts for immigrant and refugee women and service providers, as well as PDF versions of the reproductive health services maps). For every interview or focus group I imported, I created a classification sheet that contained key demographic information for the participant(s) in question (e.g., African women or service provider, case study area, and if applicable, immigration category, length of time in Canada, age group, or service provider type).

I coded the transcripts to identify and label meaningful segments of text that helped address my research questions. This coding was informed by narrative content analysis techniques. In such analyses, care is taken to preserve important contextual information in participants' stories, rather than piecing apart brief, more isolated elements (Riessman, 2008). I adopted such an approach because it was consistent with my theoretical framework and feminist research methods. It also allowed me to capture detailed descriptions of the women's reproductive health experiences and analyze these in relation to the broader social structures, relations, and forces that influenced them in the various places with which they engaged. Longer segments of narrative were necessary to understand the flow of factors that affected their reproductive health, from migration story, to settlement, to home life, to health. Unlike in-depth narrative analysis, I investigated only the content of the stories shared rather than participants' speaking styles and the nature of our engagement during the interview/focus group (Riessman, 2008).

While I coded transcripts, I had open in NVivo a copy of the map of reproductive health services for the case study area. I used this map as a reference and occasionally made annotations directly onto the map. For African women, I kept an eye on services they mentioned, whether these were located in the case study area, and if they seemed aware of other services available in the area. I also paid attention to features they gave importance to that were not captured on maps of reproductive health services (e.g., transit routes, churches), and whether their narrative focused in general on the spatial distribution of the service environment or on other aspects of place (e.g., social networks at various scales, interpersonal relations). For service providers, I coded information about the accuracy of the map, their suggestions to present a more comprehensive view of services relevant to the reproductive health needs of African immigrant and refugee women (e.g., labs for ultrasounds and diagnostic testing, daycare centres), and comments about accessibility of these services (e.g., the willingness of a particular walk-clinic to accept refugee populations).

I organized codes into separate folders for each case and, within these, for African women and for service providers in order to keep their perspectives distinguishable. As I proceeded through my analysis, I checked the codes for overlap and consistency and organized them into more general themes based on similarity of content. Throughout, I used the memo function in NVivo to catalogue my thoughts about broader implications for analysis and discussion.

Following my analysis by case, I broadened my focus to consider the findings across cases. I took note of whether the themes identified for each case were consistent or different. I also reflected on what this meant for how place influenced and was shaped by African

immigrant and refugee women in relation to their reproductive health needs and challenges. In addition, I looked across cases to analyze how the perspectives of reproductive health service providers and the information presented in the map converged or diverged with those communicated by the women in this study. This was salient with respect to potential implications for how different types of evidence are used to inform interventions to support African immigrant and refugee women's reproductive health. Finally, I re-framed my analysis and used the demographic information in the classification sheets to explore the results by different social locations (e.g., immigration category, time in Canada, religion, language) rather than by places as solely defined by geographic boundaries.

This analysis was carried out as a continuous process throughout the course of data collection and writing. Early in my data collection I conducted a first round of coding on a few transcripts. This gave me a preliminary idea of emerging themes to explore in my subsequent interviews. I found, however, that the bulk of my time during data collection needed to be devoted to recruitment efforts and to transcription. While I did not return to focus on coding until the end of my data collection, I kept track of my analytical thoughts in order to document my reflections as they evolved. Following data collection, I carried out the bulk of my analysis. I continued to engage with and revisit the analysis process as I began to write my dissertation in order to add further depth and reflection.

Trustworthiness and Rigour

In qualitative research, the academic strength and quality of studies is discussed in relation to trustworthiness and rigour. This differs from traditional quantitative and biomedical approaches that emphasize the extent to which a study was conducted objectively or captured

generalizable “facts”. Trustworthiness and rigour relate to the extent to which the qualitative researcher thoroughly approached, documented, and presented results from the study to allow understanding of the complexity of the findings and the potential influence of particular assumptions and circumstances. Lincoln and Guba (1985) provide the following four guiding criteria to maximize the quality of qualitative studies: (1) Credibility – presenting an accurate portrayal of the issue under study; (2) Transferability – sufficiently detailing context so that readers may understand whether results may be relevant to other contexts or not; (3) Dependability – describing the research process so that others may carry out similar studies at different times or in different conditions; (4) Reliability – basing the analysis on the evidence rather than vested interests or pre-formed assumptions regarding the findings. To meet these criteria, qualitative researchers are encouraged to be explicit about the steps in their research and why they made certain decisions, be open about the theoretical framework that informed their work and their own position and assumptions, use multiple sources of evidence to explore the issue, engage research participants and communities to verify findings, and provide detailed description of the research process and the study context and findings in the final presentation of results (Green & Thorogood, 2009; Lincoln & Guba, 1985).

In my research, I undertook a number of these recommendations to increase the trustworthiness and rigour of my work. Throughout data collection and analysis, I kept field notes that documented my observations and reflections on my personal role and feelings in relation to the research. I discussed some of these reflections in Chapter 1 with respect to my position in relation to the topic, and expand upon them in this chapter with reflections on my role in data collection. Triangulation, or the use of multiple sources of data, was also built into

the design of this study. I gathered information through interviews with African women, interviews and focus groups with service providers, and maps of the reproductive health service environment for three different cases. This allowed me to better understand the reproductive health experiences of African immigrant and refugee women in relation to place. I carefully documented the steps in data collection and analysis throughout the progress of this research.

Additionally, after interviews/focus groups were transcribed I returned a copy to participants who so desired so that they could verify the account of our interaction. A focus group in each case study area to check emerging results with participants was originally planned. Concerns regarding privacy and time limitations expressed by participants during data collection, as well as the long duration of my data collection period led me to rethink this strategy. Instead, all participants who expressed interest were provided an electronic summary of findings and the opportunity to provide feedback directly to me. Emerging findings were additionally presented in academic venues (e.g., 2013 Canadian Public Health Association Conference). I will also engage some of the organizations with whom I worked in this research to arrange presentations of these findings to their broader communities. Study participants will be made aware of, and have the opportunity to provide feedback to me, at these meetings if they should desire. Finally, in this dissertation I have attempted to present each case and my analysis in a detailed fashion, drawing as much as possible upon direct quotes from the participants to support my analysis and interpretation of the results.

Role of the Researcher

The researcher in qualitative studies is acknowledged as a subjective being who collects and analyzes data while having an impact on the process. The qualitative researcher

approaches the work drawing on their own experiences, co-constructs interviews with their participants, and brings their perspectives and assumptions to the analysis process (Fontana & Frey, 2005). For these reasons, I reflected on my background and approach to this project in Chapter 1 of this work.

At this point, I return briefly to the topic to discuss situations that arose during data collection and analysis that caused me to reflect on my role as a researcher. In particular, these situations highlighted for me the ways in which qualitative research is a true interaction between people that is not neatly contained to the boundaries of the specific topic under study. I share two examples to illustrate this point.

The first example relates to my own experiences with pregnancy and birth during the course of this project. I was visibly pregnant, and then gave birth to my first child and took a 12-month maternity leave, during the data collection phase of this work. Much of my analysis was completed while pregnant with and following the birth of my second child. This dissertation was written while pregnant with my third child. My personal journeys through pregnancy, birth, and motherhood have coloured my interactions with the participants in this research as well as my interpretation of the data produced. As Sutherns, Bourgeault and James (2014) discuss, pregnancy and birth are phenomena that can affect the research participants and researcher, as well as understandings of the topic and the power dimensions involved in the work. This is particularly so because pregnancy and birth are embodied and have visible manifestations that are impossible not to reveal. My own experience mirrors the themes these authors raise. The fact that I was visibly pregnant during portions of my data collection seemed to put some women at ease. It also increased my awareness of topics to probe during

interviews and led to some interesting conversations that may not have otherwise occurred. Most memorably, after we had concluded our interview one woman asked about the sex of my baby. My response that I was having a girl led to her own confession that her husband had hoped their first child would be a boy rather than a girl. This increased my insight into the gender dynamics of her relationship and the pressures she was facing during her second pregnancy. In later interactions, women would sometimes ask if I had children myself if it had not already come up in conversation. This sometimes led them to comment that I would understand what they were talking about. From my perspective, and this extended to data analysis as well, I felt that I had increased knowledge about the support and services required for new mothers as well as some of the emotions and stresses that could arise.

A second example also illustrates the sometimes complex role of the researcher in qualitative studies. This case occurred as I conducted an interview with a refugee woman who was newly settled in a shelter. Our interview was carried out in her room with some of her children present. During the course of our discussion, one of the shelter staff interrupted with paperwork to enrol her children in school. The staff member spoke only English and the woman spoke French. After watching them briefly struggle to communicate, I intervened as unofficial translator for which they both seemed grateful. I continued to act as such for two follow-up interruptions during the course of the interview. Through these interactions, I received a glimpse into some of the day-to-day challenges faced by refugee women. This included an encounter with a well-intentioned staff member who nevertheless seemed frustrated by a perceived lack of urgency to enrol the children in school. I was also privy to the woman's comments to me after the staff member had left (e.g., on the many disruptions the

children had faced as they bounced between housing in the city).

These examples help to illustrate how, even though I entered as a researcher, my personal life and the broader concerns of the women were drawn into my interactions with the participants and my understanding of the topic. Sometimes this occurred through common points of rapport (as in the first example) and sometimes this occurred as a result of carrying out data collection within the personal spaces of the women (as in the second example). Regardless, they all informed my understanding of their experiences and my analysis of the issues.

Chapter 5: Case Study - Central Ottawa

In the three chapters that follow I present the results for each of the case study areas in turn, beginning with central Ottawa, followed by west end Ottawa, and finishing with southwest suburban Ottawa. The choice to structure these chapters by area is consistent with the multiple case study design of this research. As I discuss in earlier chapters, the original research design was influenced by a growing literature in population health on the effects of neighbourhoods on health (Ottawa Neighbourhood Study, 2011; Wasfi, et al., 2016). Although my theoretical framework recognizes a more complex understanding of place, the way that I planned the cases was shaped more strongly by the concept of location than by the social construction of place. Once I was engaged in data collection, location began to take on less importance as it became apparent that social relations were often more salient to the African women I interviewed. In the methods chapter of this dissertation, I briefly discussed the evolution in my conceptualization of the research topic. I provide the findings to support this evolution in the case by case presentation of the results chapters that follow. In the results, I also highlight themes related to the social construction of place that I will revisit in the integrated analysis and conclusion of this work.

To situate the reproductive health experiences of the African immigrant and refugee women, each results chapter follows a similar structure. First, I provide a brief narrative introduction to the case that helps to illustrate some of its local features. Second, I discuss the sample of the participants who contributed to the case study. This is followed by a profile of the case study area (e.g., size, location, socioeconomics, history with respect to newcomer

settlement). Next, I focus on the reproductive health service context. Within this section I discuss the number, types, and locations of services in the area. I also include the perspectives of reproductive health service providers on key issues that are faced by African immigrant and refugee women. The following section concentrates on the voices of the African immigrant and refugee women. In this section I provide a sample narrative from one participant and present key themes that I identified from my interviews with the women. In the final section of the chapter, I provide a brief summary of the consolidated results for the case study area and begin to consider implications with respect to the theoretical framework of this research. A more detailed comparison of the views of service providers and African women, as well as analysis across the three case studies, is reserved for the discussion I provide in Chapter 8.

Introduction to the Case

A walk through the central Ottawa case study area is a study in contrasts. In this downtown core of the city, social housing is mixed with condominium developments. The buildings of small non-profit organizations and drop-in centres are just down the street from notable tourist destinations and the mega offices of the federal government. Activities on the street range from the cell phone conversations and lunch-time plans of business people to the more subdued presence of the homeless population. As you travel westward through the area, you encounter the diverse sights, sounds and storefronts of Ottawa's Chinatown. Slightly south of that are Little Italy and, again, a mix of residential buildings interspersed with commercial and government spaces.

Its combination of socioeconomic heterogeneity, urban density and history distinguish this case study area from the other two in this research. As the oldest and most central, it is

host to a number of settlement services and temporary housing options. For many newcomers, it is a first stopping point within the city. In the sections that follow, I describe the research participants, context, and findings with respect to this unique case study area.

The Participants

For the central Ottawa case study, I conducted five interviews and one focus group with reproductive health providers who specifically targeted their work at populations in this area of Ottawa. These service providers were all women and included one community health/social worker, three nurses, one pharmacist and two physicians. I also drew relevant information from nine service providers who worked in more than one area of the city and who included the central area within that focus. These service providers included eight women and one man. They represented the following professions: community health/social worker (n=3), doula (n=1), midwife (n=2), nurse (n=2), and, physician (n=1).

In addition to the service providers, I interviewed six African women who lived in the central area. The socio-demographic characteristics of these women were as follows:

- Most of the women (n=5) were refugees. One of the women entered Canada as a voluntary immigrant.
- Three of the women had lived in Canada for five years or less. One woman had lived in Canada for between six and ten years, one for between 11 and 15 years, and one for more than 15 years.

- The women came from four different African countries from the eastern and central regions of Africa. These countries were: Burundi (n=1), Democratic Republic of Congo (n=3), Djibouti (n=1), and Tanzania (n=1).
- Native languages of the women included Somali, Swahili, Kirundi, and Tshiluba. All of the women also spoke at least one of English or French. Based on their stated preference, I conducted two of the interviews for this case study in English and four of them in French.
- Five of the women identified as part of the Christian faith, while one identified as Muslim.
- One woman had completed trade school, one had at least some college or university-level education, and the remainder (n=4) had a secondary school level of education or lower.
- The women's ages varied. One was in her twenties, one between 31-40 years old, two between 41-50 years old, and two between 51-60 years old.

Profile of the Case Study Area

For the purposes of this study, the central case study area was comprised of the Centretown and West Centretown neighbourhoods. Together, these neighbourhoods encompassed an area of approximately 5.2 square kilometres (see map in Figure 3, below). This mixed urban area reached as far north as the Ottawa River in places while being bounded at its southern edge by two of Ottawa's main roads (the Queensway and Carling Avenue). The Rideau Canal waterway, a historic site, tourist destination and source of recreational pathways

for residents demarked the eastern side of this area. The western portion of the case study area was defined by the O-Train line (Ottawa Neighbourhood Study, 2011). Within the boundaries of the central area were the Parliament buildings, a density of federal government buildings, mixed residential and commercial components, as well as Ottawa's Little Italy and Chinatown districts.

In 2011, approximately 37,700 people lived in the central case study area, for a population density of about 7,246 people per square kilometre. The people and housing in this relatively dense area helped to make it one of the most socioeconomically heterogeneous parts of the city. While 20.3% of households in the central case study area had an income of less than $20,000 in 2011, 11.4% of households had an income of over $125,000 (Ottawa Neighbourhood Study, 2011). More than three-quarters of the residents were renters, in housing that ran the gamut from subsidized housing to new developments. Some service providers expressed concern about a trend towards gentrification and one referred the area as "not terribly welcoming economically". Socioeconomic struggles were reflected in the fact that 31.4% of households spent more than 30% of their income on shelter, as compared to the Ottawa average of 22.7%. To help support the varied needs of the central case study population, social housing was abundant in the area. In 2011, 4,095 social housing units were present, a number far exceeding the Ottawa average of 229 (Ottawa Neighbourhood Study, 2011).

The service providers described how many of their immigrant and refugee clients were temporary residents of the community, housed in shelters or other provisional accommodations until they were more settled. Once able, some service providers felt that

newcomers who wanted more permanent, affordable family homes moved elsewhere in the city:

> *…you get women going to areas like Vanier. If they have found housing, maybe the Barrhaven area or they are going to off Montreal Road or you get people going to Orleans, Ogilvy Road, and Bayshore areas.* (Daphne, community health/social worker)

Immigrants represented 24.7% of the population of the central case study area in 2011, with 5.0% of the population being recent immigrants. Both of these numbers were above the Ottawa average. The West Centretown part of the case study area had a particularly strong history as an immigrant-receiving neighbourhood. Migrant flows to the area included waves of Italian immigrants around the time of World War II, and many Vietnamese refugees and Chinese immigrants starting in the 1970's (Ottawa Neighbourhood Study, 2011). Despite a reputation for and businesses related to a history of welcoming newcomers from Asian countries, several service providers felt that migration trends were shifting over time. In their opinions, the clients they were seeing were diversifying: "When I started…a third of our clients spoke only an Asian language, primarily Cantonese and Mandarin. That is evolving, those numbers are diminishing as the children of those people are moving" (Rachel, nurse). This view of a shifting clientele was reinforced by Erin, a physician, who said: "Not that many of the clients that we see lately, especially immigrants, are new, new arrivals from China or Vietnam. A lot of Middle Eastern, North African women, I would say that is the two bigger populations".

Some of the service providers also described the varied socioeconomic circumstances of the women who arrived from Africa. They discussed how this socioeconomic profile differed from prior waves of immigrants to the central area of Ottawa. Implicated in these differences, according to the service providers, were women's histories in their countries of birth, the

reasons for which they left, and their pathways to Canada (including, for example, the length of time they had spent in refugee camps and the related disruption to educational and career paths). One provider spoke about newer refugees to the area, some of whom were fleeing the relatively recent civil wars, violence, and political instability in Congo and Burundi. She contrasted these refugees to an older wave of refugees, the Karen people, who had long been displaced as a result of their independence struggle with Myanmar:

> *One of the physicians I work with said, "We are seeing a bit of change aren't we?"…The people who are coming now are very well-educated. So especially from Congo, Burundi, these are the well-educated…We had a lot of Karen people come…The Karen population is not well-educated. The have been living in refugee camps for 15 or 20 years. Also they were a rural agricultural people as opposed to some of the people that are coming from Congo who were maybe in the government or had businesses and things like that, who are just not able to continue because of the violence in their country.* (Colette, nurse)

Reproductive Health Service Context

Narrowing in from a general profile of the central case study area, in the following section I paint a picture of the reproductive health service context. To this end, I present two sub-sections: (1) a map of the reproductive health service context in the central area, including comments on the map that were raised in interviews and focus groups with the reproductive health service providers; and (2) service provider perspectives on the key issues and challenges faced by African and immigrant refugee women with respect to their reproductive health.

Map of the Reproductive Health Service Context

Near the end of each interview or focus group with service providers, I shared the map that I had created of the reproductive health services in the area (Figure 3, below). I used this

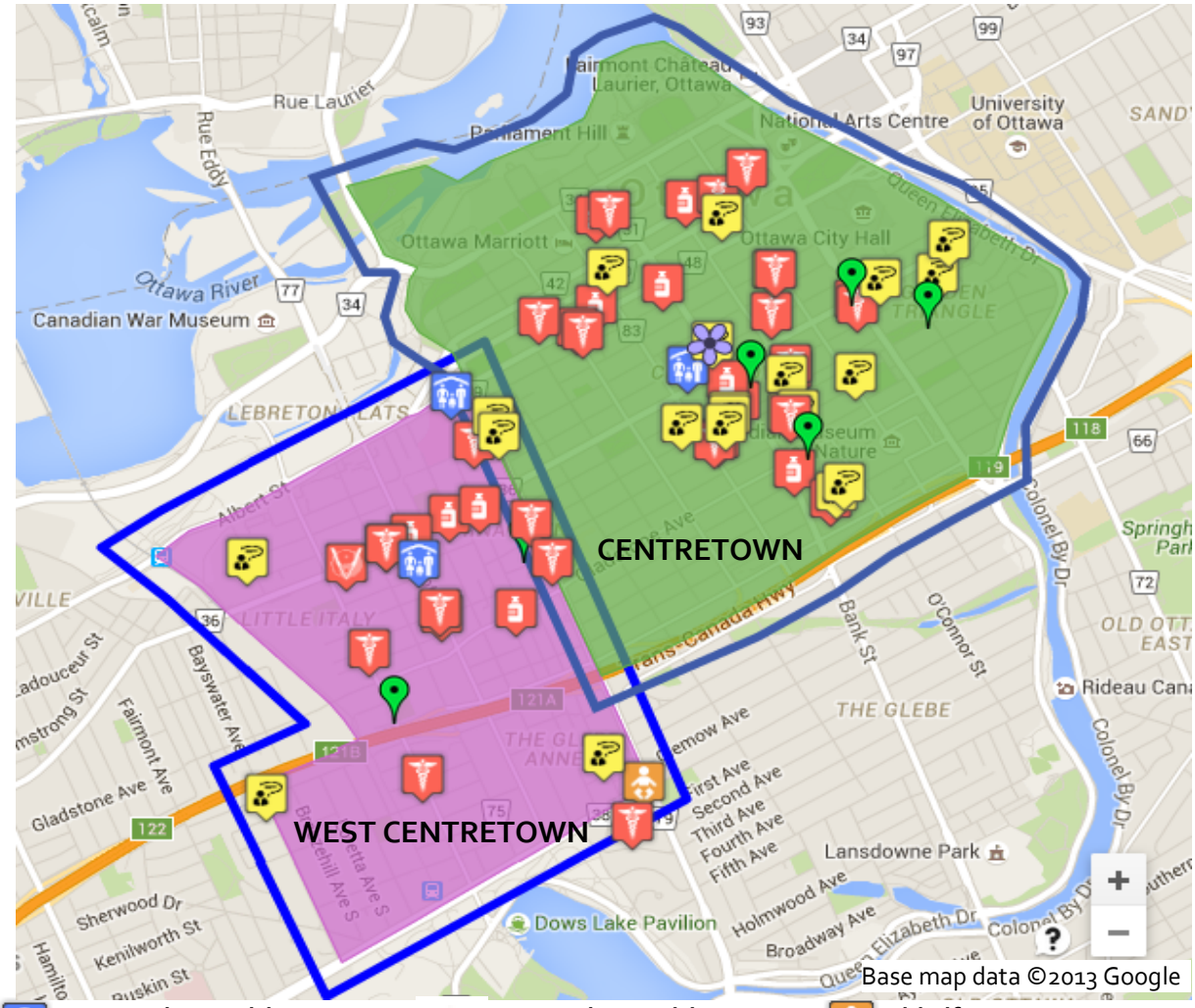
map as a tool to deepen our discussion of the context in which African immigrant and refugee women experienced their reproductive health.

The density of this urban area was evident in the map. I identified a high volume of services (e.g., 25 physicians' practices and two community health centres). A diversity of services was also notable (including, for example, a midwifery group and several non-governmental health organizations active in the area of reproductive health). Rather than clustered in selected portions of the area, the services were dispersed fairly uniformly. A number of the organizations provided programs that were targeted at newcomers. Some of these programs had direct inclusion criteria related to migration status. Others indirectly included newcomers (e.g., by focusing on socially isolated populations, those living in poverty, and/or people who lacked health insurance).

The providers all felt that the map gave an accurate representation of the reproductive health services in the area. Some commented on the relatively high number of services as compared to the availability in other parts of Ottawa. The general walkability of the area was also raised. This aspect, combined with the grid-like layout of the streets, was perceived as an asset for navigation: "The streets all meet at right angles, which is actually a really big thing if you are trying to explain to someone to go down this way and then turn there" (Erin, physician).

Several of the several providers also suggested additions to the maps. Some of these additions were health services (e.g., laboratory and diagnostic services for blood work and ultrasounds). Other providers made recommendations that showed that they viewed a broad range of services beyond traditional health care as relevant to the reproductive health of immigrant and refugee women (e.g., settlement agencies, child care services, bus routes).

Figure 3. Reproductive Health Service Map of the Central Case Study Area – Initial Mapping



Community Health Centres
- Centretown CHC
- Somerset West CHC

Pharmacies
- Al's Care Pharmacy
- Bell Pharmacy
- Independent Grocer Pharmacy
- Kent Medicine Shoppe Pharmacy
- Lyan Pharmacy
- Minto Place Drug Mart
- Ottawa Medical Pharmacy
- Pharm Can Drug Mart
- PharmaChoice
- Rexall (x2)
- Shopper's Drug Mart (x4)
- Somerset Drugs
- Tue Uyen Drugs Ltd

Community Health NGO's
- AIDS Cmtte. of Ottawa
- Bruce House*
- Pink Triangle Services

Physician's Offices
- Appletree Medical Centre (x2)
- Central Ottawa Family Medicine
- Heart of Ottawa Medical Centre
- Ottawa Newcomer Clinic
- Primrose Family Medicine Centre
- Other Physicians' Practices (x19)

Traditional Medicine
- Chinese Traditional Acupuncture & Natural Medicine Centre

Midwifery Groups
- Midwifery Group of Ottawa

Adoption Services
- Adoption Council of Canada

Counselling Services
- Bereaved Families of Ottawa
- Holy Family Centre
- House of Hope and Healing
- Immigrant Women Services Ottawa
- Pastoral Counselling Centre
- Private Counselling Practices (x37)

Alternative Medicine
- Integral Health Clinic
- Naturopathic Doctors (x5)
- Somerset Health & Wellness

*Note: Bruce House provides housing and support services for people affected by HIV/AIDS

INVISIBLE LAYERS – WHAT THE MAP DID NOT PORTRAY

As the service providers and I discussed the map together, it became clear that many of them filtered what they saw through layers of knowledge regarding the accessibility of the services for their immigrant and refugee clients. In their experience, the mere presence of services did not equate to accessibility; reality was much more nuanced and complex. Accessibility varied depending on, for instance, migration category of entry to Canada and associated health care coverage. Refugee populations sometimes found that not all health services accepted their Interim Federal Health benefits. As a result, Elizabeth, a physician, stated: "I would not even care that there was a pharmacy unless you said familiar with IFH [Interim Federal Health]".

Lorraine, also a physician, further layered on the element of time. She discussed how the map of available services looked very different depending on the day of the week or whether or not regular working hours were in session: "Primary care is not open on weekends…so for the vast majority on the weekend they are left to Appletree [walk-in clinic] or the Ottawa Hospital. And for evenings too…"

Partnerships, informal or formal, within the case study area and across the city, were used as a strategy by the service providers to help their clients. Based on their experiences in the field, providers seemed to hold network maps in their heads of organizations that were welcoming to their clients. Rachel, a nurse, explained that settlement agencies made efforts to link refugee women into a system of services that would accept them:

> *I would say most or all of the refugee settlement agencies know about us and they will say: "You should go to the nearest community health centre because they will accept your Interim Federal Health coverage". Interim Federal Health benefits should be accepted anywhere in Ontario. Realistically,*

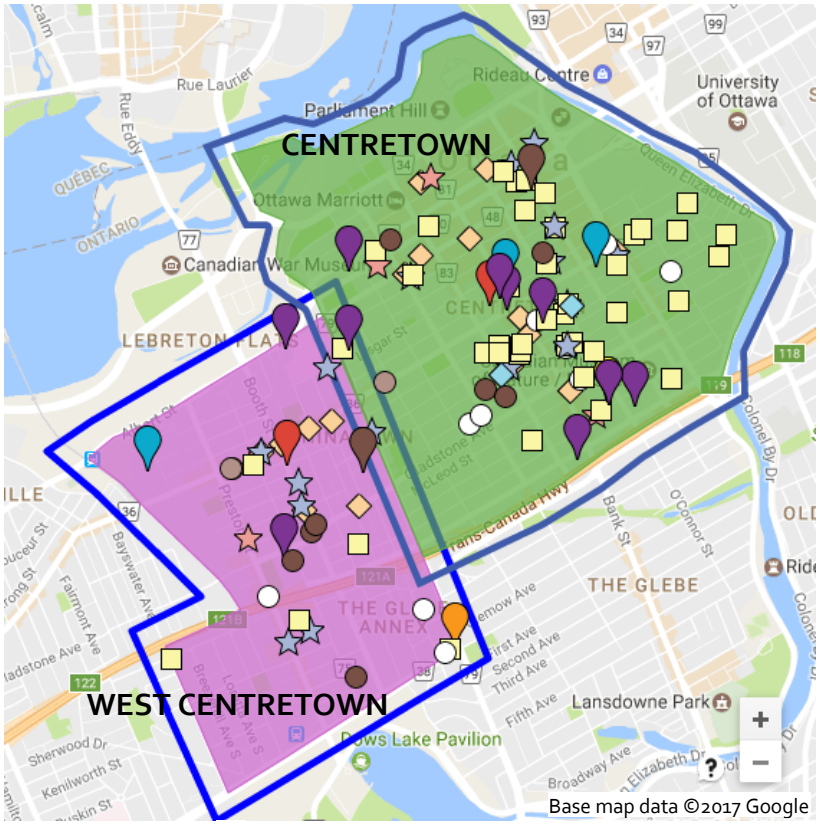
though, a lot of walk-in clinics will not take them…or they will charge a fee of $75 up front for forms completion.

A final component that was absent from the map was the dynamic nature of the work carried out by many of the reproductive health service providers. Although a fixed central office was often a necessity, many of the reproductive health services offered were not static. Home visits and community outreach took place at shifting locations and were viewed as central to making services more accessible for newcomers. These activities were particularly characteristic of the midwives, community health/social workers, and some of the nurses.

During the analysis stage of my research, I revised the reproductive health service map according to the comments I had received (Figure 4, below). This modified map included the additional categories of services that were identified by the service providers across the case study areas (e.g., ultrasound and blood labs, child care services). I also attempted to visually identify, albeit in a limited fashion, those services that were more accessible to some immigrant and refugee women (e.g., by distinguishing between walk-in clinics and the offices of independent physicians, by highlighting services that were free). In a different and more dynamic format, I recognize that other axes of differentiation could have been added to show how accessibility changed depending on other factors identified by the service providers (e.g., by time of day, by type of health coverage accepted).

To address comments about accessibility by public transit, I created a separate map (Figure 5, below). This map showed a number of bus routes, along with the local train system, that travelled through the case study area. These routes also provided access to other parts of the city in all directions. Public transit availability was further increased along the main roads during peak commuter hours.

Figure 4. Reproductive Health Service Map of the Central Case Study Area – Revised



Community Health Centres (FREE)
- Centretown CHC
- Somerset West CHC

Walk-In Clinics
- Appletree Medical Centre (x3)
- Ottawa Newcomer Clinic

Independent Physician Offices
- Booth Family Medicine
- Central Ottawa Family Medicine
- Heart of Ottawa Medical Centre
- Primrose Family Medicine Centre
- Other physicians' practices (x18)

Ultrasound & Blood Labs
- CML Health Care
- Gamma Dynacare
- Life Labs

Traditional Medicine
- Chinese Acupuncture & Herbs Centre
- Chinese Traditional Acupuncture & Natural Medicine Centre
- Shen Nong Chinese Medicine Centre

Alternative Medicine
- Alternative medicine practices (x10)

Midwifery Groups (FREE)
- Midwifery Group of Ottawa

Community Health NGO's (FREE)
- Bruce House*
- Kind*
- Ottawa Victim Services

Pharmacies
- Al's Care Pharmacy
- Bell Pharmacy
- Kent Medicine Shoppe Pharmacy
- Independent Grocer Pharmacy
- Lyan Pharmacy
- Minto Place Drug Mart
- PharmaChoice
- Pharm Can Drug Mart
- Rexall (x2)
- Shopper's Drug Mart (x4)
- Somerset Drugs

Psychiatrists & Psychologists
- Psychiatric practices (x37)
- Psychological practices (x54)

Counselling Services (FREE)
- Immigrant Women Services Ottawa
- Rwanda Social Services & Family Counselling

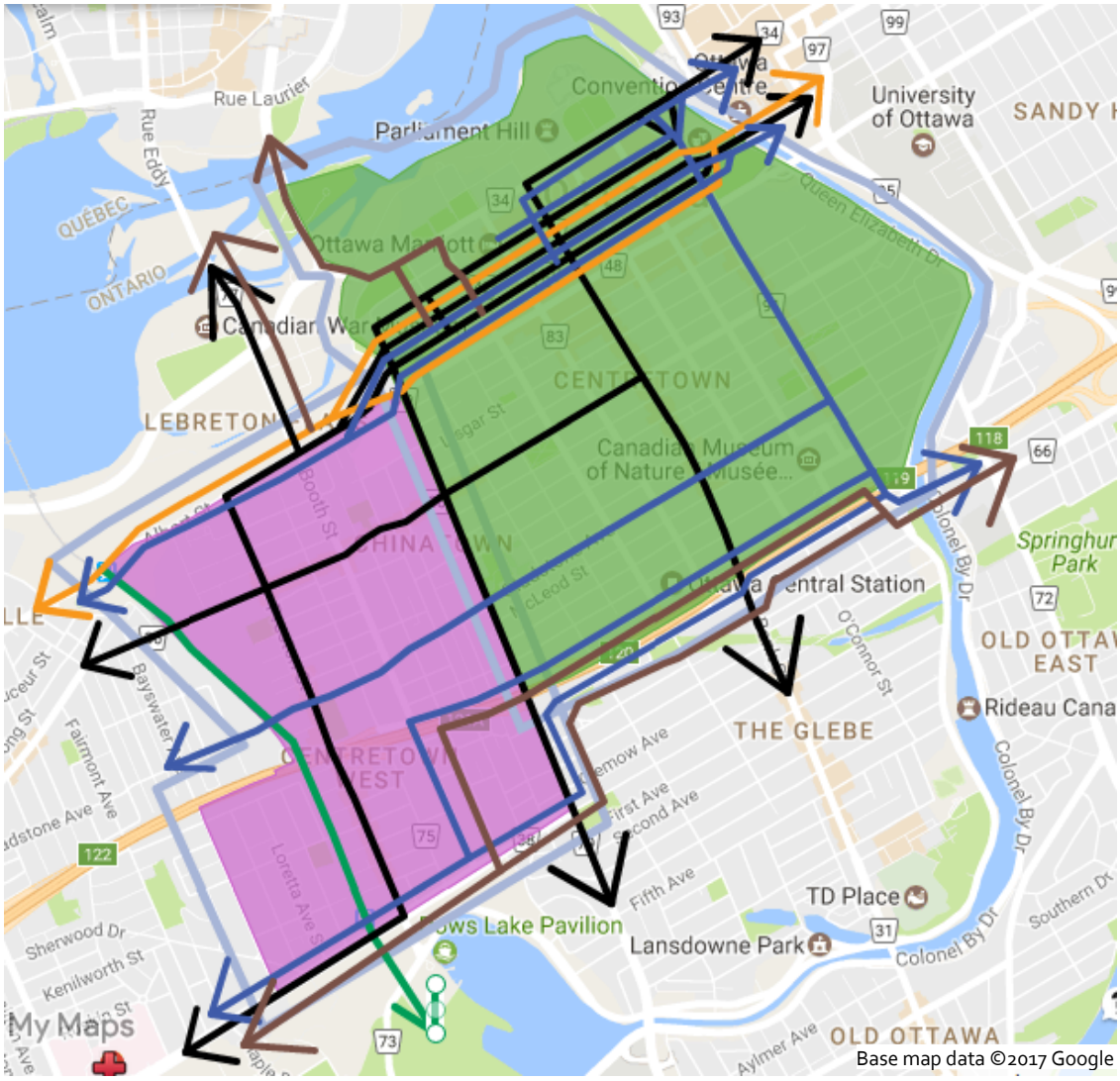
Settlement & Related Services (FREE)
- Catholic Centre for Immigrants
- Immigrant Women Services Ottawa
- Language Instruction for Newcomers (x8)
- Muslim Family Services of Ottawa
- Rwanda Social Services & Family Counselling
- YMCA-YWCA Newcomer Centre
- World Skills Employment Centre

Family Services (FREE)
- Ottawa Public Library
- Parenting & Family Literacy Centre

Other Family Services
- Child care centres (x8)

*Note: Bruce House provides housing and support services for people affected by HIV/AIDS. Kind, formerly known as Pink Triangle Services is an LGBTTQ+ community centre.

Figure 5. Public Transit (Bus & Train) Routes that Serve the Central Case Study Area



Legend

Local routes (black and blue lines). Buses make frequent stops. Intervals of departure vary, typically between 15 minutes and 30 minutes.

Transitway routes (orange lines). Buses make fewer stops and travel at times along dedicated roads. Intervals of departure vary between 5 minutes or less and 30 minutes.

Peak routes (brown lines). Buses travel only on weekdays at peak commuter times. Intervals of departure vary, often every 15 minutes.

O-Train (green line). Trains typically depart at 15 minute intervals.

Arrowheads (any colour). Indicate that the route continues in the direction indicated.

Note: The information contained in this map was derived from the website of OC Transpo (OC Transpo, 2017)

Service Provider Views on Key Issues and Challenges

In addition to insight into the service context of the case study area, I asked service providers for their perspectives on the key issues and challenges that were faced by African immigrant and refugee women with respect to their reproductive health. Based on my analysis, I grouped their comments into the nine main themes below. The order in which I present these themes flows generally from the history of the women, to their interactions with the service system once in Canada, to the broader concerns that affect those interactions.

DIFFERENT STORIES, DIFFERENT NEEDS

The African immigrant and refugee women that service providers met in their work had different home country circumstances and experiences that led to their migration. These different stories translated into varied reproductive health needs once the women were in Canada. Many of the service providers focused their discussions on the refugee populations with whom they worked as opposed to voluntary migrants. They drew further distinctions between "GARs" (government assisted refugees) and "claimants", while not speaking specifically about refugees who entered the country with private sponsorship. Government assisted refugees to Canada are officially admitted while still abroad and know their status when they enter the country. These refugees are provided with temporary financial assistance from the federal government once in Canada and receive health and prescription drug coverage under the Interim Federal Health Program until they are eligible for provincial health insurance. Refugee claimants, on the other hand, enter Canada first and hope that their submission to the Immigration and Refugee Board of Canada will be accepted. Refugee claimants are also covered under the Interim Federal Health Program (CIC, 2016).

One service provider discussed how government assisted refugees may have spent time in refugee camps. In these settings, these women may have received basic health care and access to birth control: "Depo-Provera, I think, was very much available in the camps. But these are my GARs, they are not my claimants" (Elizabeth, physician). Refugee claimants, on the other hand, may have fled their countries under acute circumstances and travelled immediately to Canada. Service providers discussed how, in some cases, women arrived close to term in a pregnancy and dealt with "the stress of their hearings" in addition to other health and settlement challenges.

According to a number of the service providers, histories of trauma and violence, including sexual violence and rape, were also key issues that they considered when they worked with refugee women. These traumatic experiences led to a host of repercussions for the health of women, which potentially included post-traumatic stress disorder and a lack of trust in formal services. Service providers discussed how it took time for some refugee women to feel comfortable and secure enough to approach and use formal services:

> *They come and sometimes they ask for a photocopy because they are so scared that something will happen. That is their only security and they are collecting photocopies of everything…the prescription, the receipts, the drug card…they are so scared that they are going to again lose something…* (Sonya, pharmacist)

Refugee status and histories of trauma, however, should not be interpreted as a past without formal education or financial stability. Service providers discussed the variety of socioeconomic and educational backgrounds among their immigrant and refugee clients. Some of their clients obtained numerous university degrees and held well-paying jobs before they were forced to flee their countries. Listening to the stories of newcomer women and avoiding

assumptions were mentioned as important by a number of the service providers. In doing so, the service providers sought to understand the broader circumstances that surrounded immigrant and refugee women's actions and needs related to reproductive health: "…when you see these women not access services, what are her priorities? What is going on for her mentally, you know? What is she, what is she dealing with?" (Eunice, community health/social worker)

EXPECTATIONS & PAST EXPERIENCES WITH HEALTH AND HEALTH CARE

Flowing from the unique histories and needs of African immigrant and refugee women, the service providers also discussed their clients' varied expectations and past experiences related to health care. A primary concern of a number of service providers was that many of the women they saw had had very little or no preventative reproductive health care. Migration trajectory was sometimes identified as the reason behind this (e.g., for pregnant refugee women who had not had the opportunity to seek prenatal care). For other African women, and depending on the health infrastructure, system, and practices in their birth country, service providers felt that the concept of seeking health care for preventative purposes was a new one:

> *…it varies again by group of where people are from, but generally the notion of preventative care is pretty foreign to a lot of the women. So the whole idea of continuing to come afterwards and starting pap screening, often it will be the first time that they have had a pap smear either in the pregnancy or postpartum. And the idea that you keep coming back for this is not—the idea of seeing a doctor when you are not sick is not a usual concept.* (Erin, physician)

In light of this prior lack of preventative care, service providers were often faced with a number of health issues that needed to be prioritized and addressed. They discussed cases where months of prenatal care were compressed into just a few visits. This included the

challenge of determining the gestational age of a pregnancy in the absence of prior medical records. Rachel, a nurse, described how happy some of her clients were when introduced to solutions for what may have been long-term, untreated reproductive health issues:

> *…there are a lot of untreated infections like, you know, yeast infections and bacterial vaginosis that are not necessarily, well, they are not life-threatening but they are very uncomfortable. And when I say to them, this is why you are so itchy and it is easy for us to fix, you just put that there…surprised and delighted.*

LINKING INTO & NAVIGATING THE SYSTEM

Another main theme that I identified was the importance that all the service providers placed on linking their clients into the service system (health, settlement, etc.). Providing education and guidance to successfully navigate this system was viewed as an important component of the service providers' work with newcomers. Eunice, a community health/social worker, described how understanding the Canadian health care system could be a challenge even for well-educated African immigrant and refugee women. With its separate and specialized organizations for particular health services (e.g., drugs from a pharmacy, blood tests from a lab), the Canadian system was described by Eunice as quite different from that found in certain African countries:

> *They come from a system that they understand very well…In most African countries when someone goes to see a doctor, they go to a hospital…Everything is there…You get what you need, you go home. So when people come here they go to a doctor's office which is, which looks like an office…They go in and see a doctor and the doctor gives them a piece of paper, whether it is a prescription or a lab request…I have spoken to people and they say, "I went there and they did nothing to me, they did nothing for me. They gave me a piece of paper and I actually threw it in the garbage because I told them I was sick and they did not even give me medicine"…"That is your prescription!" "Okay, it is a prescription but where do I take it?"*

Seven of the service providers specifically discussed strategies they used to help clients through the system. Examples of such strategies included providing maps to show how to get to a service, detailing bus routes, stapling all necessary forms together, and describing as concretely as possible who they would meet and what would occur at the next step in their journey.

The physical aspects of getting around from service to service were also highlighted. Even within this case study area that was relatively dense, walkable and well-served by public transit traveling to services was identified as a potential issue for some women. This was viewed as especially pertinent for women trying to do so with limited knowledge of English and/or while caring for one or more children:

> *…access is a huge barrier, like transportation, trying to understand the bus system. I have a hell of a time with the bus system and I speak English. So, and particularly if she has got a baby in a carrier and a toddler by the hand, trying to take a bus to get to us is, especially if she has to make a transfer…it is a nightmare.* (Rachel, nurse)

Such navigation was perceived as additionally hindered by exclusionary attitudes and practices that racialized immigrant and refugee women sometimes encountered within the service system or broader community. Service providers mentioned that some African women experienced: an unwillingness of some walk-in clinics to see refugee patients covered under Interim Federal Health, discriminatory assumptions related to education due to migration status or accent, and/or judgment related to their HIV/AIDS status or conjecture thereof:

> *…the women who come with HIV, a lot of them have stories of, they are sponsored refugees because their countries are in crisis and a lot of them came to here, we have heard stories about rape…and so sometimes you hear people say, "Oh, these immigrants are bringing AIDS to Canada." You have no idea, you know. It is terrible.* (Eunice, community health/social worker)

Despite steps they took to foster relationships with other organizations to facilitate continuity of care, some service providers worried that immigrant and refugee women occasionally got lost in the system or abandoned their efforts completely. This was cited as a particular concern for those women who may have experienced discrimination and for women who moved to a different area of the city in search of more affordable, permanent housing.

CREATING COMFORTABLE, ACCESSIBLE & RESPECTFUL SPACES

In order to ease entry to and use of the health care system, the service providers sought to create comfortable, accessible and respectful spaces in which to meet immigrant and refugee women. Some of this was facilitated by professional roles or models of care designed with the needs of such populations in mind. For instance, community health centres had specific mandates to serve marginalized populations. They also included social workers and interpreters within their holistic approach to health. Clinicians within community health centres, as well as midwives, spoke about the increased length of time they had to spend with patients as compared with practitioners who worked in independent clinics. Such time was seen as crucial to an environment in which they tried to listen respectfully to the complex stories and needs of immigrant and refugee women. They also often had to work through more than one issue in a single visit.

Gender of the practitioner emerged as an issue related to this theme. The midwives discussed how they were sometimes the provider of choice due to an association of midwifery with female care provision. In their view, the perception and reality of midwifery offices as predominantly female spaces facilitated a degree of comfort and freedom among some of their African immigrant and refugee clients:

> *…many of our Muslim clients who come…they have been to us for several babies now and they come in and they whip off their hijabs. It is like they just undress and relax in our office and it is like, okay, let my hair down. You know, we are woman to woman together, so that is kind of wonderful.* (Isabel, midwife)

INCLUDING & BEYOND REPRODUCTIVE HEALTH

All of the service providers discussed the many and varied needs of the newcomer women they worked with. Specific reproductive health needs covered the spectrum of the field, including pap screening, contraception, abortion services, STI testing and treatment, and prenatal and postpartum care. Within these discussions by service providers, the reproductive health needs of the women intersected with other priorities related to the migration and settlement process. As Daphne, a community health/social worker, described for refugee claimants: "…almost everything has to be analyzed in how to get help, how to get education, just about anything and everything. So with that comes years of trying to integrate…in areas of education, of housing, of getting jobs."

From the discussions of the service providers, mental health was raised as a particular area for attention alongside physical health and concerns related to the settlement process. For refugee populations, mental health was raised as an issue in relation to the ongoing impact of past traumas. Concern for mental health was also spoken about more generally for all newcomer populations. It was affected by stress due to financial instability, changes in sense of self and social status (e.g., in being unable to find meaningful employment appropriate to level of education), and separation from social support systems the women had been used to in their countries of birth.

LANGUAGES, RELIGIONS, & CULTURES OF CLIENTS & PROVIDERS

Languages, religions, and cultures of both clients and the providers themselves surfaced explicitly and implicitly as a theme during the interviews and focus group. With respect to African women, these issues were spoken about in relation to impact on access to services, comfort in health care settings and with providers of different genders, and acceptability of various reproductive health options (e.g., prenatal genetic testing, abortion). Within these discussions it was clear that the providers worked and struggled with their own languages, cultures, and religions as they sought to provide appropriate and respectful care for their clients. These topics are elaborated upon below.

Language, in particular, was identified by the service providers as a key factor. Proficiency in Canada's official languages was felt to partially structure the services immigrants and refugees were able to easily access in Canada. It also affected their ability to effectively communicate their needs:

> *No matter where they are coming from, if they do not speak either French or English, that is enormous…if they do not have either of those two languages then that is huge. It is very difficult for them to access services. It is certainly not impossible. If they are linked with the right agencies they get a lot of help, but it is that initial linking of agencies.* (Sheryl, nurse)

As Sheryl raised in the above quote, while reproductive health services with language interpretation existed, not all immigrant and refugee women were linked into these programs. Other service providers also spoke about the health system's capacity to provide language interpretation. This varied from the ability to hire professional interpreters (e.g., at community health centres), to a reliance on the efforts of staff who spoke multiple languages themselves (e.g., at a local pharmacy). The providers generally agreed that the use of professional

interpreters worked well in most circumstances. On the other hand, one described a case in which a woman preferred to try to communicate without an interpreter out of fear that her HIV positive status would become known in her cultural community. In addition, the availability of interpretation services varied depending on the time of day:

> *…often the language translation conditions are quite good during the day at the office. It is very different in the middle of the night when people go to the hospital to have their baby*. (Erin, physician)

In situations where professional interpretation was not available, service providers described having done the best they could or occasionally having relied on family members, including the children of their clients. While sometimes necessary, several of the service providers expressed discomfort with this last option due to uncertainty that information was interpreted with the same tone and accuracy as intended. This was raised by some as a particular concern when potentially intertwined with the gendered power dynamics of husbands interpreting for wives:

> *I have a bit of an issue with the husband translating many times. Our philosophy of care in midwifery is informed choice, and we like to be able to provide full information about a whole host of tests and procedures and to be sure that the woman understands it and that it is her choice to do this or that.* (Isabel, midwife)

Issues raised by service providers in relation to language flowed into discussions of cultures and gender roles. Some of the service providers described a sense that, in some of the African cultures with which they interacted, the women "had very little power". For this reason, they searched for opportunities to speak to women alone, without husbands present. Issues that were perceived as desirable to address with women by themselves included: how to negotiate condom use with male partners, determining whether abuse was present in the

relationship, and clarifying a woman's desires with respect to contraception and the number of children she wished to have. Some service providers felt this last point was intertwined with values in certain African cultures whereby "having children is extremely important". Women were also described as often shouldering the primary responsibility for the domestic and childrearing work that came with having more children. Two providers also discussed cases where they had worked with African women who had experienced female genital cutting as a cultural practice in their countries of birth. They described how institutional policies had been specifically developed to provide guidance to service providers on how to approach pelvic exams, childbirth, and potential requests (often from husbands) to re-sew women after she gave birth.

All of the community health/social workers also cited a "taboo" related to reproductive health among the African communities with whom they worked: "…anything related to reproductive health you cannot talk about in the open. It is nobody's business" (Dominique, community health/social worker). Dominique continued on to discuss how, for some women, this taboo made it "very difficult for them to speak" and disclose past traumas in order to seek help. Daphne highlighted how such taboos were compounded in situations where newcomer women were not able to find consistent primary care providers. With no other options, women were required to rely on the walk-in clinic system. This led to inconsistency in care providers and difficulty in cases where female practitioners were preferred:

> *They are asking about sexual history, and these are male doctors…You have to be talking about your male partners, when you last had intercourse, and protection you are using. All those sound like very basic questions, but when applied to African women they are not basic at all. Women just clamp up, because in the first place discussions of sex are taboo. Discussions of sex with the opposite sex are worse than taboo…The process would have been a whole*

lot easier if you had access to consistent care…because then you would not have to be repeating yourself…

Evident in some of the discussions with service providers were their efforts to negotiate their own cultural beliefs. This seemed to be particularly related to gendered norms and practices that differed from dominant views of women's rights in Canada. Service providers strove to understand the circumstances and desires of the women with whom they worked, while also trying to provide them with the best support they could. Related to this, I also identified the provision of culturally competent care as a central theme. Listening to and respecting patients was identified as an essential feature of providing such care. Among cultural considerations for some African women, and in addition to those already discussed, service providers cited a respect for medical authority that may limit practitioners being questioned, strong and supportive traditions of childbearing and breastfeeding, religious beliefs related to genetic testing in pregnancy and abortion, and extended family and community support following childbirth. As Colette, a nurse, described, providing culturally competent care also involved critically examining taken-for-granted assumptions about how things were done in the Canadian health care system:

…if you are trying to figure out their medical history…sometimes you think they do not understand because they are describing this and this and this and this…I think we have kind of learned that, wait a minute, that is our idea of how you get a history…whereas in other cultures the idea of the individual is not, it is kind of obscure. You are really having to look at the whole family and what is going to work for the whole family.

SOCIAL NETWORKS AND SUPPORT

Social networks and support was a key theme I identified from my conversations with the service providers. This support was cast as either the presence or absence thereof, and

social networks were discussed in terms of both positive and negative effects for immigrant and refugee women. Some service providers perceived among their clients: connections to church communities that helped the women to settle into Canada, a "sisterhood" in shelters that collectively supported each other with childcare needs, cultures of community support following childbirth that eased postpartum healing and isolation, and/or word-of-mouth cultures that could be leveraged for outreach efforts.

Alongside these positive aspects of social support, some of the service providers also discussed how such community cultures could work negatively. This was seen as the case for women who faced stigma from those communities (e.g., in relation to HIV status) and/or financial strain related to repeated obligations to provide support for others in their cultural community as well as for families back home. Social isolation was also an issue if women were not connected to social networks in Canada and were used to relying on the supports provided by extended families and community organizations such as churches. Such isolation from social networks could be compounded by a lack of awareness of or inability to go out to access services, as well as by less than ideal housing arrangements. As Elizabeth, a physician, remarked with respect to living in a shelter: "they still have to go back to that little room at the end of the day".

LAWS AND POLICIES

Although the service providers discussed their micro-interactions with women as well as the day-to-day circumstances of these women in the local context, broader forces and factors were focused on as well. In particular, the service providers identified how immigrant and refugee women negotiated their reproductive health within a system of laws, policies, and

regulations that affected their rights, their health care coverage, and the practices of the institutions with which they interacted. Within this system, service providers described the impact of such structural level factors on the daily lives of their clients. One community health/social worker, for instance, spoke passionately about Canadian laws that have been used to criminalize HIV positive women who breastfeed their children. She painted a picture of HIV positive women from Africa caught between carrying out a potentially illegal activity and being ostracized from cultural communities in which HIV was stigmatized and breastfeeding was the expected norm. This discussion was set within the further context of international health recommendations that supported exclusive breastfeeding by women in Africa itself. This was the case even for HIV positive women in Africa, when carried out in combination with the consumption of antiretroviral drugs by both mother and infant (Langa, 2010). In the words of the community health worker, despite scientific evidence that pointed to only a small risk of transmission of HIV from mother to child through breastfeeding, African women in Canada were seen as having other choices while "the argument is the women in Africa do not have an option" (Eunice, community health worker).

Other service providers raised challenges immigrant and refugee women faced in light of their health care coverage. For refugees, this discussion focused on the Interim Federal Health system and the struggle to find providers willing to undertake the paperwork involved in processing claims with the government. Policy changes to Interim Federal Health were perceived as exacerbating this barrier, leaving services providers "confused" about who and what was covered.

Recently arrived immigrants may have a complete lack of health coverage if within Ontario's three-month waiting period for provincial health insurance (OMHLTC, 2011). Even within care models with flexibility to help the uninsured, service providers spoke about the occasionally unpredictable nature of labour and birth processes. As such, women sometimes incurred large expenses for unexpected trips to the hospital. While the newborn babies of these women were deemed Canadian citizens and had their health care expenses covered, the women themselves did not:

> *…midwifery groups are compensated by the Ministry of Health and Long-Term Care…so we do get a fair number of referrals for people who don't have OHIP…so many of them will say, we are planning to have a home birth because they want to avoid the fees…The last person we had in this situation, she laboured at home for quite a few hours and after there is no progress for a number of hours you say, well we have done everything we can…and we went into the hospital. It was an emergency…and ultimately the poor woman ended up with a caesarean section. I mean, that is the most expensive. The anaesthetist and the obstetrician require money up front.* (Isabel, midwife)

It is policy in the province of Ontario for hospitals to provide emergency services to those in need without first verifying OHIP coverage or payment information. If uninsured, patients will typically receive a bill for the fees incurred following treatment (MOHLTC, 2012). As Isabel suggests above, there may be instances in which official policy is not always followed in practice.

SERVICE PROVIDER NEEDS & RECOMMENDATIONS

At the end of the interviews and focus group, I asked service providers what they recommended to better support their work and the reproductive health of African immigrant and refugee women. At the more structural level, some providers focused on the need for funding. One service provider described how services targeted at immigrant and refugee

populations were “scrambling for funding”, while others spoke about waiting lists for new clients. In the context of cuts to Interim Federal Health coverage at the time of data collection, some of the service providers argued for the repeal of these changes in order to ensure adequate care for their patients. In the realm of policy as well, other providers raised the issue of gaps in prescription drug coverage in Canada (e.g., in the context of birth control pills). Even if their clients did have coverage for prescription drugs, some of the reproductive health organizations took steps to supplement this coverage and provided funding for non-prescription items (e.g., prenatal vitamins for women of childbearing age, vitamin D for breastfed babies).

Other recommendations from service providers focused on additional services to meet the needs of newcomer women. These recommendations recognized that women’s reproductive health and wellness was affected by their broader settlement experiences and family lives (e.g., English language classes, accessible recreation classes for children). Help navigating the system was also raised. One provider suggested the need for better and more integrated “case management” to support women in their interactions with various health and social services. This physician recommended a “tour guide” to accompany and orient women. Another service provider suggested better communication could be fostered through a “circle of care” of health and social services so that clients were not lost.

More specifically focused on health, recommendations included: the need for more accessible mental health services, available and consistent counselling for HIV testing (including HIV testing provided as part of the migration process), and increased ability for service providers to work in the community and/or establish centres specifically focused on treating

immigrant and refugee women's health holistically (the Toronto-based organization *Women's Health in Women's Hands* was raised as a potential model).

Voices of African Immigrant and Refugee Women

In the next section, I present findings from the six African immigrant and refugee women in the central case study area. To increase the depth of this section and respect the voices of the women themselves, I begin with a condensed narrative compiled from verbatim quotes from my interview with one of the women. Following this narrative, I discuss the main themes that I identified based on my analysis of the information the women in this case study shared about their reproductive health stories and needs. I discuss these themes in an order that traces a trajectory from the women's experiences migrating and settling in, to accessing and using services, to concerns outside of the health and social services system. As part of this general order, the discussion also naturally flows from the lives of the women themselves to being more inclusive of that of others (e.g., their children, home country communities and cultures).

Yvette's Story

Quand je suis venue au Canada, j'ai des problèmes avec mon mari. J'étais enceinte, et je vienne demander pour me protéger parce que j'étais en danger. Si je continuerais toujours là je pouvais perdre moi-même la vie ou les enfants. C'est pour cela que j'ai fuie. J'ai choisi Ottawa parce que je voulais me cacher là où je serais à l'aise. Je serais protégée là où il y a pas beaucoup de gens qui me connaissent. Si les gens me connaissent, ils peuvent directement dire à mon mari qu'elle est à tel endroit.

Quand je suis arrivée c'était un peu difficile parce que c'est un endroit où tu connais pas aucune personne. J'étais aussi malade. Je ne mangeais pas. J'étais au YMCA, au YMCA on m'a dit qu'il n'y a pas la place. On m'a emmenée encore à un hotel. Je ne mangeais pas parce que là-bas il n'y a pas pour cuisiner, seulement dormir. Tu ne cuisine pas, il faut manger au restaurant. Pour nous les nouveaux arrivants c'est difficile parce que tu n'es pas chez toi. Tu ne peux pas faire comme tu veux. Comme maman avant d'accoucher tu veux préparer la layette comme tu veux, tu mets le berceau dans ta chambre, tu sais que ton bébé va arriver, tu organise tout soit là. Pour nous, tu es là et tu ne fais rien et tu attends d'accoucher.

Ce n'est pas une bonne chose d'accoucher au shelter. Ce n'est pas une bonne chose. Par exemple, tu laisses tes enfants. Je laisse mes enfants sans personne. C'est risquant, tu peux mourir de penser aux enfants que tu as laissé à la maison. Tu pars à l'hôpital seule avec le taxi man tu ne le connais pas. J'étais allée la nuit de dimanche, toute la journée on m'a dit : « Madame, tu n'es pas ici, remets toi ici parce que tu penses en dehors, tu ne communiques pas avec ton bébé, il faut communiquer».

J'ai retourné au shelter pas le même jour, pas le lendemain, j'ai fait quatre jours je pense. J'ai accouché le lundi, j'ai sorti le jeudi. À cause, parce que je n'ai pas préparer les choses. Par exemple, je n'avais pas la chaise auto, je n'avais pas le berceau pour bébé. On m'a dit : « Tu ne peux pas sortir parce que tu n'as pas la chaise auto, tu n'as pas le berceau. Il faut encore rester jusqu'à ce que tu trouves toutes ces choses-là ».

C'était le moment pour aller inscrire les autres enfants [à l'école], ça fait encore bloquer parce qu'il n'y a pas moyen de se déplacer avec l'enfant. Y a pas la poussette, tout là c'était blocage. Ça continue toujours. Tu es entrain d'allaiter, tu es maman des enfants, tu n'as pas

d'argent comme il le faut, tu n'as pas la liberté, et ça bloque. C'est difficile, c'est dur. Et quand tu vois les enfants et il y a des choses qui ne marchent pas et toi tu es maman, tu n'es pas à l'aise parce que c'est toi qui est en train d'assumer tout ça. Tu regarde les enfants qui ne sont pas en bonne, confortable, ça te donne la migraine tout le temps, ça te donne le stresse quand les enfants ne dorment pas bien, ou les enfants ne mangent pas bien. Toi aussi maman tu ne seras pas contente parce que les enfants, comme moi je suis quittée, laissé tout, laissé le mari, laissé mon travail, j'ai laissé ma maison, j'ai laissé tous mes biens pour fuir pour seulement me protéger et mes enfants.

Key Themes

MIGRATING AND SETTLING IN

All but one of the women I interviewed entered Canada as refugees. These women shared stories of how they had left their countries and migrated to Canada in search of safety for themselves and, if they were mothers, for their children. These women had occasionally faced persecution and violence in their countries of birth or abuse at the hands of their partners. Sometimes, the women had endured both. Such traumas were not experiences that were checked at the border once they arrived in Canada. Despite dealing with the lasting impact of past trauma, the women described being faced with the immediate challenges of settling into a new country. Even for the one woman who voluntarily immigrated to Canada, the process of starting all over again in a new place was described as difficult.

Struggles with finding permanent housing, navigating the bureaucracy for immigration applications and health coverage, and finding employment were all raised as issues. These challenges were compounded for refugee women who had left their countries in urgency and

without much formal documentation, as well as for women who did not have English as their first language. Yvette had been living in Canada for less than a year when I spoke to her. She had escaped violence in the Congo and then an abusive relationship. She described how she had to repeatedly deal with the repercussions of an error in the Swahili to English translation of her history in her immigration file. The number of children she had was not captured correctly and so she lacked appropriate documentation for herself and her family. She explained her feelings of being re-traumatized by the struggle to have her true story heard and recognized:

> *…le traumatisme ça continue parce que tu es venu pour que on te comprend les femmes et les douleurs de la femme….C'est moi qui te parle la vérité qui est dedans moi. Ce n'est pas la personne qui va venir me parler de moi, c'est moi-même qui parles de moi parce que c'est moi qui est en train de vivre… Il n'y a pas une autre personne qui va dire à ma place parce que c'est moi qui vit, une maman de six enfants qui est entrain de pleurer, qui est en train d'exprimer la douleur…* (Yvette)

Clara, although welcomed and assisted by a local settlement agency, still faced struggles to secure the appropriate documentation to allow her to attend college in Canada:

> *…parce que je suis une nouvelle, je n'ai rien comme papier. Il faut que mon avocat écrit une note pour aller présenter là-bas pour qu'on commence et je suis allée, le monsieur m'a dit non, « Ah ça ce n'est pas mon travail, je ne peux pas faire ça »*

Struggles with securing formal documentation also translated into complications with the health care system for some women, as they faced the potential of costly visits to hospitals or fees for required medications.

GETTING OUT, GETTING AROUND

Getting out of the house was raised as an important issue for breaking the isolation of parenting a new baby, especially when parenting alone. Despite this perceived importance, a number of the women discussed the difficulties of getting out and getting around, to the point

where it sometimes hindered them from accessing needed services. Beatrice, for instance, said she intended to go to playgroups but never did because it was so hard to get out. Several of the women did not have a driver's license in Canada. Navigating Ottawa's streets and buses with a stroller, particularly in the winter, was described as a significant hurdle. For Yvette, this was made worse by her status as a newly arrived refugee without any of the equipment necessary to provide her with mobility with small children (e.g., stroller, car seats). She shared the mental distress this lack of mobility caused her post-partum:

> *…tu ne peux pas sortir, tu es entrain de pleurer toujours parce que tu es bloquée de tout. Tu as envie de faire même des déplacements pour acheter de la nourriture pour faire à manger pour les enfants. Tu viens d'accoucher. Tu n'achètes pas à manger, tu ne cherches rien….tu n'as pas la chaise auto, tu n'as pas la poussette…Deux jours ou trois jours tu viens de l'hôpital et j'étais anémique, je n'ai pas du sang, et je ne peux pas marcher longue distance comme ça avec l'enfant, deux enfants encore c'est difficile. C'est trop trop difficile.*

INTERACTIONS WITH THE HEALTH AND SOCIAL SERVICES SYSTEM

It was with some humour that Safia recalled her first pap test in Canada, though at the time confusion appeared to be the dominant emotion. Her knowledge of the usual procedure during a full physical exam was taken for granted by a health care system with which she was unfamiliar:

> *…j'ai demandé au médecin une visite annuelle, donc c'est là qu'il m'a recommandé. Je ne savais même pas que ça existe j'ai dit « oh mon dieu, c'est la première fois que je fais ça »…l'infirmière me donne des habits à mettre. Elle m'a dit « Il faut enlever ça », et j'ai dit « C'est pourquoi? » Je n'ai même pas pu demander la question mais après ça il va faire le Pap test que je savais pas. Donc c'est après ce jour-là que j'ai su que c'est un test qu'il faut faire et pour quelle raison.*

The one immigrant woman I interviewed said it was difficult to get connected to health and social services. The refugee women, on the other hand, seemed to be more likely to have

been linked to settlement agencies that connected them to such systems. Once connected, though, understanding and navigating that system were still issues. One woman described immigrant and refugee women generally as "really lost" as they attempted to identify and engage with all of the varied organizations and processes to ease their settlement into Canadian society.

While many of the women said they felt very comfortable and respected in their various interactions with the health care system, not all the women felt as such all of the time. For example, Beatrice stopped participating in prenatal classes. She felt out of place attending the classes alone when all of the other women were there with a partner. Her own partner was too busy with work commitments to attend the classes along with her. Clara shared her experience of feeling unwelcome by clinicians at walk-in clinics due to her HIV status. This was the case even when she sought assistance for health issues unrelated to HIV/AIDS. She described how she was asked why she was at the walk-in clinic instead of at the office of her specialist. The way that the nurses looked her also gave Clara the sense that they were not comfortable with her presence. Two of the women discussed difficulties that they or their friends had faced as francophones. These women occasionally struggled to communicate with health or social service providers who were only available in English at the times of their visits.

REPRODUCTIVE HEALTH OUTSIDE OF THE HEALTH CARE SYSTEM

When the women shared their reproductive health stories, much of the discussion was focused in places found outside of the formal health system. These stories were set within the context of their busy lives as they settled into a new country. They also demonstrated varied experiences and emotions. One woman discussed the joy she felt when she prepared her

apartment for the birth of her first child. Another woman described her sadness as she readied for an impending birth while in temporary housing and without any of the material items usually required for a new arrival (e.g., crib). Yet another woman shared the loneliness she experienced in pregnancy. She felt isolated without the social supports she would have had in her country of birth.

The issue of housing was particularly salient for Yvette in relation to her reproductive health. She was one of only two women in this case study area whom I met in their homes. One of these women lived in a two-bedroom apartment with her partner and two children. Yvette lived in a shelter and I was immediately struck by the small space she and her six children shared. Yvette described the challenges shelter-living posed after she gave birth to her youngest daughter:

> *Il y a des toilettes communales. Tu viens d'accoucher, tu as un bébé qui a un, elle a le cordon ouvert, tu es en train de se limiter pour ne pas des microbes pour l'emmener à ton enfant. Tu le protège…tu n'as pas la place pour te laver comme il le faut. Tu viens d'accoucher mais tu ne te laves pas.*

Yvette continued on to describe how she felt she had nowhere safe to put down her new baby in the communal washroom at the shelter while she showered. She also shared her concerns that her daughter was not developing mobility as quickly as her previous children. The small space her family occupied at the shelter was perceived by Yvette as a limit to her daughter's normal development in this regard.

Other women discussed how they found safe places outside of the formal health system that made them feel supported. It appeared that these women benefitted from the presence of diverse community organizations in the case study area with programs targeted at immigrant and refugees. A number of the women who were living with HIV/AIDS described a local

community health organization as a welcoming and secure space. There, they met and talked about shared experiences with other African women who were in similar situations as themselves.

SEPARATED FAMILIES, SOCIAL SUPPORT, AND ISOLATION

Most of the women lived and/or were raising children on their own for reasons related to past abuse, partners who had passed away, or because they were single and had migrated independently. Separation from broader families was a recurring and sometimes emotional theme. Clara had tears in her eyes as she described how she was waiting anxiously for permanent residency so that she might sponsor her grown-up children to come to Canada. Attempts to stay in touch with distant family members were complicated by the cost of international phone calls and the disruption in some countries due to war.

Some of the women who were raising children on their own seemed to feel their isolation and separation from prior social networks especially keenly. Family would have provided support in relation to pregnancy, birth, and the work of raising children. Safia described the differences she perceived in the new sources of social support she had built in Canada and those in her home country. Friends and community sources were simply not the same as immediate family:

> *…ici je n'a pas de famille proche. Le support qu'on va avoir c'est vraiment minime parce que personne ne va garder tes enfants à ta place. S'il y a de la famille directe, le frère, la sœur, les parents, là ils peuvent garder pour toi. Mais si non quand il faut que par exemple quand je quitte l'école 4h au plus tard il faut que je ramasse la petite tout ça c'est comme, tout ça il faut que je le fasse tout seule.*

On the other hand, another woman described her integration into Canada as "easy". She attributed this to the extended family and friends from her home country who were

already established in Ottawa. The word "family" was also used by the group of women living with HIV/AIDS. This term was appropriate to describe the strength of the connections they had formed with peers and staff at a local community health organization.

Within their social networks, several of the women discussed their efforts to assist other African immigrant and refugee women. Some of this help was given in the form of shared children's clothing and equipment. Another avenue identified by the women was to provide assistance negotiating cultural differences with mainstream Canadian society. For one of the women, this involved advising friends to "open up" and share their problems in order to seek help from service providers. For another woman, her efforts focused on sharing her own story in order to help break down taboos and stigma related to reproductive health and HIV/AIDS within African communities in Canada.

BODIES IN ONE PLACE, MINDS IN ANOTHER

"That's when my imagination takes me to Congo" Beatrice said to me in the midst of her birth story. It was during moments when her partner left the hospital room that his absence made space to remember all the others who were not there with her. Her family had fled the Congo after soldiers raided their home; her mother had passed away while they lived in a refugee camp; Beatrice's grandmother and "aunties" still lived in the Congo. In the midst of the birth of her first child, Beatrice spoke about those missing people as the only thing that made her sad. She imagined instead a room full of family to visit and provide support.

This mixture of joy and sadness, of a body engaged in the hard work of labour and delivery while a mind drifted between the present and the imagined was not unique to Beatrice's story. Nor was the idea that this story communicated about a physical presence in

tangible places combined with mental engagement with imagined places that were more temporary and ethereal. Yvette went into labour while she lived in a shelter. She described the attempts of the nurses at the hospital to keep her focused on the task at hand. In the midst of labouring in a hospital room, Yvette's concern was for the other young children she had left behind at the shelter:

> *Je suis comme, mon corps à l'hôpital, ma tête au shelter de penser à mes enfants. Ils sont comment là-bas? Cette peur-là, tu peux mourir parce que tu es entrain d'accoucher. Tu peux mourir...*

STRESS AND MENTAL HEALTH

Stress and the associated impacts on mental health were closely linked by a number of the women to a lack of sleep and isolation following childbirth. As discussed earlier in this section, stress could also be caused by the difficulties some women faced getting outside of their homes to carry out errands, experience a new environment, and access services. In addition, some of the women spoke about discrimination that they faced and the strain that this caused. Clara was HIV positive and explained how the judgment she occasionally faced made her feel:

> *…quand tu me traite comme ça je ne peux pas dormir. Ça va me fait la tête mal pensé pourquoi? Parce que quand j'ai eu ce mal, moi je ne savais pas. J'étais mariée moi. Je ne savais pas que j'avais ça.*

Physical manifestations of stress were described as headaches or migraines, disrupted sleep patterns, and a general sense of unease. A sense of hopelessness accompanied seemingly unending settlement challenges, especially when joined with worries that an imagined better life for children might not come to fruition.

RAISING CHILDREN IN A NEW LAND

The reproductive work of the women with children extended to how these children were raised and educated. Yvette described how she perceived the important role of mothering as follows: “Maman d’une enfant, c’est une maman d’une nation, c’est une maman qui éduque”. Mothers were seen to bear the responsibility of raising the next generation of citizens and to educate them to carry out that role. For Beatrice, an important part of the education of her daughter was to carry on the religious beliefs she had herself learned growing up. These included a belief in God and values with respect to dating and sex. A part of this was to teach her daughter that: “it’s not okay to go out with a lot of boys”. Safia looked to the future and shared her hopes of moving to another part of the city once her children were older. Teenagers, she explained, were not easy to control. She would prefer to leave the central case study area to live further away from the “activités au centre-ville”.

HOME COUNTRY COMMUNITIES AND CULTURES

When Rose revealed that she was HIV positive to her family and friends, the reaction of some of them was “scary”. Some of the people whom she had trusted with her story shared the news with others in the community to stigmatize her. Despite efforts at education, HIV/AIDS was still associated with bad behaviour in some African communities, she explained. Nadine, on the other hand, felt that in Canada she was more accepted and experienced less discrimination related to her HIV positive status than she had been in her country of birth.

Beyond HIV/AIDS, a number of the women described the topic of reproductive health as a “taboo” subject in their countries of birth. During their upbringings, little discussion of reproductive health had occurred. This translated to a sense of discomfort with the subject. Some of the women discussed how it took time to get over this unease when they dealt with

the Canadian health care system. Beatrice attributed her upbringing to occasional decisions not to tell the truth with doctors in Canada because she felt "ashamed". Nadine described how her first experience with a pap test in Canada was made more difficult because the doctor was not just a man, but a man from Africa:

> *…la première fois que j'ai fait ça [pap test] ici j'étais chez un docteur c'était un Africain et je ne savais pas comment le dire…je ne savais pas comment dire le problème que j'ai. C'était très difficile pour moi…parce que c'était un Africain… en plus un homme. Si ça aurait pu peut-être être une femme j'aurais pu lui dire. Mais lui il m'avait dit que lui il pouvait me faire le Pap test, « Est-ce que je peux avoir une femme ? »*

A service provider from the same region of the world, then, was not always an asset in the women's eyes. Cultural norms related to gender were still sometimes at play. The issue of gender within some African cultural communities was also raised by Beatrice. With respect to her husband, she described herself as "lucky, he lets me out". She spoke of friends whose husbands carefully controlled their movements. These "women are suffering" she said, because they spent too much time alone caring for children. They were always accompanied by their husbands in circles of movement that primarily went from church to home and back again. Gender norms that made it usual practice for the man to speak for the family meant that these women had trouble seeking help in their interactions with service providers.

NEEDS AND RECOMMENDATIONS

At the end of the interviews, I asked the women for their recommendations on how to improve the reproductive health experiences of African immigrant and refugee women in Canada. Some of the women focused their comments on interpersonal relations between African women and service providers. They emphasized a general need for health and social services that truly engaged and listened to African women. This would help service providers to

understand needs and hardships that were not always immediately obvious. The health and wellness of mothers in a family were described as crucial to ensuring her ability to care for her children.

Some of the women focused their recommendations on improving the ability for women to settle into Canadian society and navigate the health and social services system. These recommendations included the need for shelter housing more suitable for families, financial assistance on par with the real cost of living, and an increased emphasis on language training for women. A resource to orient newcomer women to the system and accompany them through the various steps involved in getting settled was also identified as desirable.

Among the women living with HIV/AIDS, one woman emphasized the need for more places where they could go with the confidence that they would be treated with respect, "comme une personne". Another woman with HIV focused on the importance of reduced wait times for specialist services. She also identified the need for increased frequency of preventative screening (e.g., mammograms) in light of their increased risk of developing breast and uterine cancer. Finally, one woman argued for increased outreach efforts targeted at African communities in Canada to provide education and de-stigmatization related to HIV/AIDS. In particular, engagement with churches was suggested as a potential avenue for engagement. African women were perceived as less likely to go somewhere unfamiliar, while churches were thought to provide a comfortable and familiar space.

Conclusion

The reproductive health experiences of African immigrant and refugee women who lived in the central case study area took place in a dense, socioeconomically mixed urban part

of Ottawa. With respect to aspects of the location itself, the layout of the streets in this area and the public transit available provided a number of options for travel within neighbourhoods and to and from the other parts of the city. A diversity of services was also available and a strong history of welcoming newcomers infused these services and the area itself. As such, a number of settlement agencies were present as were programs to assist newcomers within health care and community organizations.

Despite this diversity of services and history, the reproductive health service providers painted a picture of a system only partially welcoming to immigrant and refugee women. The comments of these providers shed light on the more complex and social aspects of place beyond location itself. They also brought in ideas regarding the importance of understanding how the social positions of African immigrant and refugee women played into their experiences of reproductive health. These factors stretched beyond the interpersonal engagements between service providers and African women over which the providers had some direct impact. Services may have been locally available, for instance, but access for some women was limited by a policy environment that made it unlikely for some organizations to welcome refugees. Based on their home country experiences, language abilities, and domestic responsibilities, some women also faced increased challenges related to understanding and navigating a complex system. While service providers emphasized the importance of broader settlement issues to the reproductive health of African immigrant and refugee women, they also strongly focused their discussions within the health care system in which they worked. The provision of culturally competent care was highlighted as an important theme within these health care settings.

To a certain extent, the African immigrant and refugee women raised similar themes as the service providers. Their stories provided more depth of understanding into the personal impact of the issues raised. This was the case in relation to challenges the women faced when they engaged with the health and social services system. It was also evident in the discussions of the women regarding isolation and the importance of social support networks. For some women, the population and service density of the central case study area provided opportunities to form meaningful social networks. The "family" that the group of women living with HIV/AIDS built at a community health organization with a program targeted at African women may not have been possible, for example, in a different area with a different history.

Where the discussions of the women diverged from many of the service providers was in the emphasis the women placed on their reproductive health outside of the health care system. The stories they shared showcased the ways in which places of a different scale and nature than that of the neighbourhood were most relevant to their experiences. Restrictions and stresses posed by their housing arrangements were brought up, along with the fleeting, imagined places drawn from memories and thoughts of home countries. The impact of gender norms, culture, and taboos were also discussed with respect to how these affected interactions with service providers and broader life in Canada. These discussions aligned most strongly with the perspectives of community health/social workers as opposed to other service providers. This was not unexpected given how closely community health/social workers engaged with the communities and, for some of these workers, their own status as African immigrants and refugees. In Chapter 8, I revisit these themes in more detail and provide comparison across the case study areas.

Chapter 6: Case Study - West End Ottawa

Introduction to the Case

A dominant feature of the west end case study area is the Bayshore Shopping Mall. Right off the highway and bus express routes, the mall is about a 15 minute drive from the downtown core of Ottawa. People from around the city stop, shop, and leave the mall without necessarily venturing into the surrounding neighbourhoods. Behind the mall and throughout the case study area are mixed residential neighbourhoods that stretch between the busy border streets and clusters of services on those streets. Small private drives lead off the inner roads to the parking lots of large apartment buildings and rows of attached housing units. Parks are scattered throughout the area, as are pockets of larger, detached homes. Both visible and audible on the streets and in the parks is a plethora of ethnic and linguistic diversity. This diversity, in combination with its characteristics as an inner suburb, distinguishes the west end case study area from the other two in this research. A significant population of newcomers generally, and African newcomers specifically, create opportunities for immigrants and refugees to meet others who may share similar cultures and experiences. The area itself exhibits some of the density and socioeconomic heterogeneity of the downtown core. Its largely separated residential and commercial spaces are more common of suburban planning. It is within this unique environment that the African women and service providers for this case lived and worked.

The Participants

In the west end, I interviewed four service providers whose work focused specifically on the case study area. These services providers (three women, one man) included two community health/social workers, one nurse, and one physician. In addition, relevant data were drawn from the interviews and focus groups with nine service providers who worked in more than one area of the city, including the west end area. These service providers included eight women and one man. They represented the following professions: community health/social worker (n=3), doula (n=1), midwife (n=2), nurse (n=2), physician (n=1).

Seven African immigrant and refugee women who lived in the west end case study area were also interviewed. The socio-demographic profile of these women was as follows:

- A majority of the women were immigrants (n=5), while two of the women entered Canada as refugees.
- All of the women had lived in Canada for 10 years or less, with four of the seven women having lived in Canada for five years or less.
- The women migrated to Canada from five different countries in northern, eastern, and central Africa. These countries were as follows: Libya (n=3), Ethiopia (n=1), Somalia (n=1), Zimbabwe (n=1), Democratic Republic of Congo (n=1).
- One of the women included French among her native languages (alongside a local African dialect). The other six did not have English or French among their native languages. For three of these women, Arabic was a native language.

Another spoke Amharic as her native language, and the final woman spoke Shona. All of the women had some capacity in English and/or French. Per their stated preference, I conducted most of the interviews in English (n=5) and two in French.

- A majority of the women (n=4) identified as being part of the Muslim faith. Two identified as Christian and one did not indicate a religious faith.
- All of the women, except for one, had completed at least some college or university level education. The last woman of the six had completed trade school.
- Three women were between 21-30 years of age, three were between 31-40 years of age, and one was aged 41-50 years.

Profile of the Case Study Area

The west end case study area was comprised of the Bayshore and Whitehaven Queensway Terrace-North neighbourhoods. The easternmost tip of the case study area was about 11 kilometres from the downtown core of the City of Ottawa. In 2011, approximately 20,390 people lived in this 4.5km^2 area. These figures made for a relatively dense area with about 4,531 people per square kilometre. The proportion of the population in this area that was considered to be low income (23.5%) was more than double that of the Ottawa average (11.6%). Approximately a third of households spent 30% or more of household income on shelter (Ottawa Neighbourhood Study, 2011). Some socioeconomic heterogeneity was still evident in the area, particularly in the Whitehaven Queensway Terrace-North portion where

community housing was interspersed more frequently with pockets of larger and newer detached homes.

Theresa, a physician, described the general make-up of the newcomers in the area as follows: "They tend to be quite low-income. I mean, I think it's changing now with the second and third generations…but the first generation is, tends to be, quite poor, quite marginalized." Similar to the central area, the west end case study area tended to be known as an immigrant-receiving area in Ottawa. It was, however, a relatively newer one with the majority of the housing in the west end area built between 1960 and 1980. Sixty-one percent of the households in the area were renters in 2011, and a number of social housing units were available (549 as compared to the Ottawa neighbourhood average of 229) (Ottawa Neighbourhood Study, 2011). As Sagal, a community health worker, explained: "…this catchment area is composed of four or five project houses, houses that are for low-income families…most families move to this neighbourhood because they are either new and, or, they get subsidy from the government."

The service providers who worked there painted a picture of an area full of diversity. Some felt such diversity led to an increased sense of comfort for newcomers to Ottawa:

> *There is a lot of diversity in the west end. You can see it in the apartment buildings and just walking down the street…so I'm assuming that gives people a little bit of a sense, like you know, they're not the only Black person or something like that around…and, you know, there's a lot of diversity in the schools…it's like the United Nations in there.* (Morgan, nurse)

In 2011, 36.6% of the population were immigrants and 10.0% of the population were recent immigrants who had arrived between 2006 and 2011 (Ottawa Neighbourhood Study, 2011). Service providers listed a large variety of African newcomers among their clientele,

including clients from Algeria, Burundi, Cameroon, Congo, Djibouti, Eretria, Ethiopia, Ghana, Morocco, Niger, Nigeria, Somalia, Sudan, and Uganda.

Reproductive Health Service Context

As with the previous chapter, in the following section I discuss the reproductive health service context for the case study area. This context includes both the map of services available in the area and service provider perspectives about key issues and challenges faced by African and immigrant refugee women with respect to their reproductive health.

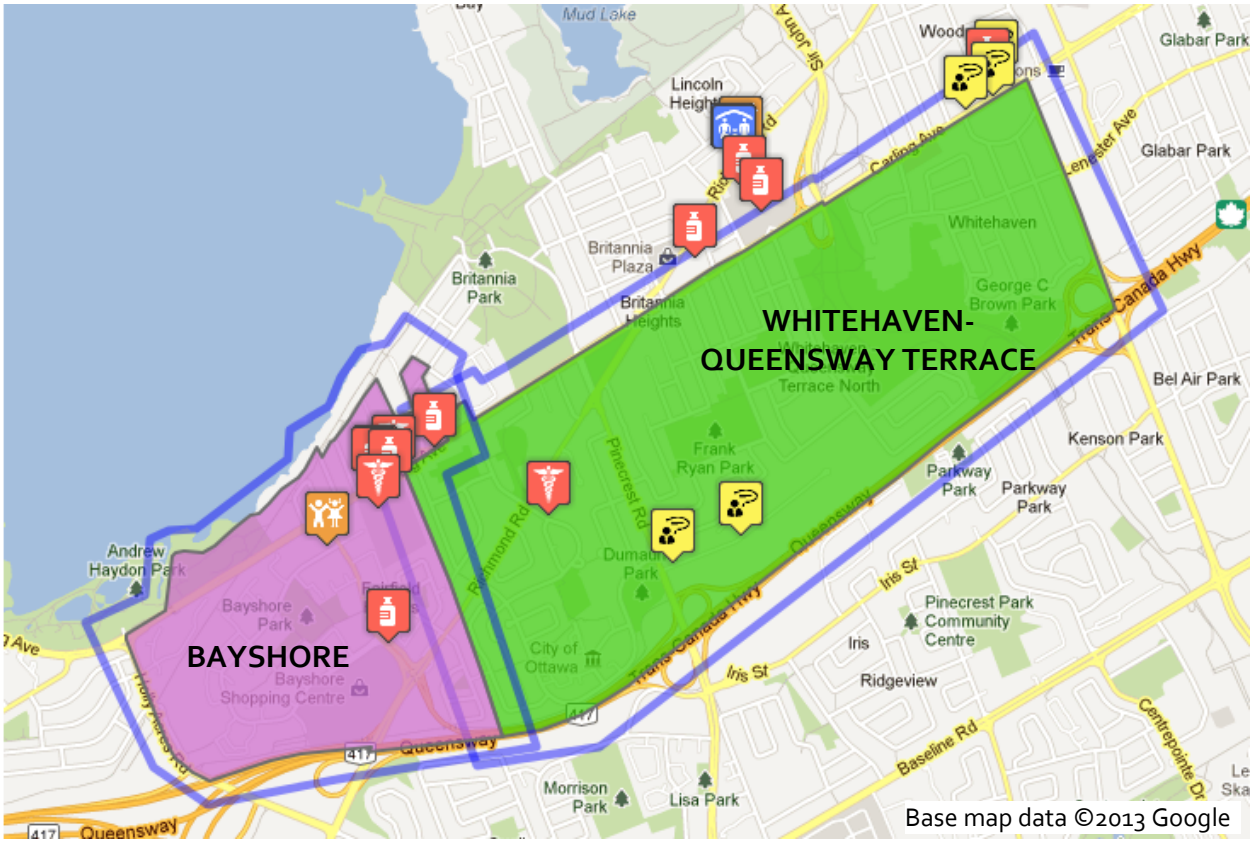
Map of the Reproductive Health Service Context

In Figure 6 (below) I present the map of the reproductive health services that I brought to interviews and focus groups with providers. Visible on this map were noticeably fewer services than what was available in the central case study area. Less diversity in services was also a feature, as was the clustering of the majority along the main road at the northern end of the case study area.

The service providers generally felt that the information included on the map was accurate. One of the providers highlighted the tendency noted above that people mostly resided in one section of the area while the services were located elsewhere. This led to the need to use the bus system to access many services. Several of the providers shared the ways in which their programs were specifically targeted at immigrant and refugee populations. Sometimes newcomer status was directly cited as a recruitment criterion for a particular program, while at other times newcomers were drawn to services that were provided in diverse

languages (African languages among them) or due to their focus on specific vulnerabilities (e.g., low-income, lack of health insurance, transient or unstable housing).

Figure 6. Reproductive Health Service Map of the West End Case Study Area – Initial Mapping



Physician's Offices
- Appletree Medical Centre (x2)
- Other Physicians' Practices (x6)

Pharmacies
- Bayshore Pharmacy
- Guardian Pharmacy
- Rexall/PharmaPlus (x2)
- Shopper's Drug Mart (x2)
- Walmart Pharmacy
- Zeller's Pharmacy

Community Health Centres
- Pinecrest-Queensway CHC

Counselling Services
- Goldstein, Moncion, Greenbaum & Associates
- Jewish Family Services
- Queensview Professional Services
- Schaefer Andrea Counselling
- Youth Services Bureau Head Office
- YSB Mental Health Hub
- Other Private Counselling Services (x4)

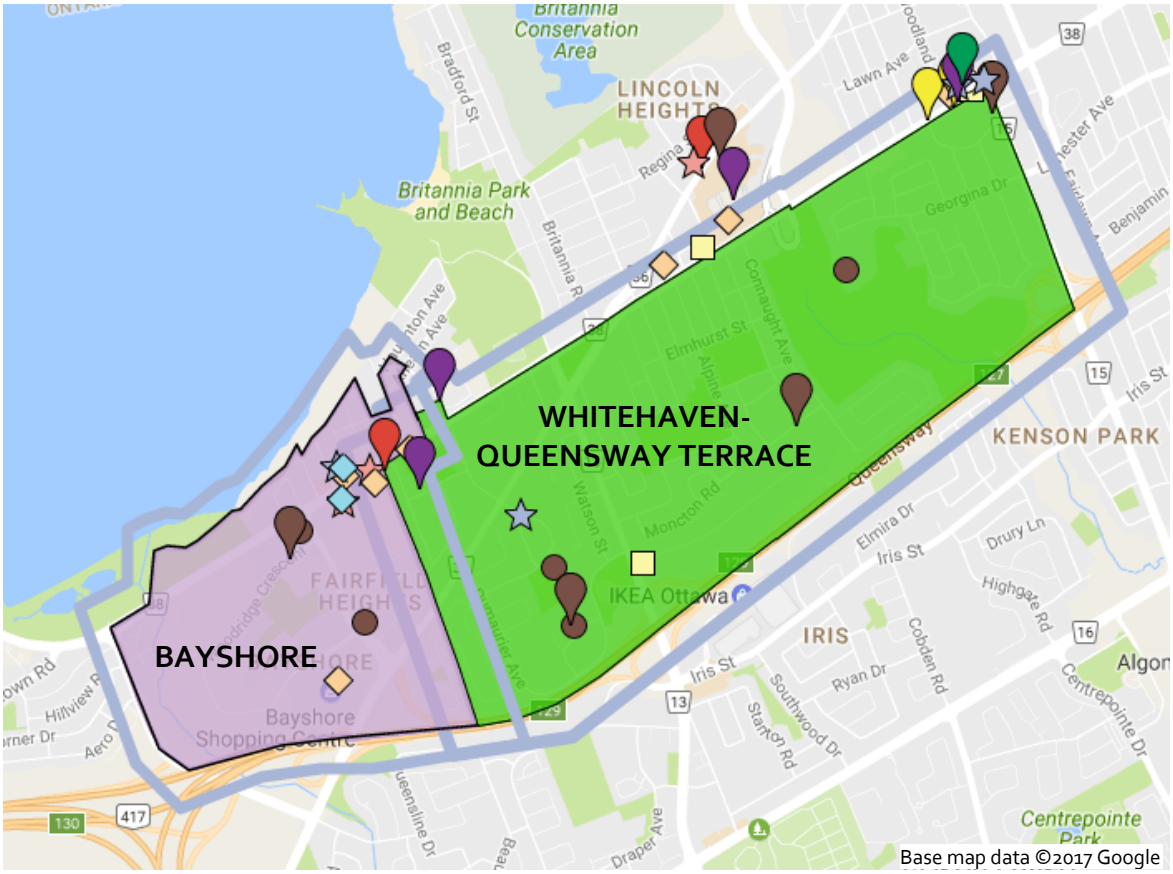
Family Resource Centres
- Ontario Early Years Centre
- OEYC Drop-In Site

Other providers suggested additional services of relevance to the reproductive health of immigrant and refugee women. These included settlement agencies, libraries, schools, and other community buildings that provided rooms for satellite programming. Another suggested

that a greater degree of differentiation on the map was needed. With respect to physician services, she explained: “I think of walk-ins versus regular doctor’s offices. So walk-ins are the ones that tend to be frequented by people who don’t have a primary care provider” (Lorraine, physician).

In Figure 7 (below) I provide a revised map that integrates service provider feedback and updates. These changes showed that the area was host to a few settlement services for newcomers, reflective of its history as an immigrant-receiving part of the city. Family services, in particular, were slightly more dispersed throughout the area than clinical ones. The separation of the residential from the commercial was, however, largely maintained. The public transit map that I created in Figure 8 put context behind service provider comments that the use of buses was largely necessary for access if people did not own a car of their own. This map showed that local buses provided transportation along some of the roads through the area. More frequent transitway routes were also available along major roads and linked at times to local as well as peak-hour buses. Outside of peak commuter hours the eastern portion of the case study area appeared less well-served. This could be a potential source of challenges for travel out of residential zone for those reliant on the public transit system.

Figure 7. Reproductive Health Service Map of the West End Case Study Area – Revised



Community Health Centres (FREE)
- Pinecrest Queensway CHC (PQCHC)
- PQCHC Satellite Location

Walk-In Clinics
- Access Medical Centre
- Appletree Medical Centre
- Ottawa Public Health Sexual Health Centre Satellite Clinic

Independent Physician Offices
- Physicians' practices (x5)

Ultrasound & Blood Labs
- CML Health Care
- Gamma Dynacare
- Life Labs

Alternative Medicine
- Alternative medicine practice (x1)

Adoption Support Services (FREE)
- Adoption Council of Canada

Pharmacies
- Bayshore Pharmacy
- Rexall PharmaPlus (x2)
- Shopper's Drug Mart (x2)
- Walmart Pharmacy
- Whitehaven Guardian Pharmacy

Psychiatrists & Psychologists
- Psychiatric practices (x3)
- Psychological practices (x5)

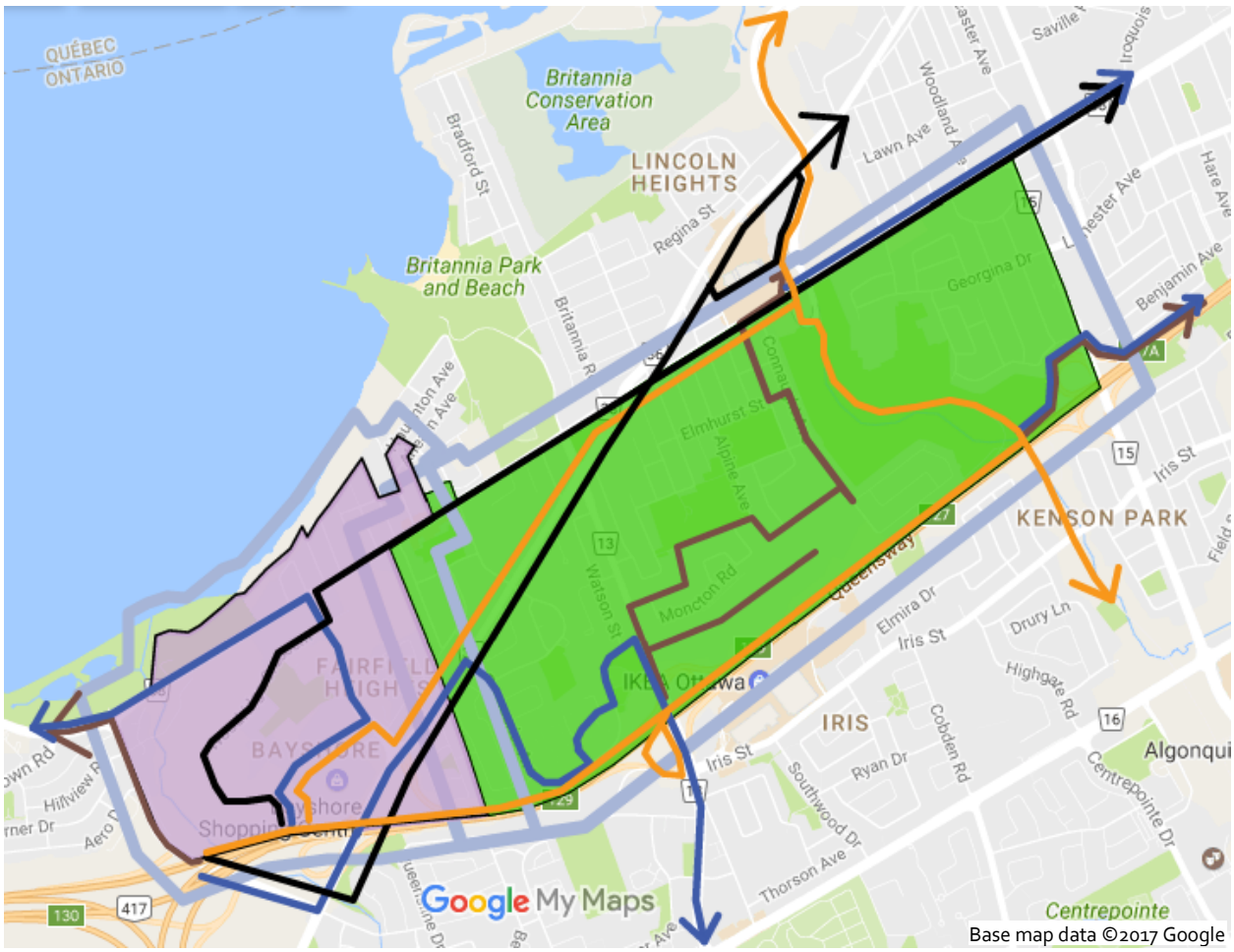
Counseling Services (FREE)
- Jewish Family Services Counseling Clinic
- Youth Services Bureau Mental Health Clinic

Settlement & Related Services (FREE)
- Jewish Family Services
- Language Instruction for Newcomers (x2)
- PQCHC Employment Services

Family Services (FREE)
- Bethany Hope Centre for Young Parents
- Ontario Early Years Centre (OEYC)
- OEYC Satellite Playgroup (x2)
- Parenting & Family Literacy Centre

Other Family Services
- Child care centres (x5)

Figure 8. Public Transit (Bus) Routes that Serve the West End Case Study Area



Legend

Local routes (black and blue lines). Buses make frequent stops. Intervals of departure vary, typically between 15 minutes and 30 minutes.

Transitway routes (orange lines). Buses make fewer stops and travel at times along dedicated roads. Intervals of departure vary between 5 minutes or less and 30 minutes.

Peak routes (brown lines). Buses travel only on weekdays at peak commuter times. Intervals of departure vary, often every 15 minutes.

Arrowheads (any colour). Indicate that the bus route continues in the direction indicated.

Note: The information contained in this map was derived from the website of OC Transpo (OC Transpo, 2017)

INVISIBLE LAYERS – WHAT THE MAP DID NOT PORTRAY

As with the central case study, interviews and focus groups with service providers in the west end showed that there were certain important elements of their work that were difficult to capture on a map. In particular, the mobile nature of some of their services featured strongly in discussions with community health/social workers and nurses. These providers discussed how they conducted home visits and operated satellite locations in community buildings (e.g., community houses, apartment buildings, shelters). In the words of Sagal, a community health/social worker: "If the clients are not coming to us at the centre, we go to them…we take the services to them". This mobility included some of the reproductive health services offered by the City of Ottawa. Providers of these services traveled from their central location to the west end so that "downtown is not the only option for people to access our…services" (Gabriela, community health/social worker).

Additionally, some of the service providers questioned the relevance of all of the services I had included on the map. They highlighted the various ways in which certain services were inaccessible for some immigrant and refugee women due to financial and other barriers. Theresa, a physician, pointed particularly to this issue with respect to counselling services. She argued that: "…the problem with counselling services is that, most of these they are private, right?" Morgan, a nurse, further drew attention to the issue with respect to some walk-in clinics: "The walk-in clinics, [Clinic Name] charges 40, somewhere between $40 and $60 for a visit…they do not take IFH [Interim Federal Health]…so that is not accessible".

Once again in this case study area, service providers seemed to draw on their knowledge regarding which services were more welcoming for their clients. They used this

information and actively built relationships to facilitate care pathways for immigrants and refugees:

> *We do have some specialists that know our patients, and know our office and facilitate appointments. We are just able to communicate a bit more effectively with them…we do tend to refer to some of the same people because we know that they are, you know, and they know how to work with interpreters and so we try to do that* (Theresa, physician).

Service Provider Views on Key Issues and Challenges

In my analysis, I identified nine main themes that the service providers felt were key issues and challenges for African immigrant and refugee women's reproductive health.

DIFFERENT STORIES, DIFFERENT NEEDS

The service providers consistently emphasized that a key part of their work was to understand the particular background and migration experiences of each African immigrant and refugee woman with whom they interacted. These experiences were felt to affect the reproductive health needs and broader circumstances of the women once they were in Canada. Some of the providers spoke about histories of violence and trauma that women may have experienced in their home countries. In cases, such violence and trauma led to women being hesitant to approach formal services and affected the trust they had in service providers. At times, it also led to traumatic recollections resurfacing at unexpected times, such as during pelvic exams or childbirth.

One service provider felt that some streaming occurred, whereby the refugee populations who were forced to migrate were those who were in the most need. Those who came to Canada had often fled political instability, violence, or persecution, while those who were better off chose to stay on the continent:

> *Over there there are other issues, other real problems. Wars and, you know, and security and safety and there are other issues that these people came here, migrated here. But those who are well-off in their countries, who do not have, you know, issues, political issues, or you know, wars, they stay in their countries*. (Sagal, community health/social worker)

A number of service providers also made it clear that the migration category in which the women entered Canada factored strongly into their settlement experiences and their health. Service providers discussed the significant challenges and stresses faced by refugees. They also noted that refugees were at least provided with immediate health coverage through Interim Federal Health. This was often coupled with some financial support through Ontario Works. Based on feedback from their clients, however, they knew that surviving on Ontario Works could be a struggle for a family and that Interim Federal Health was not accepted by all health service providers. This last point was cited as a particular difficulty amidst the confusion of cuts to Interim Federal Health that were being enacted by the federal government at the time of data collection for this study. Refugee claims were also sometimes denied, leaving families without the supports and coverage they had once received. Voluntary immigrants, in contrast, were discussed by the service providers in light of the three-month waiting period in Ontario for provincial health insurance. Service providers felt that this could lead to gaps in the care of women. One also mentioned the stress that sponsored immigrants faced due to a desire to avoid being a financial burden on their sponsors while struggling to settle in and find employment.

Despite diverse challenges that immigrant and refugee women may have faced or currently faced, two of the service providers emphasized the strength and resilience of the women with whom they worked. In their view, poverty and settlement challenges should not

be perceived as helplessness or lead to assumptions about the circumstances of immigrant and refugee women prior to their migration. Morgan, a nurse, perceived differences between refugees who had experienced relatively recent upheaval and the "generational poverty" facing some Canadians:

> *…it is a bit hard to generalize, one of the funny things about working at the shelter, one of the things that strikes me a lot is that you have, you have this interesting mixture of people that have arrived as refugee claimants living in a shelter with Canadians that have probably been in generational poverty for…and the interesting thing is that the newcomers tend to be more higher functioning in some ways, at least in terms of emotional self-regulation. Whereas the Canadian born are often totally stressed and sometimes maybe substance users and stuff whereas the newcomers those are not their issues so much…lots of stress but…but they tend to have intellectual resources and social resources, cultural kind of resources in a sense as a strength.*

PAST EXPERIENCES WITH HEALTH AND HEALTH CARE

A number of the service providers discussed the relation between African women's past experiences with health and health care and their varied needs and perceptions related to reproductive health in Canada. Two of the service providers identified a general lack of prior opportunities for reproductive health screening and preventative care, especially pap tests, amongst their African immigrant and refugee clients. Insufficient systems and funding for such screening in some African countries at times led to "fairly severe conditions that are diagnosed just soon after arrival" (Theresa, physician). A lack of familiarity with screening also occasionally intertwined with past experiences of trauma and required a particularly sensitive approach by service providers:

> *…more often than not these women have never had a pelvic exam in their life and often times they have experienced rape or sexual violence. So you have to be really gentle*. (Morgan, nurse)

Understandably, service providers also identified that the reproductive health options women were used to in their home countries were those about which they were most knowledgeable and accepting when in Canada. This was specifically mentioned in relation to Depo-Provera, a form of birth control some felt was more widely available in African countries than other forms of contraception (e.g., the patch, the ring, the IUD). Education about alternative options was viewed as an important part of the work of the service providers.

Another issue raised by one of the providers was that perception of health risk sometimes changed once women left Africa and migrated to Canada. The focus and volume of public health messages about certain issues, HIV/AIDS for instance, played a role in fostering such differences in perception:

> *…back home they may have, it is like a daily part of your life, HIV is plastered everywhere. It is not here, so it is almost like it is not an issue here because you do not see it. If it was an issue, we would see those posters.* (Gabriela, community health/social worker)

LINKING INTO & NAVIGATING THE SYSTEM

Linking women into the health and social services system was identified by the service providers as a particularly important and sometimes challenging issue. Engaging women was felt to be difficult if they had language barriers, were isolated (e.g., with small children at home and no feasible way to get around), and/or had difficulty trusting the formal system. A connection to settlement services upon arrival was ideal. This was viewed as more likely to take place for refugees than for immigrants. Even for those initially connected, maintaining continuity of care over years beyond the scope of initial settlement programs or through multiple moves was perceived as occasionally difficult:

> *… if they are linked with an agency where somebody speaks the language and they feel comfortable going and accessing that service, those agencies are really helpful. Most of the moms who come as refugees are linked…it is some of the moms who are here a little bit longer and end up back in the shelter system. I find they tend to have a harder time because they have lost those initial links to services. So say they were in Winnipeg for a couple of years, then they went to Montreal, then they came to Ottawa, those moms tend to get a little more lost in the system. The ones who were here as new newcomers are linked through the refugee system. So they are linked through various agencies that will help them for that first year. So they tend to be a little less isolated.* (Sheryl, nurse)

Naomi, a doula, also remarked that women sometimes found the system overwhelming. She spoke about the number of different agencies and officials with whom immigrant and refugee women met to manage their settlement and health needs. As a result, Naomi felt some women were less likely to accept additional support, even when needed (e.g., by accessing the free doula support her organization offered for woman who may otherwise go through pregnancy and birth alone):

> *…there is the issue of just being really overwhelmed with workers can be a problem too. And there are so many people, like if there is OW [Ontario Works], or if there is you know counsellors at OCISO [Ottawa Community Immigrant Services Organization], or that you have your nurses and you have your doctor's appointments and you have, like that can just be really overwhelming. So, you know, sometimes people are hesitant to take more help because it is like okay…or you show up for a visit and they have no idea who you are or where you are from or even though they had consented to having a birth companion.*

Once linked into the health and social services system, service providers still identified challenges for immigrant and refugee women. These included understanding how the system worked, and how to connect to and travel between different services. Language and transportation barriers were seen as factors that made these challenges worse for some women. Additional issues raised were not having a driver's license or car, having qualms about

using the bus system, and a general lack of walkability in the west end area. The particular difficulties that winter posed for getting around were also mentioned. Theresa, a physician, discussed the amount of time her clinic devoted to assisting women who faced such barriers. Despite such assistance, gaps still occurred:

> *a lot of our…medical receptionist time is spent arranging like phoning, organizing, organizing transportation, you know helping to facilitate like social work. Stuff that you usually people would be able to kind of do on their own, but they cannot because of the language barrier. So and, it also means, like missed appointments. You know. No shows, unfortunately. Right? It is just a drain on the system. Um, but, but you know I think if we just invested a bit more time…and our office staff are really crunched.*

BRINGING SERVICES TO THE WOMEN

To help mitigate barriers, a number of service providers placed importance on bringing services to immigrant and refugee women. The rationale for doing so was linked to increased accessibility as well as comfort for immigrant and refugee women who used reproductive health services. Some mobile services were offered by the local community health centre. Examples included playgroups and seminars offered in apartment buildings and community houses, home visits by community health/social workers, and a walk-in clinic offered in a local shelter. Other mobile services were offered by providers who worked city-wide. These included the home visits of midwives and doulas, as well as the care provided by the nurses and social workers of Ottawa Public Health's Healthy Babies, Healthy Children Program.

As Hala, a community health/social worker, explained, home visits also provided a bridge for the client to become more comfortable with formal services. She felt this was particularly relevant for immigrant and refugee women who faced multiple access barriers:

> *…they do not come to the groups. All the time we invite them, we know that they need this service but they do not come for any reason. Sometimes they*

have other young children…they afraid to go and use transportation, other things. Maybe in the winter they are not used to get out…too many reasons. So a newcomer, they still have that fear from the country they cannot, they do not want to go here. So we go. And after a period I found them, they start to, with this program, 'Oh, what about try this, try this,' and then they come to the other things.

In addition, for programs physically based at the community health centre, the service providers described how their model of care strove for comfort and accessibility for newcomer and marginalized populations. Longer appointment times were the norm to allow service providers the flexibility to listen to their patients, work through multiple issues, and use the services of an interpreter if needed. Located alongside and working with health care services were multidisciplinary teams that sought to provide opportunities to address health in a more holistic fashion than more traditional physician's offices in Canada.

INCLUDING & BEYOND REPRODUCTIVE HEALTH

The picture of African immigrant and refugee women that emerged from my interviews with service providers was that their reproductive health needs intersected with a host of other settlement and integration issues. These varied in exact nature, but were true regardless women's socioeconomic status or migration category. Among the potential settlement and integration issues identified were: submitting immigration papers, finding temporary and permanent housing, filling out applications for health coverage and financial support, finding a job and/or submitting applications for additional training, enrolling children in school, locating acceptable food, churches, and/or mosques, etc. One nurse, for example, detailed how in the course of several postpartum home visits with a client she had helped carry out the following activities: contacting the World Health Organization to determine the vaccination status of one child who had lived in refugee camps; enrolling that child in school; putting together a stroller

and crib for the woman's newborn; and, teaching the woman how to use an infant car seat. These activities were in addition to standard postpartum health checks and support for the mother and the newborn.

Set within the context of these other needs, tending to reproductive health was described by some service providers as but one of many pressing priorities. The urgency and severity of these other needs was perceived to be higher among refugees and very recent arrivals than among immigrants and those who had been settled for longer periods of time. Seeking out contraception, prenatal care, or childbirth support were among some of the reasons that women came into contact with the health care system. Service providers used these encounters as an entrée to engage the women more deeply. One issue per visit was far from the norm among the service providers with whom I spoke. These providers oriented women to the Canadian health care system, learned about their broader lives, and asked for their consent to test for and treat a host of other potential health issues. The concept of regular pap tests would, for instance, be introduced and hopefully scheduled. Condom use and contraceptive options available in Canada were also sometimes raised. Examinations and blood tests occasionally revealed other infections, such as "latent TB infections", hepatitis B, or H. Pylori infections.

Mental health was also raised as a concern by a number of the service providers, with particular reference to post-traumatic stress disorder among refugee populations. This was identified by some as an under-recognized and under-serviced issue for the refugee population in Ottawa. One nurse who worked with refugees stated that he would estimate between 50-70% of his refugee clients were dealing with some form of post-traumatic stress.

In the realm of mental health as well, community health/social workers pointed to stresses some African women faced in relation to the burden of work associated with traditional gender roles. Housekeeping and childbearing/rearing responsibilities were layered on top of work outside the home for some women along with the stresses of settlement: "…they are just go and go and go and go until they have nervous breakdown" (Sagal, community health/social worker).

Seeking help for mental health issues was also identified as a potential challenge. Some service providers felt that African women occasionally had difficulty verbalizing their emotions or feelings. They also sensed that mental health was not valued or prioritized in the traditional cultures of these women. In the context of what service providers saw as a dearth of affordable counselling services in Ottawa for immigrants and refugees, women may also be required to go out of their way to seek out help. Alongside a host of daily obligations and settlement challenges, taking care of their mental health may not be seen as a priority for women:

> *…so many people that have post traumatic stress and emotional health issues and I refer people endlessly to the Ottawa Immigration Women's Services for counselling but the number who actually go down there for service is actually quite small. And I think a big piece of it is that it is like saying, it is like somebody saying to me like "Oh if you just go to the other side of this Canadian city and look for this person that lives under this area and just ask for this person", it is like, I am like, "Well, maybe that is important, maybe it is not. I do not know."* (Morgan, nurse)

LANGUAGES, RELIGIONS & CULTURES

The ability to provide services to immigrant and refugee women in a language of their choice was a key theme discussed by the service providers. One of the service providers referred to language barriers as the "biggest issue" they were faced with when they worked

with immigrant and refugee women. The community health/social workers, nurses, and midwives who spent time with women in their homes explained that the impact of language barriers extended far beyond the health care system. Due to such issues, the work of the service providers occasionally included helping the women to make phone calls to secure financial assistance through Ontario Works, find secure housing, and/or submit applications to get their health cards.

Within the health care system, the availability of language interpretation services partially structured the types of health care organizations that different women could access. "Our front desk reception staff do not speak French, so all of my patients have to have a little bit of an appreciation for being able to make an appointment in English", explained Lorraine, a physician who worked in an independent practice. Providers who worked at the community health centre, on the other hand, were able to call upon interpretation services. The centre also offered a variety of different programming in some African languages, such as Somali and Arabic. Venturing off-site to the local shelter once again reduced the ability to provide services in multiple different languages. The walk-in, rather than appointment-based, nature of health services at the shelter did not always allow them to "match somebody with an interpreter on the fly" (Morgan, nurse).

While the use of professional interpreters was generally viewed as favourable, this was not always an option. Lay interpreters, such as family or other community members were relied upon when needed. This occasionally led to challenges:

> *…they are not trained as interpreters, they are just kind of fulfilling that role…that can be difficult because sometimes there is like all this chit-chat going on and you, you wonder like what is going, you know, it does not feel like a direct, it should be a direct interpretation…And I have had interpreters*

> *actually say like I am not asking her that, that is not an appropriate question…they have decided that it is not appropriate to ask, for example, the sexual health history or that kind of thing. Or sometimes they just do not ask the client and just answer…* (Theresa, physician)

Cultural beliefs related to the appropriateness of discussing reproductive health issues were found by the service providers to be varied between women. Some of the women the service providers met seemed "shy" and were very concerned about privacy with respect to their conversations. Worries about privacy or a cultural reluctance to discuss reproductive health in public intersected at times with issues of language. Some of the service providers discussed cases in which women were not willing to discuss issues with an interpreter present or in front of an interpreter of a particular gender. The gender of the health care provider was also raised as a potential factor that played into hesitancy to be open about reproductive health. One male service provider felt that his gender further intersected with a deference that some African women already tended to give to medical authority. He identified that such deference was due to the high social status of health care professionals in the countries of birth of these women.

At other times, cultural beliefs about the importance of family and fertility came into play. For example, Morgan, a nurse, described how he had heard from some African women that caesarean sections were seen as "taboo" because recovery from the surgery extended the period of time between one pregnancy and the next. A high value on fertility occasionally led to cases where women requested forms of birth control that would be easier to conceal from their partners (e.g., longer-term contraceptive options such as an IUD or Depo-Provera over the daily use of birth control pills).

Service providers also spoke about some African cultures in which public breastfeeding was the established norm, as well as cultures of community support for raising children. The absence in Canada of such supportive cultural practices was identified as a potential factor that caused isolation among African women who were not used to relying on the formal system. Sagal explained that in some African countries, a woman who has just given birth was provided with devoted support to take care of household needs while she focused on rest and recovery. The separation from such cultures also left gaps in the education that women may have received about birth and caring for a new baby:

> *Many times they are coming from communities where all the women bound together to talk about these things and they taught by, by oral tradition. This is not happening here. So that is a really big piece, right, is birth is not a community event in Canada. It is getting that way slowly, but it is not there yet and so, just like a profound difference in how the whole experience is processed is really big.* (Naomi, doula)

To help provide sensitive and appropriate care to their clients, some service providers emphasized relationship building with them. Others also mentioned that they sought to provide information without making assumptions about past knowledge or preferences, and took care to answer questions of their clients.

SEPARATED FAMILIES – WOMEN ON THEIR OWN

Sagal, a community health/social worker, described to me the case of an African immigrant woman who had recently come to Canada. While pregnant and parenting three other children, she and her husband were based in different Canadian cities. As a result, she was largely alone as she tried to negotiate the challenges of settling in Ottawa:

> *They were sponsored…So one year the brother has to take care of them, and the brother cannot take care of them. So the, the father has to go to Alberta to work, and the mother and the children, and she was pregnant, has to stay*

> *here. She had the baby, he is not here. It is cold, he is not here. Three children, he is not here. Language barrier, he is not here…*

Whether due to an unavailability of jobs, losses to violence in their home countries, partners not yet able to come to Canada, or women who had left abusive or unhappy relationships, it was not uncommon for the service providers to discuss how many of the African women they met were parenting alone. The isolation and lack of support that came from such separated relationships was exacerbated by the loss, through migration, of other family and community members on whom African women may have relied to support them through pregnancy and birth.

Despite such separation from family and prior social networks, some service providers described other supportive connections that immigrant and refugee women in Canada found and created. The number of newcomers in the west end case study area and the housing arrangements available to them sometimes fostered such connections. This was the case, for example, in the close quarters and shared spaces of the shelters where newcomer women sometimes lived temporarily. These linkages, however, were not present for every woman and did not necessarily compensate for those lost:

> *I just find that like if there's a lady who's pregnant in the shelter she's usually got two or three friends that can help out a bit. A lot of times the moms are helping watch each others' children while one's cooking or one's going to an appointment, but it is a challenge. It's not enough support for most women. And a lot of times women are, they are isolated a lot of times and they don't have supports. Some women are just here completely on their own, they don't know a soul and they just basically go through it all on their own.* (Morgan, nurse)

HEALTH CARE COVERAGE

The majority of the service providers I spoke to provided free services within specific mandates to serve those who may have otherwise fallen through the gaps of the Canadian health care system. As a result, issues related to health care coverage were seen amongst many of their clients. Barriers that refugee populations faced with respect to Interim Federal Health coverage were raised as a central issue. Some service providers made note of the fees that were being charged by certain walk-in clinics in the area to process the paperwork associated with Interim Federal Health. Policy changes to Interim Federal Health that were being introduced at the time of data collection were also discussed. Some of the providers shared stories that described challenges their refugee patients faced as a result of these changes. These included stories of patients who had been denied care by obstetricians unsure of the implications of the policy changes, and of patients themselves who were not clear whether or not they were still covered for care. While prenatal care was intended to remain covered, associated services such as ultrasounds were identified as at risk. Regardless, the reality described was that certain clinicians refused to see patients with Interim Federal Health, covered or not. Some of the service providers discussed their own advocacy efforts with the federal government on behalf of specific patients and to oppose the cutbacks to the Interim Federal Health Program.

SERVICE PROVIDER NEEDS & RECOMMENDATIONS

Resources challenges were mentioned by a number of the service providers. Those who participated in this study devoted considerable time and effort, within and outside of work hours, to advocate on behalf of their clients and help them to the best of their abilities.

Although the service providers viewed this work as integral to their jobs, some also discussed the personal toll it took:

> *Sometimes we get sick because the problems of the families we take with us…We take it and we internalize it and then we get sick about it because we get so much stress*. (Sagal, community health/social worker)

Additional resources, particularly to help women to navigate their way through the system and to increase the number of multicultural staff, were recommended. One model suggested was to train community members as peer outreach workers. Such a role was viewed as beneficial because of its potential to offer meaningful job opportunities to community members in addition to "interpretation, accompaniment, advocacy, and some education" to newcomer women about the health and social services system in Canada. In Morgan's opinion, peer outreach workers could also provide newcomer women with a "sense of safety" as they engaged with system.

Increased counselling services were also recommended, particularly those targeted at and affordable for immigrant and refugee populations. Within such counselling services, some service providers identified a need to recognize the potential for post-traumatic stress disorder alongside postpartum depression among immigrant and refugee women. To the point of counselling requirements, Gabriela, a community health/social worker, specifically described "a vacuum" in relation to services able to support African immigrant and refugee women in Canada once they were diagnosed with HIV.

Naomi, a doula, raised the unmet need for emergency child-care for immigrant and refugee women in the city. She viewed this as particularly urgent to address for pregnant women who had few social supports as they approached their due date:

> *There are many women who truly are here alone. Who either left their partners, did not have partners, fled here, where they are truly by themselves. In those scenarios, usually it is the care for subsequent children that is one of the biggest issues. So the belief that because the tradition was to birth in a community scenario with all your other kids present maybe where they have come from, there is an assumption that they can bring all their children to the hospital. So child-care for the subsequent children is a real problem. And it is a really underserved issue in this city. Like it is not, there is nowhere that women can drop their children in an emergency situation. So we have seen that as being a really big issue, a really big issue.*

Another service provider mentioned that accessible recreation programs that women and their children could use together would be helpful. A final recommendation by a number of the service providers was to repeal the cutbacks to the Interim Federal Health program that were being put in place by the federal government.

Voices of African Immigrant and Refugee Women

From my interviews with seven African immigrant and refugee women who lived in the west end case study area I identified thirteen key themes. Below, I provide a brief narrative from one of my interviews and then discuss each of these themes in turn below.

Nesreen's Story

The first time when I came to Canada to visit, I met my husband. Then I go back home to tell my job and I came back to get married. When I came here, I'm scared. Everything is new. The winter is long here and it's hard for me to walk in the snow. I think about my family, I think about my job. At first we lived downtown and I see all of them white Canadians and I feel my different. And at first when I came, my language is bad. Now, the area where I live is the best thing. Here is lots of Muslims and they're from Africa. It's normal to see someone cover hair and cover the face.

A year in Canada and I was pregnant. I would tell my sister-in-law back home, she married before me, that today I see my doctor. I have to do blood test, I have to do ultrasound. I hear it's not big different from back home. But if I'm born here I have my family here, I have sister or I have my mom to explain to me, to tell me everything. People born here they know everything because they used to go to school here and they know everything from the school, from the friends, from the family. For immigrant you catch the information from here, from here, from here, and sometimes when you go somewhere you have someone give to me a flyer. And at home the relations between people are so easy. Here, you need to make an appointment for everything.

I'm so comfortable with my doctor. I chose a female and I like the female. The first baby, I meet her in the hospital. But the second one, it's a difficult delivery. She tell me she can't do anything for me. There's the professional, he has to come and see me. I said: "No it's a man, it's a man". I tell her to try and do it. She tell me no it's too hard. But you know I tell her if I don't have any other choice it's okay. I remember the man come and once he see me they have to do the surgery.

I call my family back home at least two hours a day. They call me when I was at the hospital and when I'm here my mom always tell me I have to call her every day. I tell her how's my feeling and I'm okay or no. Every morning when I wake up I phone her. I'm okay and the baby's okay. Just support me by phone. And most of the week I meet my friends. We are everyone from somewhere. We talk about everything. For the milk, I use this milk. It's very good. This milk has iron. What is the best diaper? And it's even to help each other: "I have highchair. It's in good condition. I don't use anymore. I can give to you".

Key Themes

MIGRATING & SETTLING IN

The migration trajectories of the immigrant and refugee women were quite different and not always linear. Among the voluntary immigrants (n=5), all of the women explained that they had come to Canada because of their husbands. Three of them were sponsored by husbands who were already settled in Canada and whom they had recently married. Another two accompanied husbands who pursued their education in Canada. These women returned to their home countries to submit immigration applications before they moved to Canada permanently. The back and forth journeys between countries in pursuit of educational and career opportunities sometimes resulted in families that were divided. One of the women who had come to Canada while her husband studied remained in the country and raised their children. Her husband returned to their country of birth to find work. Two other women who I interviewed were refugees, and their migration experiences were again different. Due to instability in her country of birth, one of them applied for refugee status in Canada following her postsecondary education in the United States. All of these migration stories were quite unlike that of the last woman with whom I spoke. This woman's urgent flight from her country of birth meant that she and her children entered Canada with almost nothing:

> *On sort pas avec l'argent, on sort rien, on vient ici dans ce pays avec rien…moi j'ai perdu d'abord mon mari, et j'ai perdu tout ce qu'on avait comme de biens à cause des guerres. On s'est retrouvés dans les camps de réfugiés, alors, dans les camps de réfugiés là, qu'est-ce qu'on va sortir avec ou quoi? Rien. Même pas une bague en or. Rien du tout.* (Aurélie)

These different reasons for migration affected the settlement experiences of the women. Although they left their broader families behind, some of the women had family

members and/or friends who already lived in Canada. These existing connections helped to ease the transition into new lives in a new country. Others faced the settlement process largely alone or felt isolation in becoming acquainted with a new spouse while separated from prior social networks and supports.

For a number of the women, employment and training featured strongly in their settlement stories and was a primary source of struggle. For Aurélie, who had left her country with nothing, her responses to all of my questions eventually led back to the financial difficulties she faced. The impact of such hardship on herself and her children was evident in her comments. These difficulties were due to her inability to find a job without formal documentation. She had also been unsuccessful in attempts to secure a loan to start her own business in lieu of outside employment. Even with a university diploma in hand and strong work experience in her country of birth, Esyete was also disappointed to face barriers to entry in the job market in Canada.

> *…I know, like, the degree from those African countries is not really a credential here, but my job experience was somewhat international…And I know I can do it, but the thing is here they don't like when you say your degree is from Ethiopia. So that was really disappointing, and I was this close to going back to my country because my job back home was really nice and I was really enjoying it, and I actually go through a lot to get this Computer Science degree…*

As a result, Esyete worked a retail job full-time while she pursued another university degree in Canada. She discussed how the de-skilling that occurred as a result of unrecognized credentials caused some immigrants to socially isolate themselves from cultural communities who might otherwise have been a source of support. Partially, she explained, de-skilling led to feeling ashamed about the work you did and a lack of desire to share this with other people. It

also led to the necessity to carry out one or more lower-paying jobs that made it difficult to find time to interact with others:

> *…you're not a professional that, a professional person that can have a regular job. Like a job that you can go at nine o'clock and then leave at five….you have to work 'til midnight, you have to work early in the morning, you have to work two jobs, maybe three jobs. That's the only way that you can help your family, you can pay your rent, you can pay your bills.* (Esyete)

For Fatima, the financial challenges of settlement also stemmed from a lack of health insurance when she first arrived. She was a voluntary immigrant, pregnant but without OHIP coverage until her immigration claim was processed. Fatima calculated that she incurred fees of $300 per ultrasound and $2,000 for her hospital stay to give birth.

Beyond the tangible considerations related to settlement, Nesreen described how "scared" she was when she arrived in Canada and "everything was different". She recalled how she thought to herself: "I can't change myself and I can't go into, everything is new. New program for the school, new program for the health". Despite these initial feelings, Nesreen also discussed how trips back to her birth country made it clear that she had in fact changed since she had immigrated:

> *…when I go to my, visit my back home…I'm surprised sometimes what my [was] family doing. And they are surprised from me. "Wow, you used to do like this, why you think now it's not normal or why we are doing like this?"*

MAKING A HOME IN THE WEST END

Most of the women described how they felt generally happy that they had settled in the neighbourhoods in the west end case study area. Some of the geographic features of the area were evident within these discussions. The proximity of the mall, the community health centre and "the Arabic store" were all listed as assets, as were the number of parks and community

events organized by one of the apartment management groups in the area. Views on the ease of public transit use were mixed, as were thoughts regarding grocery store access in the area.

Beyond these features of the location, the women pointed to the opportunities that the area presented for building connections with other newcomers. The diversity of the population, and the way in which community services had responded to such diversity, was cited as a definite asset by a number of the women. As Zainab explained:

> *You can find people from Asia, Africa, Europe. Just name, you find here…even the school, you can feel it in the school…They know about our culture. Even our celebration, Eid, the school send us paper saying: "How many days your kids going to be absent for Eid"?*

Nesreen had lived in the central area of Ottawa before she and her family moved to the west end. She described how the social environment in the west end, and particularly the presence of a sizeable Muslim population, affected her feeling of belonging. Downtown, she would go to the parks and see only "white Canadians", which made her feel different. Muslim immigrants like her, she explained: "live in this area, in the west area because there's a lot of Muslim…it's normal to see someone cover hair and cover the face. It's normal". Despite these positives, three of the women discussed hopes that they would one day move away from the area. Their shared ideals were homes of their own that were quieter than the apartment buildings in which they currently lived. They described how these homes would provide more room for them and their families. Housing in other areas of the city would also allow for the opportunity to own an outdoor space (i.e., a backyard) as well as an inside one.

FINDING AND TRAVELING TO INFORMATION & SERVICES

Unexpectedly pregnant again only six months after the caesarean birth of her first child, Maryam shared with me how she wasn't yet physically or emotionally ready for a second child.

Her search for an abortion in Ottawa was hindered by an unhelpful physician and exacerbated by her unfamiliarity with the services in the city:

> *...Il [le docteur] a dit, non. Il faillait que tu le garde…il voulait pas que je le fasse. Si lui il fait le pas il fallait qu'il m'envoie à des cliniques. Mais moi je savais pas des cliniques. J'ai jamais allé, des cliniques pour avortement. J'ai regardé l'internet, j'ai cherché. Comme rien de tout.*

Once she was five and a half months pregnant, Maryam was past the time when clinics in Ottawa would perform an abortion. It was not until this time that her physician finally shared information for the Morgentaler Clinic, which was located in the central area of Ottawa. Although they did not perform abortions so late in pregnancy, the Clinic said she had the option to travel to Montreal to seek services there. Uneasy with a later-term abortion and tired of fighting the system, she said "laisse-faire" and decided to have the baby. Maryam described her emotions related to this decision as follows: "J'etais vraiment triste. Toujours, tout les soirs j'étais pas bien parce que j'était pas à l'aise".

Although the repercussions of Maryam's story were the most dramatic that I heard, other women also shared the challenges they sometimes faced locating reproductive health information and services in a new city. Esyete and Nenyasha, for example, had both faced difficulties finding a family doctor. Esyete also discussed how she had heard nothing about HIV in Canada, in contrast to the constant educational messages on the topic in her country of birth. Nesreen, who had not faced difficulties herself, described how you had to "catch the information from here, from here, from here" to learn about the health and social services offered. Some of the women also described how they talked about health information with their friends, and used the internet to figure out where to go for assistance.

Once a service was identified, the next step was for women to figure out a way to get there. Most of the women either owned a car or had a friend who was willing to drive. For these women who were not reliant on the public transit system, mobility was not presented as much of an issue. Despite this, one woman described the challenges of loading multiple children into car seats. She wished that there were more services in the area that she could walk to with a stroller. With respect to the bus system, this woman also indicated that the ease of its use varied by proximity to the express routes. If you were not located close to one of these routes, the public transit system was more difficult to access. Winter weather was also mentioned as a particular challenge by a number of the women for getting out and around to services.

LEARNING HOW THE SYSTEM WORKED

Having grown up in different countries, the women shared information about the health care systems they were used to in those settings. Some of these systems lacked infrastructure and resources. Some were privatized, centralized around hospitals, and/or used only by the general population in case of emergency. What the women were used to translated into challenges for some of them as they learned how to interact with health care institutions and providers in Canada:

> *…people do not really go to, to the doctor unless if something is wrong. We do not really do like annual checkups. Of course some people do but it is not, like I mentioned like the way I came here, I am not from a privileged family financially. So those are some of the services that we do not really even talk about because it is expensive to go to the doctor. But here now that there is free healthcare, you don't really pay to get a checkup, I still don't know what to talk to my doctor about. I take the kids all the time, but I don't know what to talk to my doctor about…I have never even had an appointment for myself…It is something that I want to do but when I think about it I am like, "Okay what do I really, how do I ask the doctor what I need?" So it sounds*

like something simple but now it's been years I've never went to do it…I am just afraid that when I, they will ask me what I want, and I won't be able to know like what to tell them…if I had seen my mom doing that, I would be like, "Oh now it's time for me to just go and say what it is." But it is not that easy for me because I've never seen, seen it that way. (Nenyasha)

Maryam ran into trouble when she tried to get birth control pills, which she attempted to do without her husband's knowledge. In Somalia where she grew up, she was used to buying the pills directly from the pharmacy. In Ottawa, Maryam made an unsuccessful trip to a pharmacy to do the same. She had expected a similar process as in Somalia, but was disappointed to find that a prescription from a physician was required. Esyete, on the other hand, described the confusion she felt as she tried to understand who was who in a local walk-in clinic. She was used to a system in which health care providers wore uniforms. Without such visible indications of professional roles, Esyete said: "…you don't even tell who's the nurse, who's the doctor…they don't even have their names in Canada…this is not good, you know".

INTERACTIONS WITH THE HEALTH CARE SYSTEM

"Is this how they treat patients?" Esyete asked incredulously as she related to me her various, unsatisfying, interactions with walk-in clinics in the area. A university-educated, young professional from an urban area back in her country of birth, Esyete described her expectations for the Canadian health care system as "high". She could not believe that in Canada the physicians she encountered did not sit down to talk to her, appeared rushed, and "don't give you the time to express your feelings". This was especially confusing to her as she approached the system believing "in telling everything that I feel so that they can bring this together". Esyete also could not believe that the results of an HIV test she had once taken had been lost. She described how she had spent weeks worrying about the results and had taken time off

from her full-time job and her studies as she chased them down. The culmination was that she physically traveled back and forth from the laboratory to the walk-in clinic over and over. Through this process, she helped the staff at these services to identify the issue and work through trouble with the fax transmission. As is standard practice in Canada, the laboratory would not simply hand over the results to Esyete herself. The collected impact of these feelings and experiences were summarized by Esyete as a decreased likelihood to seek help in the future: "Sometimes they just disappoint me. I don't feel confident to go and see the doctor."

Esyete was not the only one who shared stories of interactions with the health care system that made her uncomfortable and/or dissatisfied. Zainab was used to privatized care in her country of birth. To her, the issue of wait times in Canada was an important one. She described how "scary" she found the month that passed between the time her family doctor found a lump in her breast and her appointment for a mammogram. Nenyasha, who arrived in Ottawa pregnant and without a family doctor, described the difficulties she faced securing a referral to an obstetrician:

> *…I ended up going to a walk-in clinic. And the first one that I went to, they made the referral and then they sent me a letter instead of calling me. And by the time I got the letter with the referral, I had already missed my appointment…I tried to call the doctor they had referred me to because I had missed my appointment. They tried to, to reschedule it. It had turned out that he was going on vacation for three weeks. By the time he got back it would be too late for me to see the doctor for the first time as a pregnant lady. And then I went to another walk-in clinic, I waited in line for I will say for about two hours. And then when I finally saw the doctor and told him what I wanted, that I needed a referral, he said he doesn't give referrals to other doctors because, his reason was, "I don't want your new doctor to keep sending me information about you, so I'm not going to do a referral".*

Positive experiences about their interactions with the health care system were also shared by a number of the women. These included descriptions of feeling "very comfortable"

with their family doctors, supportive public health nurses who conducted postpartum visits and helped them learn how to take care of a baby, and the connections the women made when they sought breastfeeding help and attended playgroups offered by the community health centre. Nesreen also discussed her pleasure with the nurses in the hospital who cared for her while in labour and delivery. She referred to these nurses as "very soft and kind".

STRESS & MENTAL HEALTH

Throughout most of our interview, even as she discussed hardship, Esyete struck me as determinedly optimistic; strong and indignant, if anything, but not sad. At one point, however, she explained how she forced herself to focus on other things rather than to dwell on the challenges she faced:

> *…I keep myself busy so that I don't get depressed, or I don't get, you know, "Oh my god, why am I here? I have to go back, I miss my…" I don't want to go through this, you know…So that's why I chose to be busy.*

I felt similar emotions in the sigh that Nesreen injected into the middle of her statement about how happy she was in Canada:

> *Yeah [sigh] I'm so happy and my life is, ah, you know, it's very, very well… It's not exactly, but you know I like my life here and I'm so happy and the, my kids they are so happy and I'm happy for my kids.*

These women would not routinely describe themselves as depressed or even sad, but the collected impact of being separated from their families and the struggle of settling into life in Canada seemed to take its toll. This was much more explicit in Aurélie's case. She explained to me how the difficulties she encountered in Canada affected her health, both mentally and physically:

> *Si tu avais peut-être une maladie là qui ne pouvait pas se manifester mais non ça va manifester en ce moment là, par ce maintenant tu as beaucoup des*

problèmes dans ta tête. Il y a des factures à payer, il y a les enfants…Des fois, je pleure et je dis pourquoi je vais souffrir encore? J'ai quitté dans mon pays dans la souffrance et je viens ici pour souffrir?

SOCIAL NETWORKS & SUPPORT

The energy and joy as Nesreen described her network of friends was infectious. It flowed into the room. To me, this room had previously seemed like a decently-sized, but regular family apartment. It was situated in just another tall, brown apartment building in an area that felt like it was full of them. Through Nesreen's stories and laughter, I saw instead a hive of activity as she and her friends hosted in turn other women and children in their homes. All Arabic-speaking but not all from the same country, they served coffee and food, while they shared stories of their home countries and cultures, their kids, themselves, and their lives now. Sometimes these women instead met up at the playgroup the Pinecrest-Queensway Community Health Centre hosted regularly in the basement of the building. On nice days they tried to get out, packing picnics and meeting in local parks. In the context of the diversity of the area, the apartment buildings that had seemed so nondescript to me created a density that was a vital piece of how these women met and supported each other.

For Zainab, a strong network of friends helped to break the isolation of parenting: "…my husband is busy and I'm staying with the kids all the time…it's good to meet people that you can talk and other, different things, not only the kids and the house". Nesreen further discussed how her group of friends supported her after the birth of her most recent child:

…when I'm in the hospital, all my friends come visit me and all of them bring the gift and the food. And when I come back from the home, ah, home, they organize every, each day they cook…For example, Saturday for, ah, for someone, Sunday for someone…They organize each other, which day she want to cook for me.

The contrast between this view of life in one of the west end's apartment buildings and that of some of the other women was unmistakable. To protect herself from the judgment she felt she would incur for being a single mother, Nenyasha rarely sought out friendships with other women in the area. She sometimes visited the basement playgroup with her girls, but she made small talk only and avoided sharing personal details of her life with other women in attendance. Instead, Nenyasha, capitalized on the use of technology and sought her social networks through the virtual spaces of online communities:

> *I also have a very good network on Facebook of mothers with children around the same time as me…mainly in the U.S…The Ottawa community I don't, I think there's that thing about talking to someone that you're never going to bump into so you can ask any questions, you can share your story. If you're depressed about something they can lift you up. But with Ottawa people, sometimes you don't want to share with something and have them guide you.*

Fatima also described how she felt isolated during her first pregnancy. She came as a newlywed and became pregnant the first month after she immigrated. Getting connected to others in this new country was difficult for her. She struggled with nausea and vomiting in pregnancy at the same time as she sought to acclimatize. Long days were spent alone in her apartment while her husband worked "nine to nine".

Some of the women connected with home country organizations and received support through their churches (e.g., being picked up and taken grocery shopping). The limits of what could be expected from these sources of support were also discussed by some women. The primary responsibility for having and raising their families still belonged to the women themselves:

> *…la communauté s'il est là il ne va pas prendre la charge de ma famille, non. Ils va pas…La communauté ils sont là pour aider les gens quand ils arrivent ici*

> *et pour trouver les travailles et pour trouver d'autre chose, mais pour le reste du part de la famille, non, la communauté il ne peut pas aider parce que ce n'est pas son travail. Ce n'est pas son travail.* (Aurélie)

SEPARATED FAMILIES – MISSING PEOPLE IN THE MOTHERHOOD JOURNEY

As they related their stories of being pregnant, giving birth, and recovering postpartum in Canada, many of the stories the women told were intertwined with the theme of family. These people were the loved ones whose presence, caring, and support were missed. Mothers and female relatives were particularly mentioned. I had the impression that the burden of traditional women's work was different when carried out alone in apartments in Canada instead of surrounded by a host of family and friends. At the same time as she offered me beautiful home-baked pastries left over from Eid, Fatima told me that she hated to cook. While the expectations from her husband for the feast marking the end of Ramadan appeared unchanged, in Canada Fatima's domestic workload was not shared. This same sentiment translated over to Fatima's answer when I asked how her pregnancy, birth and postpartum experiences might have been different if they had taken place in her home country: "…my family is there and my husband's family is there. Here, I do all the cleaning, everything by myself. I have to do everything myself".

Some of the women shared stories of how they used formal services (e.g., postpartum home visits from public health) or received baby showers and gifts of required items from colleagues, church groups, or friends. Despite such help, the perception was still that there was only so much assistance that people who were not family could give. Support was needed during pregnancy, rest and recovery were needed postpartum, and time away was needed from full-time parenting:

> *…we are here, no family with you. Even if you have friends. But everyone here have their, their life. Like, after five everyone they are home with their kids, with their husband. It's not like when you back home and have all your family. If you get tired, you just call your mom. You take them to your mom or your mother-in-law or your sister. (Zainab)*

The separation from family members was made worse in some cases by the ways in which international travel was limited. Plane tickets to travel back to Africa were expensive. In addition, policies restricted the mobility of newcomers while they navigated the process of application for permanent residence:

> *…in Canada it took about three or four years for me to get permanent residence. And I couldn't even travel—even to visit the U.S. My sister was studying in the U.S. at the time. I couldn't even go to visit because I was not a permanent resident yet. (Nenyasha)*

Despite the challenges, the women took great effort to stay connected to their families "back home" by phone or via the internet (e.g., through the use of Skype). Many of them spoke of regular, if not daily, interactions with their families that sometimes lasted for hours. Nesreen described how she stayed close with her mother during and following her most recent birth, even with the physical distance between them:

> *You know they call me by phone when I was at the hospital and when I'm here my mom always tell me, should be I have to call her everyday. Just, you know, I tell her how, how's my feeling and I'm okay or no. Every morning when I wake up I phone her. I'm okay and the baby's okay. Just support me by, by phone…*

RAISING CHILDREN IN A NEW COUNTRY

Six of the women I interviewed were mothers. Three of these mothers were raising children alone because their partners had been killed back in their home country, had returned there to find work, or because relationships had broken up. For all of these six women, the topic of their children was raised during the interviews. Some of them shared their happiness

as they watched their children grow up in Canada, playing rather than being uncomfortable in the snow, and attending "good schools". Nenyasha also spoke about the importance she placed on integrating her religious beliefs into the upbringings of her daughters:

> *I also want my kids to have the same upbringing that I got. So if they can have their Sunday School…that teaches them who Jesus is and why we pray, how to pray and so forth.*

In contrast to these more joyful conversations, Aurélie shared with me her pain as she increasingly felt that her hopes for her children were in jeopardy. The barriers to employment and a stable income that she faced as a refugee were also now being encountered by her eldest children. This was not what she had envisioned when they had fled the Congo in search of safety and security in Canada:

> *Je ne peux pas m'en sortir, je ne peux pas réussir à résoudre ça. Ça va me faire tomber malade. C'est au moins, vraiment, ça fait mal…quand tu es parent, quand même tu es papa ou tu es maman, mais tu n'arrives pas à t'en sortir avec ces fardeaux. Ça fait vraiment mal...les enfants ils sont venu ici on vient dans des pays de guerre. On laisse les enfants à l'école intermédiaire…Ils sont au Canada. Ils sont entrain de chômer, pleurer à tous les jours. Ils tournent « maman, on trouve pas le travaille, maman, qu'est-ce qu'on doit faire? »*

Two other women also discussed their worries for their children. In these cases, their fears were about who would care for their children if something should happen to them. These worries were set within the context of the absence of other family members in Canada. As Zainab said, she tried to protect her own health because: "…if I get sick, who's going to take care of my kid"? Nesreen also explained how she had to adapt her parenting practices when separated from the people and communities she had known for years. Children had more freedom to play outside in her country of birth, she said. In that context, you knew that the community watched out for them and could bring them home if they got lost. Without a long

history in a given community, Fatima explained how she wanted to be very careful that her daughter socialized with "the right people". These people, for instance, wouldn't expose her children to inappropriate content on TV or through the internet.

CULTURE, LANGUAGE & RELIGION

Her first encounters with people on the streets in Ottawa were surprising to Aurélie, who was used to smiling at everyone back home and stopping to say hello. She recounted how her children had teased her: "Oh maman, toi tu crois que ici c'est l'Afrique que to vas dire à tout le monde bonjour". A social culture was more than just the norm for some of the women. These encounters were how they felt connected to others and how they were used to finding and sharing information in their home countries:

> *You talk, you ask. That's how you usually find oh, where is the good doctor for this and this…the social activity is, you know, it's always there. It's always there so people can talk and discuss and you can just pass information…It's not a planned thing, it just goes like that. It's a natural talk, you know? But people get information…They just, after work everybody get together almost every day or something. There's a coffee ceremony that all the families can sit down and then discuss about some other stuff almost every night.* (Esyete)

Talking about reproductive health, however, was another issue. Some of the women said that they did not have any problems discussing reproductive health with service providers. Other identified how the cultural norms of their upbringing occasionally made it difficult to seek out information and services. Esyete explained that, even as a well-educated woman from an urban area, she grew up in an environment where reproductive health issues were not spoken about openly. Using the example of HIV testing, she described how difficult it could be to seek out such a service even in Canada:

> *…in Africa it's shame to just say, 'Oh, I want to do an HIV test.' You know it's, it's really hard. You're going to struggle with yourself. Even when you go to the clinic to do this test, you have to be strong enough because you don't know what the result's going to be and you have no idea how you're going to be after your result. Who you're going to be, you know? So, if we grown up with this kind of environment and when you come here…it's going to be the same for you anyways, whether the culture here is not the same as, like, back home.*

As a Muslim, Nesreen also shared how she had to adapt her beliefs during the course of the delivery of her second child about being undressed in the presence of a man who was not her husband. Although she started with a female doctor, the need for an emergency caesarean section left her with no other option than to be placed under the care of a male surgeon. Care preferences for female clinicians were not always attributed to religion or culture, and were not homogeneous among women. As Fatima, who is also a Muslim, stated:

> *I prefer woman as my doctor because it makes me more comfortable. It's not because of my religion, I'm just more comfortable like maybe you are too. But I'm now with a man because I have no choice.*

The struggles women occasionally faced in engaging service providers around reproductive health issues were described as compounded in the context of health care settings where doctors appeared rushed and/or if women faced language barriers. A number of the women spoke about the issue of language and how it could make settling in and interacting with health care providers more difficult. For Fatima, who didn't speak English when she arrived in Canada, this meant that she relied on her husband to translate when she visited her physician for prenatal appointments and during the birth of her daughter.

ASSUMPTIONS, JUDGMENT & DISCRIMINATION

Although not always labelled as such, a number of the women described situations where they had encountered assumptions about themselves or outright judgment or

discrimination. Some of these experiences came from within the health care system. Two women related encounters with doctors in which the clinicians had made assumptions about the size of family that was best for them, as well as their ability to take care of that family. Nenyasha, for instance, described how she felt that doctors and others treated her differently because she was raising two children on her own:

> *…my life is not really, this is not really what I dreamed of. I thought I would get married first and then have kids. And so every time that I meet somebody who's married with kids, I feel like I didn't do things the right way and they're just looking at me like, this girl what is she thinking….especially when you go to the doctors and they're like, "Oh these are your kids for now." You know, as if they're planning my life for me, like I made a mistake by having them…So they'll kind of tell me that I shouldn't be having any more kids anytime soon…If I had someone to have another baby with, I wouldn't mind having another one soon. It's up to me. But if a doctor looks at me and kind of feels sorry for me and, yeah. And the other thing is I was a very independent person, like growing up. And for years I've had a good job. I take care of myself.*

When she sought an IUD (a form of contraception that is inserted in the uterus to provide up to five years of birth control), Maryam found herself in the opposite situation from Nenyasha. Her provider, instead, assumed that she would want more children sooner. This was despite the fact that Maryam had just given birth to her second child from an unplanned pregnancy while she used birth control pills:

> *…ils voulaient pas…'Deux enfants tu va faire ça? C'est trop, comme, cinq ans. C'est difficile cinq ans'…Alors elle, elle avait dit vous avez du temps, au-moins pensez-vous d'autre choses…elle voulait me donner des pilules. Moi les pilules, non. Parce que les pilules ça va pas marcher. Parce que les pilules, c'est ça que j'ai tombé [enceinte], j'ai oublié.*

A few of the women spoke about their level of comfort in the broader community. The west end was the area of choice for some because of its diversity compared to other areas of the city. Even within these diverse neighbourhoods, two of the Muslim women who wore

hijabs had experienced discrimination out in the community. Zainab told the story of being targeted by such discrimination when with a friend. She described her powerful reaction to the experience:

> *…an old man and woman coming across us and [friend's name] took her cart aside. She said, like, "It's old man, let him go first". And then he look at us and he start to talk…"Why you coming here? Go where you come." …So I got very upset, and I told him, like, "You have no right to talk to us like that. You're Canadian and we are Canadian too. You citizen, we are citizen. We have the same rights as you". That's why we came here, because we couldn't get that right back home*.

RESILIENCE & PRIDE

Despite the hardship she had endured prior to and since arriving in Canada, Aurélie's resilience and pride were evident throughout our discussion. I found myself given an impromptu tour of her home with the purpose of showing me her many efforts to find a job in Canada. Failing that, Aurélie, had also unsuccessfully tried to start various businesses to provide for herself and her children. I was shown the manila folder overflowing with documents from her unsuccessful attempts to secure a bank loan. I was shown the backyard where a small smoker stood from her effort to sell smoked fish to other families interested in authentic African food (the policies of the social housing complex where she lived ultimately would not permit its use). I was taken to the basement to see the sewing machine and piles of fabric with traditional African prints to make into clothes. Even though she seemed exhausted and sad, I was left with the impression of a woman who was still fighting hard for her family. She appeared desperate to prove that she was trying everything in her power to succeed in Canada.

Such resilience and pride were also evident in my interviews with other women. For instance, in the determination with which some of them were pursuing additional studies to re-train, in the statements from two of them that they lived alone but worked hard and were able to support themselves, and the steps that a number of them took, even within the context of their busy lives, to help other newcomers to the city.

RECOMMENDATIONS

Based on their own experiences, a few of the women identified potential improvements to the health and social services systems in Canada that would help the reproductive health of African immigrant and refugee women. These recommendations varied depending on the circumstances and experiences of the women themselves. Aurélie focused on the pressing concerns of stable employment and financial security with which she herself struggled. She discussed how banks in Canada needed to be more understanding of the circumstances of refugees. These institutions should recognize that refugees often entered the country without any of the paperwork or credit history that would usually be required to secure a loan. Just a small amount of money, she explained, could help provide someone with the opportunity to start a business as a route out of poverty.

Nenyasha and Esyete targeted their recommendations on resolving some of the issues they had faced within the health care system. Nenyasha wondered why her family doctor, to whom she brought her children regularly, would not ask why she had never made an appointment for herself. This initiative on the part the doctor would help Nenyasha to overcome some of the uncertainty she felt given that routine physicals had not been a part of her upbringing. In a similar vein, Esyete hoped that physicians would slow down and take the

time to make African women feel comfortable. This included really listening to their needs, being sensitive to the potential that women were not always comfortable to talking about reproductive health issues, and providing interpretation services.

Conclusion

The west end case study area was one rich in diversity. It was a key area of settlement in Ottawa for African immigrant and refugee women and their families. The service providers and the women in this area both pointed to the relative density of newcomers as an asset. This presented opportunities for African women to meet and build support networks with others around common points of culture, language, religion, and/or migration experience. It also contributed to a sense of belonging for some of the Muslim women who felt that their choice to wear the hijab was common with other women who they regularly encountered in the area.

While the case study area featured some of the housing and population density similar to the central area, the service map also showed less variety in services and a greater separation of residential zones from pockets of commercial space. The women I interviewed had settled within the many rental and social housing units characteristic of the area. Present as well were a community health centre and various walk-in clinics. Bus routes travelled along some main roads within the neighbourhoods and gave access to other parts of the city that varied depending on whether timing was within peak commuter hours or not. The clustering of many services next to these main roads contributed to views by African women and service providers that they were not always easily accessible.

It was common among both the service providers and African women to set reproductive health within the broader context of immigrant and refugee women's migration

experiences and settlement challenges. This again showed the ways in which experiences in place were partially structured by factors that extended beyond the neighbourhood. Such forces helped to shape the varied positions of the African women and the opportunities and resources they had at their disposal. Both groups of participants described the different backgrounds newcomer women had with respect to health care and cultural or religious beliefs regarding reproductive health. Another theme raised by both service providers and African women was the particular challenge of navigating an unfamiliar health and social services system.

Housing additionally crosscut many of the discussions of service providers and women. Arrangements such as apartment buildings and shelters helped to structure social interactions and the services that were available in different locations. Particularly important was the way in which apartment buildings were a site in which some women actively built places of their own to share information, gain support, and break the isolation of pregnancy, birth, and parenting in a new land. Instead of being spread out horizontally across a neighbourhood, the close vertical proximity of households in these buildings facilitated social connections between the women. Assisted by these physical arrangements, the women made less formal and more temporary social places in the interests of their reproductive health and overall well-being. Not all the women I interviewed, however, felt comfortable with or were able to access such networks. Some of these other women sought out virtual communities in which they felt more anonymous and accepted, or remained isolated by their circumstances (e.g., by sickness in early pregnancy or in social housing outside of the apartment complexes).

What differed the most between the service providers and African women were not necessarily the main topics raised in our discussions. Rather, they were the underlying feelings or concerns that were continually returned to within these main topics. For the African women, family seemed to crosscut and underlie almost every issue. This manifested in different ways: in wishing for the support such family would have provided, in feeling sadness due to separation and loss, in missing the culture of giving birth and raising children amongst large groups of other women, in sharing hopes and fears for their own children. Indeed, for the women, their own reproductive health seemed inextricably linked to the concept of family and raising their children.

The issues of separated families and supportive community cultures were raised by the service providers, but were not necessarily at the heart of many of our discussions. For the service providers, language barriers and other settlement and access challenges (e.g., health care coverage) were returned to most often. The predominant focus of the service providers on new refugee populations may have been at play. All but two of the women I spoke to were immigrants. Even among the two refugee women I interviewed, one had migrated to Canada indirectly after completing her university education internationally. That is, she had not fled her country of birth under acute circumstances. Differences between service providers and the women may have also been partially due to the location of the service providers within the health care system. The issues that they encountered every day within that system were those that were most relevant in their work.

The next case study chapter again presents a unique context for the reproductive health experiences of African immigrant and refugee women.

Chapter 7: Case Study – Southwest Suburban Ottawa

Introduction to the Case

At times during the drive from downtown Ottawa to the southwest suburban case study area you pass stretches of rural land that give the impression that you might be lost. If you keep driving, though, the next cluster of suburban development is just up the road. The size of the case study area itself is large. Collections of big box stores and services are visible across their parking lots that adjoin the main roads. The high speed limits on the major commuter routes can leave little time to consider street signs and landmarks. Once you turn off into the interior zones, the pace of traffic slows dramatically along curving residential streets. Well-maintained detached homes fill the spaces in between the main roads. Small parks are associated with each grouping of houses. School crossing signs are common. A large and relatively new library and community centre are co-located in a hub near the north end of the area.

The size, lower population density, and suburban nature help to distinguish the southwest suburban case study area from the other two case studies in this research. Compared to the other two, the area is host to a population with a higher and less mixed socioeconomic profile and a smaller population of newcomers. These aspects of the local case study context are visible and integrated within the findings that I present below.

The Participants

For this case study, I interviewed three service providers whose programs were focused specifically on the southwest suburban area of Ottawa. These three providers were all women and included two community health/social workers and one nurse. Additionally, eight service providers who I interviewed and who worked in more than one area of the city had this southwest suburban area as part of their scope of practice. These eight providers included seven women and one man, and represented the following professions: community health/social worker (n=3), doula (n=1), midwife (n=2), nurse (n=2).

I interviewed six African immigrant and refugee women who lived in the southwest suburban case study area. These women had the following socio-demographic characteristics:

- Most of the women were immigrants (n=4). Two of the women were refugees.
- None of the women had lived in Canada for a period of five years or less. Two had lived in Canada for between 6-10 years, three for between 11-15 years, and one for more than 15 years.
- The women represented five different source countries from the eastern, western and central regions of Africa. These countries were: Kenya (n=2), Zambia (n=1), Ghana (n=1), Nigeria (n=1), Democratic Republic of Congo (n=1).
- None of the women referred to English or French as their native language. Five spoke English as a second or third language and one spoke French as a second language. The native languages of the women included Yoruba, Shona, Twi,

Kikuyu, and Swahili. I carried out five of the interviews in English and one of the interviews in French.

- All of the women who I interviewed in the southwest suburban area identified as being part of the Christian faith.
- Most of the women who I interviewed in this area had at least some college or university-level education (n=4). One of the women had completed trade school and one of the women had a high school or less level of education.
- Two of the women were between 31-40 years old, and four of the women were between 41-50 years old.

Profile of the Case Study Area

The southwest suburban case study area was composed of the two neighbourhoods of Barrhaven and New-Barrhaven-Stonebridge. By car, the southwest suburban case study area was approximately 25 minutes west and south of the downtown core of Ottawa. This drive varies greatly by time of day, as the few main roads that carry commuters to and from central Ottawa face heavy traffic at peak hours. Together, the two neighbourhoods that made up the southwest suburban case study area included a population of approximate 54,875 people in 2011 and covered an area of 31.9km^2. This was about six times the physical size of either of the other two case study areas. Correspondingly, the population density was much lower (1,720.2 people per square kilometre (as compared to the Ottawa neighbourhood average of 2,350.8 people per square kilometre, and 7,246 and 4,531 people per square kilometre for the central and west end case study areas respectively) (Ottawa Neighbourhood Study, 2011).

Most of the houses in this area were built since the 1980's to accommodate a rapidly growing suburban population. As Anita, a community health/social worker, described:

> *…over the last two census periods Barrhaven's population has really exploded and, at least a year ago, it was the municipal ward with the highest birth rate…there are 20 schools by one of the school boards…none in danger of closing…it gives you an idea of a booming population and, you know, my impressionistic view of the number of houses increasing almost on a daily or weekly basis.*

The nature of these houses also contributed to the low population density of the area. Most of the households in the area were home-owners, with only 6.6% being renters in 2011. This percentage was much lower than the Ottawa average of 32.7% (Ottawa Neighbourhood Study, 2011).

Socioeconomically, the area was also of higher income and less mixed than the other two case study areas. Only 6.4% of the population of the southwest suburban case study area was low income in 2011, as compared to the Ottawa average of 11.6%. 34.6% of the households had an income of over $125,000. Despite being an area wealthier than the Ottawa average, some service providers pointed to signs that the southwest suburban case study area was diversifying socioeconomically. They identified, for instance, the presence of a shelter and a number of social housing units (211 as compared to the Ottawa neighbourhood average of 229) (Ottawa Neighbourhood Study, 2011). Newer developments were also perceived as more affordable for some families since they featured smaller homes and townhouses than the earlier housing developments that were built in the area. Yasmine, a community health/social worker, also explained that: "…the Barrhaven Food Bank…their request for emergency food assistance has doubled since 2009…and the number of households that are requesting assistance with utilities is also quite high in Barrhaven, so there's some stuff happening…"

Increasing diversity was also described with respect to the ethnic makeup of the community. The service providers described how the suburban area was becoming a destination of choice for newcomer populations as it grew:

> *…40 years ago there was just this part of Barrhaven, West Barrhaven, with just a few families and those were like old, traditional Canadian families, like no newcomers or anything. And from that to now is like a huge change…if you go to Walmart you feel like, "Wow, I'm in another place" because every face you see is from a different part of the world, and languages, so many languages.* (Anita, community health/social worker)

In 2011, 25.3% of the population of the southwest suburban case study area were immigrants and 3.4% of the population were recent immigrants who had arrived in Canada from 2006-2011 (Ottawa Neighbourhood Study, 2011). As they detailed the newcomer populations in the area, the discussions of the service providers intersected with notions of class. In her experience working with immigrants and refugee populations, one provider described how the area had a reputation for being where "people who are kind of middle-class live. So they say, people who are doing well, both mom and dad have a good job, live in Barrhaven" (Eunice, community health/social worker). Despite potential socioeconomic diversification and pockets of more affordable housing, this view of a general middle- to upper-class population was reinforced by other service providers. They shared their feelings that newcomers tended to settle in the southwest suburban case study area if they had entered Canada with greater financial resources (e.g., as skilled workers) or had been settled for a number of years. The search for their own home, good schools, and a "suburban atmosphere" were seen as factors that pulled these immigrants and refugees away from their original destinations in Ottawa towards the southwest suburban case study area.

Reproductive Health Service Context

Within this overall suburban context was the service environment in which African immigrant and refugee women experienced their reproductive health. I shed light on this service environment in the sections below.

Map of the Reproductive Health Service Context

Figure 9 (below) presents the map of reproductive health services in the southwest suburban case study that I prepared and discussed with service providers. This map showed a fair number of more traditional health services (e.g., walk-in clinics and pharmacies), but relatively little diversity beyond these (through, for example, the presence of community health organizations). Large expanses of the case study area without any services were also evident on the map. By and large, the services available were clustered along the main roads that formed the older and more established part of the area (Barrhaven). This demonstrated the separation of land uses between the residential and the commercial, as well as the general lack of services in close proximity to the newer developments in New Barrhaven-Stonebridge.

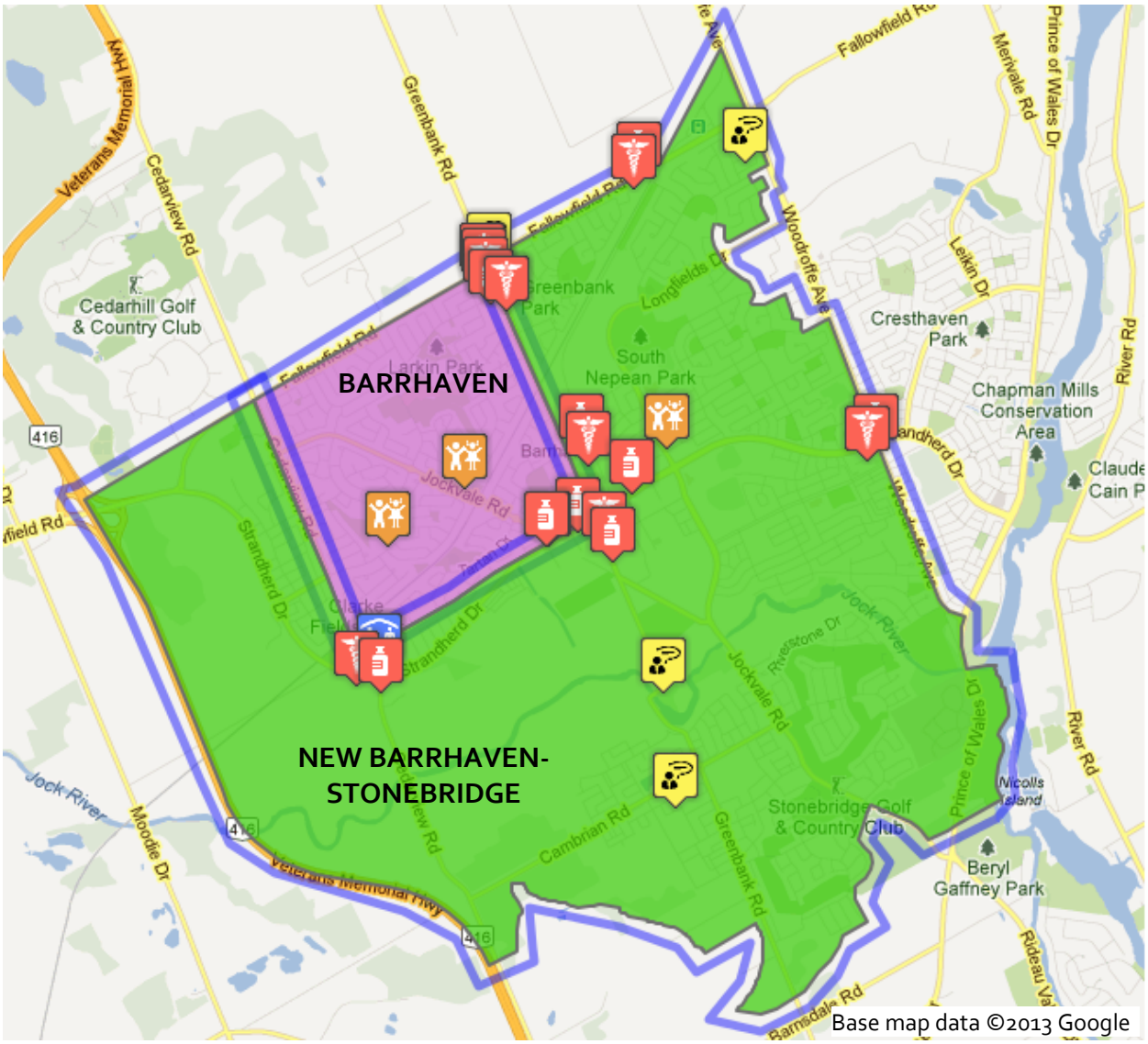
The service providers commented on the large geographic area covered by the neighbourhoods they served. They discussed how it was sometimes a challenge to deliver services with this context. Given the large area and low density of the population, one of the providers felt that there was no ideal place to be located in order to be easily accessible by everyone. This was particularly so as bus service within the area itself was not viewed as very good. Overall, they felt that the map accurately captured the reproductive health services

available in the area. A few of these listed services (e.g., the community health centre) included a specific focus on immigrant and refugee populations within their programming.

As with the other case studies, the service providers suggested that I broaden the scope of the services I had included on the map. They particularly felt that childcare services and the public library (a potential site for city-run programming) were relevant to the reproductive health of immigrant and refugee women. One also recommended greater specificity with respect to physicians' offices. While a number of family physicians and walk-in clinics were available in the area, she noted that there were no nearby obstetricians/gynaecologists. One service provider also suggested that I make note of the closest midwifery group, even though it was physically located outside of the case study area.

Where possible, I have included these suggestions and updates in the revised version of the service map in Figure 10 (below). As with the other case studies, I have created an additional figure (Figure 11) to provide a sense of accessibility by public transit. The number of bus routes that operated only during peak commuter hours was visible on the transit map. Notable as well were the winding paths that the local buses followed through these geographically-large neighbourhoods.

Figure 9. Reproductive Health Service Map of the Southwest Suburban Case Study Area – Initial Mapping



Physician's Offices

- ActiveCare Medical Centre
- Appletree Medical Centre (x2)
- Barrhaven Mall Medical Centre
- Medical Clinic Walk-In
- Nepean Family Health Group
- Rideau Valley Health Centre
- Sexual Health Centre Satellite Clinic
- Other Physicians' Practices (x9)

Pharmacies

- Guardian Pharmacy
- Independent Grocer Pharmacy
- Loblaw's Pharmacy
- Pharmasave (x2)
- Rexall Pharmacy (x2)
- Shopper's Drug Mart (x2)
- Walmart Pharmacy

Community Health Centres

- South Nepean Satellite CHC

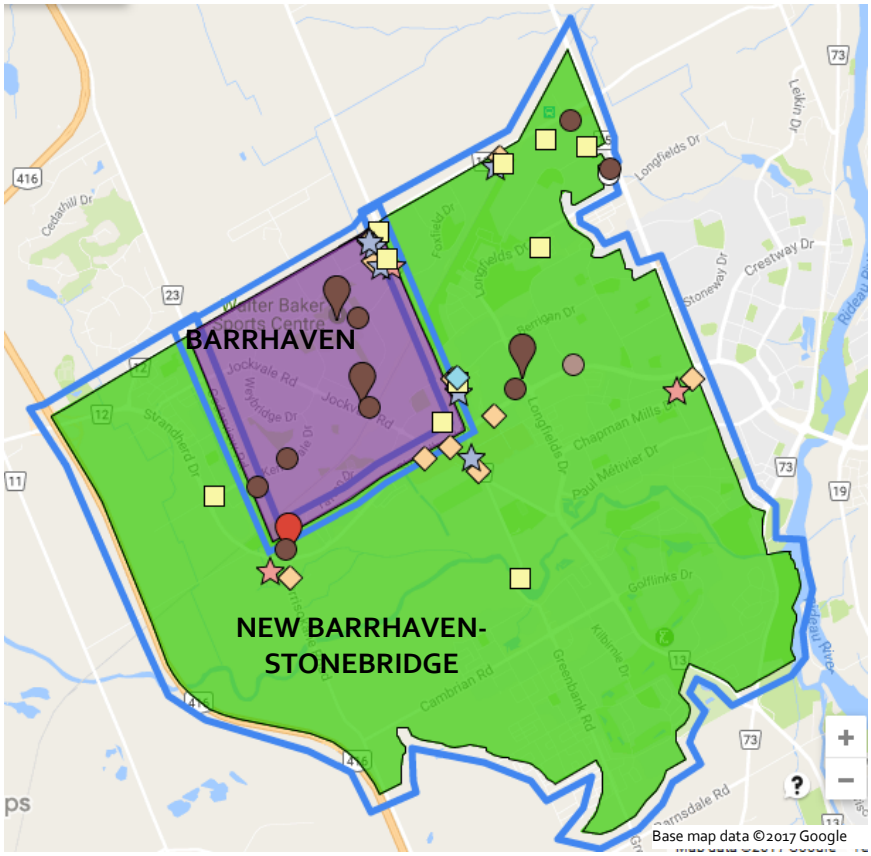
Family Resource Centres

- Barrhaven Family Resource Centre
- Family Resource Centre Drop –In
- Ontario Early Years Centre

Counselling Services

- Child & Family Psychological Services
- MCT Counselling Services
- Relationship Resolution Centre
- Satir Learning Centre of Ottawa

Figure 10. Reproductive Health Service Map of the Southwest Suburban Case Study Area – Revised



Community Health Centres (FREE)
- South Nepean CHC

Walk-In Clinics
- Appletree Medical Centre
- Ottawa Public Health Sexual Health Centre Satellite Clinic
- Strandherd Crossing Medical Centre

Independent Physician Offices
- Greenbelt Family Health Team
- Marketplace Medical Centre
- Rideau Valley Health Centre
- Other physicians' practices (x14)

Ultrasound & Blood Labs
- Gamma Dynacare

Traditional Medicine
- Barrhaven Chinese Acupuncture Clinic

Alternative Medicine
- Alternative medicine practice (x1)

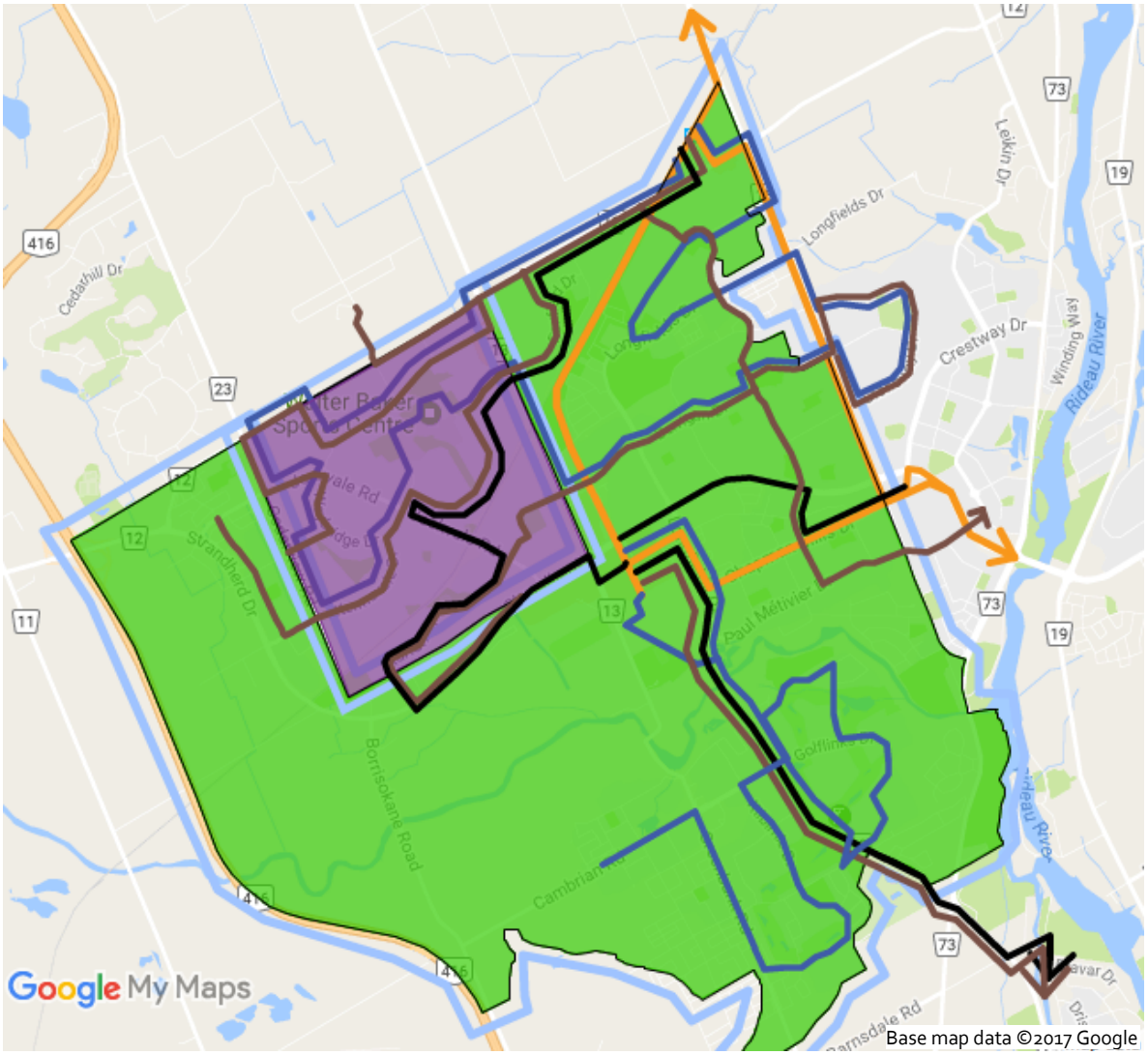
Pharmacies
- Barrhaven IDA Pharmacy
- Cedarview Guardian Pharmacy
- Drugstore Pharmacy
- Fallowfield Pharmasave
- Green Street Pharmacy
- Loblaws Pharmacy
- Rexall PharmaPlus
- Shopper's Drug Mart (x2)
- Walmart Pharmacy

Psychiatrists & Psychologists
- Psychiatric practices (x2)
- Psychological practices (x8)

Family Services (FREE)
- Barrhaven Family Resource Centre
- Ontario Early Years Centre
- Ottawa Public Library

Other Family Services
- Child care centres (x8)

Figure 11. Public Transit (Bus) Routes that Serve the Southwest Suburban Case Study Area



Legend

Local routes (black and blue lines). Buses make frequent stops. Intervals of departure vary, typically between 15 minutes and 30 minutes.

Transitway routes (orange lines). Buses make fewer stops and travel at times along dedicated roads. Intervals of departure vary between 5 minutes or less and 30 minutes.

Peak routes (brown lines). Buses travel only on weekdays at peak commuter times. Intervals of departure vary, often every 15 minutes.

Arrowheads (any colour). Indicate that the bus route continues in the direction indicated.

Note: The information contained in this map was derived from the website of OC Transpo (OC Transpo, 2017)

INVISIBLE LAYERS – WHAT THE MAP DID NOT PORTRAY

Implicit in the comments of the service providers again for this case study area, was a complexity related to the reproductive health service context that was not easily captured on a static map. From the community health/social workers came the strong message that services (reproductive health and other) were still in the process of building up to meet the needs of a booming community. The growth of the area was described as "exciting" in some senses (for instance, in relation to community fundraising for and the planned opening of a new mosque). In other ways, rapid growth presented challenges for planning programs and services to meet the needs of the population:

> *The rate of growth is not in line with the Census data and so we always really find that really challenging. So we know between 2006 and 2009 there was a 17% increase in population…and then, so you are always behind. It is almost irrelevant by the time that gets released. So it is sort of challenging for some planning around that.* (Yasmine, community health/social worker)

As a result, service providers discussed how many of the organizations in the area were relatively new. One provider also described how community development aimed at immigrant and refugee populations was in an earlier stage than in parts of the city with longer histories as immigrant-receiving communities.

As with the other case study areas, service providers described how they used linkages with other organizations to help them better serve their clients. An important component of these partnerships was to listen to immigrant and refugee communities and provide support to address their needs. Given the large geographic area and rapid growth of the southwest suburban case study area, partnerships were also identified as an important tool to help meet

the emerging needs of the community. Partnerships were also useful to secure space in which to carry out programming.

The simple presence of services was not seen as sufficient to guarantee accessibility. Olivia, a nurse, described one instance in which it was crucial to foster relationships in another part of the city. This was done in order to find ultrasound clinics that welcomed immigrant and refugee populations:

> *We have a relationship with some of the clinics where if we write, "they're non-insured, bill our clinic" they have no problems. Other clinics, we've had problems within the community where they will refuse to see them. They want money right then and there…If we don't have a relationship established with them, we cannot just send them there. So that means we cannot access local ones. We have to send them into west end of Ottawa.*

Service Provider Views on Key Issues and Challenges

I grouped the views of service providers on key reproductive health issues and challenges that faced African immigrant and refugee women into eight main themes. As with the other case studies, I present these themes in a general order that flows from home and migration experiences, to gaining access to and using the service system, to broader factors that affect the women's reproductive health.

WOMEN ARRIVE WITH DIFFERENT NEEDS & PAST EXPERIENCES

The service providers discussed the diversity of African immigrant and refugee women with whom they worked. Particularly mentioned was the impact of women's past experiences and migration trajectories on the nature of their needs once in Canada. The migration category in which the women entered into Canada was one element of the diversity that the service providers identified. Some of their clients were refugees who lived in shelters and received

financial assistance through Ontario Works while they searched for stable housing and employment. The past experiences of these women may have included time spent in refugee camps and/or exposure to trauma and violence. Other clients were sponsored or independent immigrants who may have had the support of others in Canada and/or greater financial resources at their disposal than the refugees. Within these migration categories, other areas of diversity were discussed. This included, for example, socioeconomic variation. Some migrants struggled financially in Canada but had a foundation of prior formal education, whereas others may not have had such educational opportunities in their countries of birth. Finally, a distinction was drawn between women who had previously lived in well-serviced urban centres as opposed to those who grew up in rural areas. A history of urban living was associated with potentially greater access to regular health care than those who had lived in more isolated rural parts of their countries.

ENGAGING WOMEN & CONTINUITY OF CARE

In the context of the changes and stresses of getting settled in Canada, the service providers spoke about how important it was to get women connected to the health system. If women faced multiple access barriers (e.g., language barriers, lack of insurance), they felt it was particularly important to link women to the sub-sections of the health system specifically designed to meet their needs and vulnerabilities (e.g., community health centres, Ottawa Public Health). Some of the service providers discussed their feeling that immigrant and refugee women were not generally aware of the existence of their organizations or of the range of services they offered. They also shared stories of programs that they had brought to the community for newcomers, such as the prenatal nutrition and support program *Buns in the*

Oven, which had a much lower uptake than they had anticipated. These conversations linked into the relative newness of some of the services in the area as they adapted to the growing community and its greater diversification.

In the "car culture" of the southwest suburban case study area, some of the service providers mentioned the challenges of getting around for those women who did not drive or have regular access to a vehicle. Given the general separation of commercial from residential zones, as well as the large geographic area, walking to services was not a realistic option for most. They also discussed the limitations of the public transit system. Getting downtown on an express bus was presented as relatively easy, as compared to navigating the case study area itself. A transfer between buses would likely be needed, and local routes did not run very frequently. Time of day played a factor in accessibility because buses operated even less often in the evening and night-time hours.

In a growing and diversifying community, building relationships with community leaders was felt to be an important way of to increase awareness of services among immigrant and refugee women. These leaders were viewed as a bridge to build trust with migrant women from particular cultural groups. Such trust was integral to the process of introducing and creating comfort with new organizations:

> *I find that in Barrhaven we need that a few women, if it's a women group, we need a few women that are very engaged and who want to spend time for this and then that's how they build the trust relationship, they bring them over to the space and people feel "oh really", you know? "Do you really do this sort of thing?"* (Anita, community health/social worker)

Once women were engaged, service providers identified further challenges related to continuity of care. Refugee claimants who resided temporarily in the local shelter upon arrival

in Canada likely moved to more permanent housing in other areas of the city. Service providers within the community health centre system often communicated with other centres to transfer patients. They were then left to "hope that the same services are picked up" (Yasmine, community health/social worker).

The changes in the Interim Federal Health Program at the time of data collection were felt to be a key barrier to continuity of care. The environment at the time the changes were being introduced was one of confusion. The federal government clarified and adjusted proposed cuts and coverage for pregnant women as media stories of women who were denied care, as well as opposition, grew. Regardless, refugee women and service providers were unsure of what was covered and what was not. Refugee claimants whose applications had been denied were not covered at all. The impacts of these changes were visible:

> *…women have been here for a couple of years under Interim Federal Health benefits, under, as refugee claimants, and then the new kind of rules got set in place and they had been having regular obstetrical care like you know, one or two visits with their OB…all of a sudden Interim Federal Health is wiped out. The OB will not see them anymore…So months go by, two, three months where they have had no prenatal care at all. And then they come to us and we have nothing, they have no paper work, nothing, no documents to say that they have had any testing done so, we try to get in contact with the OBs to get that information.* (Olivia, nurse)

COMFORTABLE & RESPECTFUL SPACES

It was with excitement that Yasmine explained to me her hopes with respect to the new mosque in the area:

> *There is a new mosque opening…that is really going to change the sense of, of just place here for newcomers. It will be, because it is going to be a marker for people, anybody that that faith fits with, it will be, it will probably be a walk-in point of entry for a lot of people. We will probably be going there for cross outreach, you know, because that is something that is going to be*

visible to people, and they will say "I know I can walk in there and then find some resources".

A new space that Muslim newcomer women would readily identify and feel comfortable within was welcomed as a great opportunity to carry out more effective health outreach. This would help to engage women who may otherwise have fallen through the gaps. Finding or creating comfortable spaces of relevance to newcomer women of different faiths, was the reason that the work of the community health/social workers, midwives, and some nurses I spoke to was often carried out in community buildings and women's homes.

The local community health centre was a more formal space, but was also presented as a potentially more welcoming option than some of the other clinics in the area. Partially this was felt to be because of its mandate to help marginalized populations. The particular model of care designed to help facilitate this mandate was also mentioned. Free care for those who could not pay, multidisciplinary teams comprised of nurses, social workers, and physicians, and enough time allocated to understand patient needs were all cited as key parts of creating an affordable and accessible environment for immigrants and refugees.

THE CHALLENGE OF PREVENTATIVE CARE

The diverse past experiences of African women linked to their likelihood to have had past opportunities for reproductive health screening and preventative care. Even if women had had such opportunities, service providers still faced the challenge of understanding how much previous reproductive health care had been received as well as its exact nature:

> *…sometimes they arrive in Canada pregnant with either very little prenatal care done, or you know, if they were in an urban city maybe they've had some prenatal care like an ultrasound like some blood work, but we never get the records of that.* (Olivia, nurse)

In addition to the availability and accessibility of preventative care in women's countries of birth, service providers felt that cultural norms related to health care played a role in their interactions with African immigrant and refugee women. The concept of regular visits to a doctor for check-ups and screening may not have been part of some African women's everyday lives prior to migration. Pap tests and screening for breast cancer were identified as particularly salient in the realm of reproductive health. Service providers described how they encountered African women who had no previous experience with such screening and who were not used to a making regular visits for such purposes. One service provider related how some of the women she met with declined screening due to the belief that they would physically know already if they had cancer.

In light of some African women's lack of past opportunities for reproductive health screening, it was not surprising that the service providers encountered women with more than one pressing need when they arrived in Canada. A key task service providers described was to prioritize which of these needs should be addressed first so as to alleviate the most amount of stress for the woman involved.

STRESS & OTHER ISSUES BEYOND REPRODUCTIVE HEALTH

The factors that the service providers felt to be of relevance to the reproductive health of African immigrant and refugee women extended far beyond reproductive health in and of itself. Stress was primary among the issues they identified. In their view, it could be derived from a number of potential different sources. One among these was the ongoing impact of past losses and traumas. Olivia, a nurse, said that she often first tried to alleviate what she could in terms of physical health concerns so that women were free to focus on healing their

mental health. Trauma counselling services offered in other parts of the city (e.g., the Ottawa Rape Crisis Centre) were identified as an extremely important connection to make for women in such cases.

Other sources of stress identified for immigrant and refugee women were the process of immigration hearings, the search for permanent housing and employment, getting children settled and enrolled in schools, and unrealized expectations about what their lives would be like in Canada. Financial pressures were also spoken about by the service providers as a major stressor. Newcomers were felt to move to the southwest suburban area in search of their own homes. In the view of a number of community health/social workers, however, appearances of a comfortable socioeconomic status were occasionally deceiving. Food bank use in the area was on the rise. Families who were "struggling with mortgages and electricity bills" were also identified as an issue. In comments that illustrated some of the workings of class, Eunice, a community health/social worker, discussed how some African immigrants felt pressure to maintain the social status that they held in their home country (e.g., as a result of their educational achievements in that country). She perceived this to be the case even if the newcomers were not doing well financially in Canada. To relatives back home and within cultural community groups in Canada, Eunice discussed how financial contributions were expected as part of this perceived social status:

> *…even when you go to Barrhaven…some of those big homes, we still call them the, I don't know what, the something poor. They are, they look like they are doing so, so well, but they are not…The working poor…There is pressure within the community. There is pressure, if someone is working for the government or has a PhD, there is pressure that they should, they should contribute more but they should live better.*

The cuts to the Interim Federal Health Program were felt by the service providers to be a source of potential stress for refugees, as were gaps in health care coverage for immigrants or failed refugee claimants. While midwives accepted women without health coverage, as did the local community health centre, immigrant and refugee women did not always appear to be aware of these services. Even when women were connected to such accessible services, pregnancy and childbirth sometimes led to unexpected events that produced costly encounters with emergency hospital services. One service provider described how this additional financial stress occasionally came at already emotional times for immigrant and refugee women:

> *…miscarriage or abortion services for reproductive health, they are being charged $500 for a therapeutic abortion. If they go to emerg with miscarriage bleeding who require a D&C, they are looking, they are looking at hundreds to thousands.* (Olivia, nurse)

LANGUAGES & CULTURES

Language barriers for women who did not speak English were mentioned briefly by two of the service providers, but were not discussed in detail. The issue of culture, on the other hand, was considered in more depth. It was important, they said, to understand the beliefs with which women arrived in order to work with them towards their health. Being aware of different gender roles and norms was felt to be a part of such understanding. Service providers made reference to the fact that some African women were not comfortable being seen by male clinicians, or had difficulty protecting themselves from sexually transmitted infections if it was the norm for male spouses to have more than one sexual partner.

Canadian cultural norms related to pregnancy, childbirth, and raising children were also spoken about by some of the service providers. One acknowledged the tendency to medicalize pregnancy and birth in Canada, with much more surveillance and screening than was typical for

many women from Africa. Another spoke about how women may feel unsupported by service providers when their home country practices for raising children were not officially approved of by the public health system in Canada:

> *Feeding the baby is so culture specific and people have mentioned that as some of the examples where they felt that public health was really not supporting. But then again that's sort of a grey area because, you know, just because you've always done it doesn't means it's the right thing to do.* (Anita, community health/social worker)

Finally, several of the service providers discussed the importance that many African women tended to place on their families, to the extent that the family was prioritized over their own needs. While not necessarily unique to African women, children and families were perceived to be highly valued in a number of African cultures. Awareness of this could be an opportunity to engage women by listening to their priorities and providing outreach programs targeted at families and children. Once aware of and more comfortable with services in a given organization, newcomer women were felt to be more likely to seek out assistance for themselves.

SOCIAL NETWORKS AND SUPPORT

The large size of the case study area, as well as its lower density of newcomers and services, was seen to partially structure the opportunities that African immigrant and refugee women had to create systems of social support. Yasmine, a community health/social worker, explained how she felt the physical layout of the southwest suburban case study area affected newcomer women's experiences forming social networks:

> *I think if you are moving out here with an existing linkage, it's probably quite seamless. But if you are not, I think it would take some time because it's not walkable so people aren't really outside of their cars and there aren't the common gathering spaces. So if you are new to the city, and then new to*

> *Barrhaven, it would be isolating I think. Your best point of contact would be if you have children and they are in the school system and you got linked in that way. But people don't sort of meet each other in the stores, in the restaurants.*

In her view, African immigrant and refugee women's experiences of social support in the area were partially dependent on the connections that they brought with them before they moved to the community. One of the other service providers shared her observation that a number of the African women she worked with seemed to come to Canada without a spouse or extended family members. She also noted that these women had not yet been able to find established pockets of their particular cultural communities in the area for support. Another service provider pointed to the isolation that some women faced when overwhelmed with caregiving opportunities for children for which they alone were responsible.

This view of greater spatial isolation and more limited opportunities for informal encounters with other newcomers was in contrast to some service provider's perceptions of other areas of the Ottawa. One provider, for instance, mentioned that housing in other parts of Ottawa (e.g., apartment buildings) fostered closer interactions than the more separate housing in the suburbs. Opportunities to build supportive networks in the suburbs were still discussed by the service providers. Alice, a midwife, related her impressions based on home visits to women in different parts of the city:

> *I get an image of high rise apartment buildings…walking into one of the buildings and just smelling all the delicious cooking smells and knocking on a woman's door and you go in and maybe her kids are with her friend down the hall and…You know, it just seems like a beehive of community that just feels lovely. So I notice that, you know…there's the people who live in the suburbs, which are much more separate. But, okay, how do people get together there? Well they gather in the parks and so on. So, you know, just kind of different social gathering points is certainly something I notice amongst the different neighbourhoods or communities, if you will.*

SERVICE PROVIDER NEEDS & RECOMMENDATIONS

When I asked the service providers what would help them in their work, they identified a number of needs and recommendations. Among these, were funding for specific programs as well as sufficient staff to improve coverage of the large geographic area. One service provider spoke about how she had observed a general reduction in the last few years of "funding pockets" for programs targeted at immigrant and refugee populations. As a result, she explained, settlement and community health organizations were more likely to be in competition for limited resources. Partners sometimes needed to act strategically "in terms of who applies for what at what time so that we can get the most number of things done" (Anita, community health/social worker). Related to the issue of resources, one of the service providers identified a need for more program space in the neighbourhoods they served. In her experience, it was sometimes difficult to find locations for community outreach in different parts of the case study area. Many program rooms were already reserved by local community associations or by the City.

A final recommendation from two of the service providers was for more affordable and accessible mental health services. While some free counselling services were present at the local community health centre, these provided only short-term assistance. Longer-term, free counselling for immigrant and refugee women, and mental health programming for youth, were noted as important areas for future investment and development.

Voices of African Immigrant and Refugee Women

I identified fourteen key themes based on my analysis of the interviews with the six African immigrant and refugee women in the southwest suburban case study area. Following a glimpse into Abike's story, I discuss each of these themes below.

Abike's Story

My story is a bit different from people who come to Canada and it will take them a long time to find a job. I was lucky enough to find a job. I had friends that were already settled here and they knew where things are and everything. It's like, Service Canada, we'll drop you off at Service Canada, drop you off at Ontario Health. The first person that comes to a place is the one that goes through all the trouble. Once that person is there, the people after don't have to go through the same thing. You try to make it a little bit easier for somebody that came after you.

I'm trying to sponsor my husband to come to Canada. When I started the process, the timeline was 18-36 months. If I was coming from the U.K. it's 3-6 months, just to give you an idea of how different it is. This is not an isolated case. I've seen people wait five years, you know. There's a lot of people that just say, forget it and move back home. But, you know, I have a life here. I consider this place home. And it's funny because Canada sells itself as very family friendly, you can bring your husband, you can bring your parents. It's very hard to bring your husband.

When I first got married I was able to go back home. I was pregnant when I came back. It was just me, but I was fine. I worked, I shopped for the baby. I didn't take any of those

[prenatal] classes. I had talked to tonnes of people. People's experiences were different, and before even when I went to the hospital I made up my mind I was going to get the epidural. You talk to five different people and they have five different stories. Every pregnancy and birth is different. I went in, it's like let's see what's going to happen. I called my husband after I had the baby because I can't imagine calling him and saying: "Well, I'm going to the hospital". Right after I had the baby I'd call him and say I had the baby 'cause there's no point, there's no point. My cousin here, she was the one that stayed with me. She was in the OR both times.

Family is huge. We have a saying back home: "After a while, a friend becomes your family". You know, so when we come here, if I take you out I can introduce ten people to you and I will tell you they are my aunts. You know, that's what they are. Not because we're from the same family but because that's what they are to me. So I have a lot of family here. Most of them not related by blood, but they are my family. A week after you have the baby people will come to your house. You pray for the baby and then you officially name the baby. People surround you, bring you gifts, bring you food. Most people work. They have their own schedule. Most work nights, but they will still create the time to help somebody that needs it. Back home, there is no social security. There is no government assistance. You learn to support yourself and look for those in your circle to support you. So, I guess, you try to find the same thing here. I'm lucky that I have all this support.

Key Themes

MIGRATION EXPERIENCES & GETTING STUCK

Jobs, education, and opportunity featured strongly among the reasons the immigrant women cited for their decisions to migrate. For some of these women, it was a conscious and

straight path of leaving their homes to beginning new lives and careers in Canada. For one, the journey was less linear; she first studied elsewhere and then immigrated to Canada. The two other women I interviewed were refugees. Their migration stories were noticeably different from some refugees in the other case study areas due to their lack of recent upheaval and traumas. Véronique, for instance, had left the Congo over twenty years prior and described her motivation for migrating as a search for a better life. In Canada on a work visa with her husband, Stella had previously experienced hardship due to food shortages and a deteriorating economic and political situation in Zimbabwe. They watched from afar as the circumstances in their home country got worse, and decided to apply to stay in Canada for humanitarian reasons.

While migration entailed physical relocation to Canada with the right to stay permanently, a number of the women seemed mentally divided between here and there. Two of the women described how, even as they completed their immigration forms, they felt they could always return home if their hopes were not met. One woman told me how, despite such initial feelings, she now viewed Ottawa and Canada as a permanent home. Other women shared desires that they would still one day return to their countries of birth. From their discussions, returning did not always sound easy. Complications were added because of "getting stuck" in Canada due to practical considerations. This was added to a feeling of not fitting in back home after a long period away, and the attachments that had been formed by their Canadian born and/or raised children:

> *…we said, "Okay should we go back home?" We have nothing there right now, so it was like going, you have no way to start. My husband had resigned work. So it's like we had sold most of our stuff, like we had nothing…actually to think of it if we had gone that time it was going to be*

> *much better compared to now. I mean here we are okay right now, but right now if we go back home, we won't fit in...we have been here for 11, almost 12 years now…so we are stuck. But we are just waiting for our kids to…they don't want to go back home but we don't want to leave them when they are this young*. (Stella)

AFRICAN IMMIGRANT AND REFUGEE WOMEN ARE DIVERSE

Laughing, Abike said to me: "In the eyes of the government, I'm no different than you. You know, we're the same…she's not new anymore". She was making a point, drawing a contrast between her situation and that of some other African women in Canada. Abike entered Canada as a skilled worker with a job already secured. She had lived in Canada for nine years when we spoke and, prior to that time, had completed a graduate degree in the United States. Her experience of having "choice" and "power" in the migration process, of settling in, and of having and raising children in Canada was important to differentiate from more newly-arrived women in more precarious circumstances. A woman, for instance, "who's been here less than a year who's trying to have some part-time job at Walmart while looking for a better job, who's having a baby" (Abike).

Abike was not alone in the emphasis she placed on the diversity of African immigrant and refugee women in Canada. These well-educated and comparatively well-off women who lived in the suburban area felt that it was important to clarify that their experiences were not necessarily representative of those of African immigrant and refugee women more broadly. They merely shared their own stories and realities. They recognized the impact of the different circumstances from which they had come, the voluntary nature of their migration (four of the women I spoke to were voluntary immigrants), and the length of time they had been in Canada.

Faith eloquently described the depth of diversity in the large African continent in

relation to regions, cultures, languages, and colonial histories. In Faith's view, all of these factors played a role in shaping who a particular African woman was and the personal resources she drew upon when as she negotiated a new life in Canada. Faith's discussion also cautioned against grouping all African women together in an undifferentiated way and making stereotypes or generalizations about their lives:

> *...if you are talking about African women, Africa is so diverse…you could put three African women together and they are so totally different….some of us coming from the east, the culture there is different. Those coming from the west, the culture there is different. Those coming from the north, those coming from the south. And those coming from the south especially like in South Africa, apartheid was there until very recently. That has greatly impacted a lot of, I mean, it's not just your life, it's your attitude. And suddenly you are either timid or very aggressive just because of the circumstances that you had to grow up in…we have all different language backgrounds…And depending on where, like for me like I would say I'm very lucky that my parents, despite the fact that I was a girl, enabled me to go to school and not just school but even to get a degree and go to higher education. But for some it's not that. And so coming here, depending also on your level of literacy, it affects how you integrate and how you view life and see.*

SETTLING IN, THEN MOVING TO THE SUBURBS

"Your home is beautiful" I found myself commenting again and again as different women graciously welcomed me inside their houses to carry out interviews. These spacious, relatively new, and well-maintained family homes, were not the first stop for the women upon their arrival in Canada. Some had lived in hotels, others in apartments or with friends as they got their bearings and looked for permanent housing. These other types of housing were more characteristic of the homes of the women I had interviewed in the central and west end case study areas. While one of the suburban women had lived in Toronto before she moved to Ottawa, other women described how they had lived in downtown Ottawa or other areas of the city prior to their eventual relocation to the southwest suburban area. Upon arrival in Canada,

one woman was met by friends and cousins who were already here. A number of others described how they almost immediately looked for a church. In Makena's words: "We arrived on a Thursday. On a Saturday, we were there". The church was viewed as a recognizable place to find comfort in their faith and to build connections to potentially facilitate the transition to life in Canada. It was an institution within which, regardless of the area of the city in which it was located, social relations to help newcomers were fostered.

Even with efforts to establish such connections, the initial settlement period was described by all but one of the women as difficult: "basically you are trying to survive and make the best of the situation" (Faith). Having lived in the United States to complete her studies, Abike, on the other hand, found that her move to Ottawa was a "very smooth transition".

Among other settlement issues, housing was frequently raised. One woman commented that although they had their own money, it was a shock to find that it was difficult to find an affordable family apartment without Canadian job references. After almost a month in a hotel, a connection through a friend eventually secured her family a basement apartment. As a new refugee to Canada, Véronique had also spent time in a hotel before she received a place in the city's social housing downtown. What she felt was an undesirable environment for raising a family, drove her desire to move away when possible:

> *…après j'ai déménagée au Barrhaven. Pourquoi? Parce que quand on vous donne des logements, ce sont des logements sociaux, donc le logement sociaux c'est des logements pour, comment je peux appeler ça? C'est pour les basses classes…pour les gens qui n'ont pas, pour les gens qui n'arrivent pas…moi j'appelle ça une prison, je n'appelle pas ça des logements. C'est une prison. Pourquoi? Parce que c'est là que ou tous les enfants sont entrain d'être détruit d'abord. Vous pouvez donner une bonne éducation à votre enfant dans la maison mais dès qu'il sort dehors, il va trouver, c'est là ou la drogue passe, c'est là où il y a des dilemmes…*

Now settled in the southwest suburban area, a number of the women related their happiness with the community in which they lived. In the time since they had first moved to the area, Effie, for example, had noticed an increasing number of African families. She also discussed the expanding number and range of services, which meant that she could walk more and had little need to travel to other parts of the city.

FINDING AND ACCESSING INFORMATION & SERVICES

To learn about the health and social services system in Canada, the women drew on friends and family, church communities, printed resources they'd been given upon arrival, and the Internet. These places of information acquisition and sharing were not confined to the boundaries and locations of the southwest suburban area. Instead, they were transient social encounters facilitated through important institutions (e.g., the church), informal spaces (e.g., the home of a friend), and online destinations (e.g., websites). The ability to speak English was noted as a definite asset by one woman as she discussed how she had learned about such services. In addition, a real person "coaching you" seemed to be the ideal method to become familiar with the system because: "If you don't have anybody and you are doing everything by yourself you tend to make lots of mistakes" (Effie).

With the help of these resources, some women found their experience accessing information and services to be easier than others. One of the immigrant women I spoke to regretted that she had not been automatically connected to more formal settlement supports as were some refugees:

> *There are no signs telling you go and ask here, go and find out here, you know? It's not like you walk in and there are these handouts, and you find out everything, instructions and what to do. No, really, I'm sitting in my house, where do I go to find out? How do I know that there is something that exists*

> *out there? Unless, let's say maybe you have a social worker. Maybe you came in through, as a refugee or something and that social worker thinks and covers all the basics, and tells you "If you need health care, this is where. If you need this, this is what you do."* (Faith)

Using the information book she was given when she first arrived, Makena and her family quickly found regular care with a nurse practitioner at the local community health centre. Her nurse practitioner was based in the downtown area where she first settled, but Makena remained with her over time because she was unable to find a primary care provider in the southwest suburban area. Difficulties in finding consistent care were discussed by a number of women. Due to limited availability, figuring out where to go to seek care was not always sufficient to securing such services. All of the women owned cars and used them to travel away from the southwest suburban area in search of services. In a way that showcased the potential challenges of living in an area with low service density, Makena said to me, "I don't think I would manage", when I asked what her life would be like if she did not own a car.

With respect to reproductive health specifically, the women seemed to view the health care system as their primary source of information. Several of them also spoke about how they used the internet or drew on circles of friends or churches as sources of information on the topic.

INTERACTIONS WITH THE HEALTH CARE SYSTEM

The immigration medical examination was usually the first encounter that immigrants and refugees to Canada had with the requirements of the country's public health and health care systems. One woman mentioned that this was her only visit with a doctor for a period of time after her arrival in Canada. Once in the country, her interaction with health care institutions and providers required her to first figure out how to gain access to the system.

Another woman discussed how her migration medical exam had provided her with new information about her reproductive health. That is, that she had uterine fibroids. Unfortunately once she settled in Canada and found a doctor, she discovered that she could not afford the birth control pills to treat the condition. Covered by OHIP but without private insurance while she searched for a job, she would have had to pay for the pills out of pocket. She was not the only one to raise the issue of gaps in Canada's public health care system with respect to prescription drugs. Another woman described how she felt thankful that her children never got sick during the period of time she had to wait to receive the paperwork for her Interim Federal Health coverage.

Several of the women discussed how they had relied on walk-in clinics, including for pre-natal care and referrals to obstetricians. Other women had managed to secure a permanent care provider. Makena described the nurse practitioner who cared for herself and her family as "the best thing that ever happened to us". In addition to caring for their health needs, the nurse practitioner would "give us advice, talk to us, help, oh she really helped us to settle". Positive interactions with clinicians, from family doctors to practitioners in hospital settings, were shared by other women as well. Véronique, for instance, related how her treatment by nurses during a hospital birth in Canada was more gentle than what she had experienced with her other two births in the Congo:

> *au Congo…ils commencent à dire des mots qui vont te faire fâcher pour que tu sois en colère pour te faire pousser le bébé plus vite... Tandis qu'ici, c'est comme si on voulait, on te cajole...« oh elle va avoir un bébé, oh elle a mal, oh madame, tu peux marcher un peux, tu as de la douleur, comment tu te sens? »*

Not all the experiences the women described were positive. One woman spoke about the frustration she felt when she was not discharged more quickly from the hospital after a caesarean birth. She wanted to return home as soon as possible to her older child who she had left in the care of friends. Another woman was left with the impression that the doctor who cared for her through two pregnancies never made her a priority and was always in a rush. Yet another shared that she was not initially empowered to voice her questions during interactions with clinicians in Canada. She partially attributed this to her upbringing in a culture in which authority figures were treated with deep respect. With increased time in the Canada, she gained the confidence to speak her mind:

> *...before they just say "do this test" and you do it, and you don't question. But now I'm at a point I don't do any test unless you tell me why...We are raised to just do it as long as it's somebody older than you or in authority... And I think some of us really come with that attitude, even if when you go to a doctor and they are prescribing something, you don't ask why, you just take it. They say, 'oh this', and you take it. For example, with my first experience going for contraceptives, so they gave me something. I didn't question, I didn't ask what are the side effects…But now I have learned.* (Faith)

In addition to stories about their interactions with the health care system, a number of women spoke about services they did not use. These omissions illustrated some of the structural level barriers to access for migrants as well as the kinds of places in which they felt the most comfortable. For instance, some women did not attend prenatal classes because they needed to work as much as possible prior to giving birth or because they preferred to rely on the knowledge and support of women in their own social networks. Another woman discussed how she felt she could not use the postpartum home-visiting services of public health nurses because she did not meet the eligibility criteria for priority patients. Abike shared her frustration with the system and how, in her experience, it did not meet her needs. She

expressed how she felt that she needed to be low-income or suffering from postpartum depression in order to qualify for home visits. She also felt that the public health nurses who conducted the screening questionnaire assumed that she was depressed because she was parenting alone in Canada:

> *…you don't even qualify once you say, you know you have a job that makes more than whatever…Only low-income people are lonely when they have babies?…and then, you know, they try to…the public health nurses they're just doing their job but they try to, you know, make me admit that I'm depressed. I'm like, "I'm not depressed"…"It's just you, your husband's not here, do you you feel?" I said, "Listen, I'm not depressed, you know, so just, just forget about it".*

REPRODUCTIVE HEALTH OUTSIDE OF THE HEALTH CARE SYSTEM

The reproductive health experiences of the women I interviewed were not entirely situated within the health care system. For those who shared birth stories, their postpartum experiences at home were a key piece. I discuss the important role of social support networks to this postpartum period under a number of other themes in this chapter. If adequate social supports were not present, women spoke about how the immediate postpartum timeframe was a very isolating and stressful period in their lives. Effie described painful struggles to breastfeed. She felt "stuck" by herself as she tried to care for her newborn while not knowing what to do. Faith told me that people would praise her on how quickly she lost the weight from her pregnancy. She, on the other hand, attributed the weight loss to the combined effects of stress, nursing, and not getting sufficient rest because financial reasons had compelled her to return to work soon after the birth.

Other women talked about how some African women they knew suffered in private outside of the health care system. Véronique spoke passionately about Congolese women she

knew who were in abusive relationships in Canada. She felt that these women were unwilling or unable to leave their relationships because the constraints of a traditionally patriarchal culture and their newcomer status merged with the challenges women often faced when fleeing abuse. Two other women discussed their knowledge of African newcomer women who suffered at home without appropriate diagnosis or care for uterine fibroids. Women from Africa face are at a disproportionate risk of experiencing uterine fibroids (Stewart, Nicholson, Bradley, & Borah, 2013):

> *I know that I'm not the only one that's got fibroids. Most of the women that have, most of my friends that I know that have fibroids don't know what to do with them. And most of them it's giving them problems. Most of them they are bleeding through it. They're having so many issues with it. Some people cannot have children with that. Some people when they have their menses they bleed and bleed and bleed, it's uncontrollable…* (Effie)

FINDING WORK & FINANCIAL PRESSURES

Faith used to tell her colleagues, "Give me 20 minutes" and then she would run out to the parking lot. Her husband would be sitting in the car, in the middle of the night, with their newborn strapped in the backseat waiting to be breastfed. This was a time when Faith was still a recent arrival to Canada. As they scrambled to make ends meet, Faith had returned to work two months after the birth. She and her husband both worked shift in jobs far beneath their levels of education. To avoid the added expense of childcare, her husband worked from 1pm to 10pm and Faith worked overnight from 11pm to 9am. They lived in Toronto back then, and so "exchanged the baby in the subway" at the beginning of her shift and the end of his. This was a number of years ago and Faith has since found a job closer to, but still not matching, her level of education. Her frustration with respect to the job market was evident during our interview. So too was her sense of having been misled in relation to employment opportunities in Canada:

> *I thought "Wow, nice, I'll come here, get a job [laughter], start working", because that's what we know and when you look at the website, the government website, the immigration website, you think it's easy. Nothing in there says you must have Canadian experience or you must have any of that. So you land here and then there's a rude awakening.*

Other women also discussed a mismatch they perceived between the image Canada presented to potential immigrants overseas and the reality of job prospects once they arrived. In these discussions, the inability to find a job mixed with struggles to meet re-training expectations and the stresses of financial pressures. Pursuing additional schooling further intersected with the difficulty of combining career aspirations with the work of motherhood:

> *…at the time my son was a baby. He just turned two when I started school so it was tough. And you know the way this nursing program is, especially when you have to go do practicals. Sometimes you have to be at the hospital at 6 o'clock in the morning, so I have to take him to a day care provider for like what, like 5 in the morning so I can go catch the bus because I was going all the way to CHEO. It was insane.* (Effie)

Some of the women temporarily relied on the social support system for financial assistance during their period of initial settlement. One of these women described for me how difficult her family had found it to pay rent and utilities with the money provided through social assistance while preserving enough to buy sufficient food.

SEPARATED FAMILIES & SOURCES OF SOCIAL SUPPORT

Her husband was still in Nigeria as well as most of her extended family, but Abike said to me:

> *I have a lot of family here. Most of them not related by blood, but they are my family…you leave your family back home and you miss, you miss them, you know. But here, when you find other people in the same situation, you kind of band together and become families.*

In light of families divided and social networks disrupted through the migration process, the women spoke about new connections they had made in Canada. For most of the women, the root of such social connections did not appear to be the southwest suburban area in which they lived. The more separated housing arrangements characteristic of the suburbs did not facilitate the casual encounters found in the hallways or elevators of apartment buildings in more dense parts of the city. Makena described how she had "good neighbours" in the southwest suburban area. Her interactions with those in her neighbourhood differed, however, from those she had experienced in the downtown apartment building where she used to live:

> *At the apartment in the elevator you meet people every morning, every evening, when you are coming back from work there is always somebody to talk to but here, rarely.*

Instead of neighbourhood or apartment building, the church appeared to be the social hub of many of the women's lives. Some women described how it was one of the first things they looked for upon arriving in Canada. Others noted that church was a full-day affair on Saturdays and a place of weeknight activities for children as well. Another spoke of how she and her family would travel by bus to Orleans to get to their preferred church before they owned a car.

For some of the women, their "church family" along with other friends helped provide considerable support postpartum. These people brought food, cleaned, and helped the new mother to rest.

> *I gave birth on a Sunday. They didn't let me until Thursday because I was a first-time mom and they knew I was going back home by myself, so they didn't want to let me go. I'm like, I want to go home, you know. Are you going to have support? Yes, yes, yes, you know. And I did, like, you know, I had people coming in and out. For a month after I had the baby there's still*

> *food in my fridge. People coming to do my dishes and, you know, clean my house.* (Abike)

Even when connected to a church community or with other family in town, the strength of the support Abike received postpartum was not true of everyone I interviewed. Physical proximity to their social networks and the busy schedules of newcomers settling in a new country played a role in the support some women felt that had as they gave birth and raised children in Canada:

> *…if you are back home you have aunties, you have uncles, you have your nephews and your nieces, everyone's around you. You have lots, lots, and lots of support. Here we lack that big time. So, even if your sister is with you in the same country, she's probably living in Orleans or closest maybe on the Bank Street and you are living here. And she has to go to work, you know it's tough for her to come over and stuff like that…when I had my baby, when I had my first one it was tough.* (Effie)

IDENTITY, SOCIAL STATUS & SELF-WORTH

As she attempted to help a fellow Congolese friend seek medical care during pregnancy, Véronique told me about how she had faced the following accusation from this same friend: "…toi tu es colonisée par ces gens ici, tu as oublié la culture de chez nous". The implication was that because Véronique had embraced westernized medical care, she had somehow forgotten who she was. Despite such occasional criticism, Véronique explained to me that she felt it was important for newcomers to detach from their culture of birth, to mix more with others in the population, and learn about and adjust to where they were now.

It was evident in the discussions of a number of the women that their identities as African women were still partly tied to their countries of birth. As Faith showed in the following statement, this notion of identity was also applied to children born in Canada. It also sometimes raised issues with respect to medical care: "…you are using Canadian charts and

Canadian measurements for this kid who is really a Kenyan". The strength of the connection between country of birth and current identity was not the same for every woman I interviewed. Abike, for instance, told me: "…if I go back home to Nigeria, they're like, oh yeah, we have a visitor…I'm now the visitor back home and I consider here home".

What was evident in the interviews was that the identities of the women I spoke to were not static. Reference points of continent, country, culture, and social status were all changing and being challenged as the women settled in Canada and spent increasing amounts of time in this country. All of the immigrant women spoke about changes they had experienced with respect to socioeconomic status. Sometimes these women talked about the effect of such changes on the burden of domestic work they undertook here. Within these discussions it was clear that the social class with which some of the women identified back home was very different from that which they experienced in Canada. This included implications for the types of work they were used to and the extent of paid help that had been the norm in their lives. For instance, Abike mentioned that in Canada she could not afford to hire a nanny and a housekeeper as she would have done back home. Changes in socioeconomic status were intertwined with frustrations related to job searching and re-training requirements. Makena discussed how the first job she took in Canada was cleaning houses, "something I never thought I would do". The effect of being asked to return to school in Canada, regardless of prior training and experience in their country of birth, could be powerful:

> *…for some people honestly it affects not just you but yourself, everything, everything about you. You come here thinking "Okay first of all I am educated. Okay, I think I can hold my own, I think I could work", and then suddenly somebody says: "No, all the four years you did basically amount to nothing, and you have to do it all over again."* (Faith)

Identity and socioeconomic status were also evident in the different ways that three of the women talked about government financial assistance. These women seemed to take care to separate themselves from disparaging stereotypes sometimes found in the media regarding the presumed reliance of newcomers to Canada on the social support system.

RAISING CHILDREN IN CANADA

Véronique told me the following saying from her upbringing: "Quand l'enfant est dans le ventre, il appartient à la maman. Mais quand l'enfant sort, c'est l'enfant de tout le monde". For her, the words nicely summarized the differences between raising children in Canada and doing so back home. In the Congo, family, neighbours, and the entire community watched, corrected, and took care of your children, as you did theirs, once they were born. A number of the other women talked about how much they missed this communal culture of parenting, which was also present in their own countries of birth. One woman called it "beautiful" and spoke with regret that her children "missed out on that". Véronique herself had different feelings. She spoke proudly about knowing that her children belonged to her. They would grow up, she said, with the knowledge that she had fought and done everything for them.

The shift to a different culture of parenting was not easy for some of the women. They spoke about challenges, changes, and anxieties in relation to having their children grow up in Canada:

> *…a child belongs to the community. Like when a child does something wrong out there, even if it's not my child I'll be able to take them aside and correct them. But here, it's not that nobody cares, it's like you cannot do it…it's like they have that freedom that is not so good, whereby they can talk back to somebody, a grown up. When I should be able to see a child doing something wrong and go talk to them.* (Makena)

Makena continued on to discuss how she and her husband tried to recognize that their now-teenaged daughter was growing up in a different culture. Afraid that they "might lose her in the process", they were "letting go" of some elements of their own cultural values and tried to "stand firm" on others. In the realm of reproductive health, and related to this last point, a number of the women felt it important to pass on values regarding the formation of stable relationships rather than frequent and casual dating. They also mentioned a concern for HIV/AIDS. It was important for them to instil in their children an understanding that the risk of the disease was present in Canada rather than confined to the boundaries of Africa.

Children featured during my interviews with the African women in other ways as well. Some women spoke about how their decision to come to Canada was partially fuelled by hopes for their existing or future children. Another woman shared her fears about what would happen to her children if she got sick, given that her family lived back in her country of birth. Several women shared the details of their busy lives in which they had little time to themselves as they juggled work outside of the home alongside raising children. Finally, having children born or raised in Canada also acted as a tether for some women. Despite their own preferences to return to their home countries, these women stayed in Canada because their children were settled and happy.

REPRODUCTIVE HEALTH BACK HOME – CULTURAL NORMS & PAST EXPERIENCES

Part of what informed their reproductive health experiences in Canada were cultural norms and past experiences related to reproductive health in the women's countries of birth. Culture and past experience sometimes melded together in their discussions of reproductive health back home, and at other times they were kept separate.

Two of the women raised the issue of how health care was administered through private systems in their home countries. For those with the resources to do so, the ability to pay created a choice of service providers and lack of wait times as compared to Canada's public system. On the other hand, one woman spoke about how doctors back home were only visited when you were sick and not for screening or other forms of prevention. This practice was shaped, at least in part, by the expense that would be incurred by visiting the doctor.

The practice of regular physicals and pap tests, and the amount of surveillance during a pregnancy, was new to some women. Differing norms with respect to preventative care and medical intervention were also, therefore, a factor that potentially limited women from engaging with the health care system. Some of the women were also brought up in cultures in which there were taboos associated with reproductive health. Churches in Canada with strong African populations were spoken about in mixed ways with respect to culture. These institutions had the potential to foster supportive community connections. On the other hand, they sometimes helped to perpetuate traditional practices that were not always in the best interests of women's health (e.g., in seeking healing through the church rather than by visiting a doctor). One woman from the Congo discussed how her traditional culture encouraged women to keep a pregnancy a secret for as long as possible. This protected the developing fetus from negative thoughts and harm from others. Véronique described how she continued with this traditional practice when newly arrived and pregnant in Canada. A potential result, was to isolate women from needed care:

> *Quand j'ai eu la grossesse de mon fils, le dernier qui est né ici au Canada… il fallait chercher des petits mensonges pour pouvoir cacher la grossesse… C'est la mentalité qu'on a apporté ici…Il y en a que tu vas voir le médecin à partir de cinq mois de grossesse et pendant ces cinq mois-là tu as fait des infections,*

> *peut-être que tu saignes, peut-être tu as fait la levure…Et tout ça, tu te caches, tu ne veux pas que les gens te voient à l'hôpital, tu ne veux pas que les gens te voient en dehors de ta maison. Pourquoi? Parce que les gens ne doivent pas savoir que tu es enceinte.*

Cultures strong on family and raising children as a community were also mentioned by a number of the women. "Aunties", uncles, nephews and nieces all helped out back home. Being "treated like a queen" in the postpartum period was how this was described by one of the women I interviewed. The potentially negative effects of strong cultural support for fertility were also discussed. This was particularly so in light of the lack of power that women may have with respect to men in some African cultures. Some of the women felt that such a dynamic potentially placed African women in Canada in a position where they were unable to negotiate condom use, where it was acceptable for men to have more than one partner, or where the importance of bearing many children was placed higher than that of their own health.

STEREOTYPES & ASSUMPTIONS

Two of the women shared with me experiences in which they'd felt judged, as though stereotypes and assumptions were made about them as African women. Neither of these women labelled their encounters as racism or discrimination, but their feelings of being wronged were clear. As Faith said to me when I asked whether she felt her experience had occurred because she was a Black woman:

> *See the problem is I am not a white girl, so I don't know how they would treat one. But I know how they treated me and I have heard stories from some of my friends. So I cannot speak for the other side, I can only speak for the experience I had.*

I had asked Faith that question after she had related to how she had felt stereotyped by staff at walk-in clinic. When she entered as a "young Black woman", she said that they

immediately assumed she was there due to pregnancy. This assumption was made without asking for the reasons for her visit. Contrary to what their stereotypes may have been, Faith had in fact been in search of birth control pills to avoid pregnancy in her long and stable relationship. Now married with children, she continued to feel occasional judgement in relation to her fertility:

> *I have my three kids and there's a fourth on the way and I'm walking around and you can tell, and some people are brave enough and they say "You are having four kids?" Like ok, excuse me, you are not paying for my kids' education. You are not feeding them. It's almost, you can feel the judgement. It's expected, oh you'll have one or two and that's fine. But four? Why? I have actually had people ask me that*.

While the African immigrant and refugee women occasionally encountered such experiences at the interpersonal level, discrimination was also talked about in the structural sense. In Abike's case, she discussed the ongoing process of trying to sponsor her husband to come to Canada. Her struggle with the immigration sponsorship system was one she felt would have been very different if her husband was born in, for example, the United Kingdom:

> *…it's presumed people coming from Africa are trying to get here just to come to Canada. So it's like your marriage is presumed as not genuine until you prove otherwise, not the other way around…I mean, if I'm in Canada I can marry somebody in jail. I mean, a criminal in jail and it's okay. But I'm marrying somebody from Africa and you're asking me all kinds of just ridiculous questions. Just ridiculous questions.*

With no results after four years engaged in the process, Abike had given birth to and continued to raise their two children alone in Canada. They continued to hope that her husband's application would one day be successful. After all, the reason she ultimately chose to immigrate to Canada instead of the United States, was because of its "family friendly" sponsorship policy.

STRENGTH AMIDST STRUGGLE

At the conclusion of her story about trying to sponsor her husband, Abike explained how staying busy with the kids helped to keep her mind from dwelling on her problems. She also drew strength from her faith, and from an upbringing that taught her to be grateful for what she had:

> *…coming back from where we, where I come from where it just, you know when you go back home you just see…people going through a lot of stuff. If I'm here and I say I'm depressed I must be very ungrateful, you know? 'Cause we have a saying back home. It goes: "I was crying that I had no shoes, and then I met a man with no feet".*

Abike was far from the only woman I interviewed whose resilience amidst stress and hardship was evident. For a number of these women, discussions of church and God intertwined with their hopes and determination. As Effie said after she had detailed her struggles to obtain a nursing license in Canada:

> *I wish that I would be able to get my license someday. I don't know when, I don't know how. But I am praying that there will be an open door sometime, somewhere.*

Even though they had busy lives themselves, and were still in the midst of the ongoing process of getting established in Canada, two of the women described their efforts to help other African women who were newcomers. For one, this was through the work of the home country community association she had founded. For another, her efforts were directed through her personal social networks and connections. Véronique, for instance, described several instances where she had urged women from her home country to engage with the health care system. She physically accompanied some women throughout their journey through the system to provide explanations and support as needed.

NEEDS & RECOMMENDATIONS

The organisation that welcomed Véronique to Ottawa as a refugee over twenty years ago no longer existed. This organisation had met her at the airport, taken her to temporary housing, and returned the next day to walk her through the process of seeking financial assistance, health coverage, and employment. While the city still had a number of hard-working settlement agencies, Véronique felt that cutbacks had changed the overall support available for newly arrived immigrant and refugee women. Now, she said: "les femmes immigrantes quand ils arrivent ici, ils sont délaissées à eux même, c'est comme débrouillez-vous, vous êtes arrivées ici, on vous a fait venir ici, maintenant débrouillez-vous." Relating this to reproductive health, she mentioned that with no one who followed up closely with such women, she knew a number of newcomers from Africa who suffered from persistent infections and relied on traditional cultural remedies from their home countries.

When I asked the women what was needed to help improve the reproductive health of African immigrant and refugee women, a number of them raised similar themes. That is, that they knew of some African newcomer women who were in need with respect to their reproductive health and yet who suffered in silence. They described how some of these women did not know where to go for help. Others were not comfortable using the organizations that currently existed and some struggled with relationships in which they did not have much power to act independently. To help themselves and other African women they knew, the women whom I interviewed suggested that more specific guidance was needed to orient newcomers to health care and help them through the system. Recommended as well was a clinic, or people who carried out home and community visits that were multicultural and

focused specifically on immigrant women. Effie felt that such services would create trust and comfort for African newcomer women to open up about their needs:

> *if there's somebody that we could go and talk to or even if that person could come to you while you are vulnerable to talk to you and hear what your concerns are, maybe they could help us you know a bit. And us we getting stuck, we don't know, we just keep going, coming, going, coming, and then one day the person would just drop and that's it. And that's when we would go do the post-mortem and find out "Oh, she had this issue and she had that issue and that" but it would have been too late.*

Another woman identified the need for increased efforts to connect pregnant women to community organizations before they gave birth. She described how it wasn't until her stay at the hospital that she was given a list of community resources, such as the local Early Years Centre. She felt that the opportunity to orient herself to, and become familiar with, such services before she had a new baby would have been helpful. This same woman also identified the need for more affordable daycare in the city. Even with a good job, she relied on friends for support in light of the high price of childcare in the city. She emphasized that those who did not qualify for low-income daycare subsidies still faced challenges finding affordable care:

> *…thank god I had friends that provided all the support I needed. But what if I didn't have any friends, right? What if I just came to Ottawa nine months ago and I had this baby but I wouldn't qualify for any of those services?... So you expect me to go on Kijiji and look for somebody to come home to watch my kids because I can afford it?...the thing is, by the time you pay, let's say you have two kids. You pay, you know, $3,000 daycare. You are now low-income. You don't have money to buy anything else.* (Abike)

Conclusion

The reproductive health experiences of the women in the southwest suburban case study area were set within the context of a rapidly growing suburban community. It was a geographically large area in which housing developments were largely separated from zones of

commercial space. The services contained in these zones were clustered in pockets along the main roads of the older part of the case study area, leaving the newer portions largely without nearby reproductive health services. As a result of such aspects of location, both the service providers and African women discussed a need to rely on cars for transportation. The public transit system was not generally viewed as an efficient option for navigating the local area itself. Rather, it was largely structured to help residents of the area commute to more central areas of the city at regular working hours.

The community was beginning to diversify, but did not have a strong history as an immigrant-receiving area. The reproductive health service providers described how services were trying to keep pace with the population trends. They were also striving to build strong and lasting relationships with immigrants and refugees in the area in order to better serve their needs. The relatively low density of migrant populations and the housing in which they resided played in to the issues discussed. Detached homes were perceived by the service providers as potentially isolating because they did not facilitate the same degree of social interactions as the apartment buildings or shelters characteristic of other parts of the city. Indeed, the African women seemed to ground their meaningful reproductive health experiences around places other than those based in their neighbourhoods. The relationships formed in church communities emerged as a very important support network for some women. For some of the women, socially constructed places such as these helped to provide assistance with pregnancy, birth, and parenting that family and local communities would likely have filled in their countries of birth. Other women relied on connections with extended family and friends that they had formed prior to moving to the suburban case study area. These findings showed that the

women sought to engage with other African women to support their reproductive health, but did not do so through reliance on a density of newcomers in the southwest suburban area. The more ephemeral places formed within institutions such as church and family were instead the basis for health-facilitating social connections.

It was also noteworthy that socioeconomic status formed a part of the discussions of the service providers and the African women. The southwest suburban neighbourhood was generally higher income and more homogeneously so than the other case study areas in this research. The African women who lived there had often settled elsewhere in the city before moving to the suburbs once they were established. A few of these women emphasized their relative privilege as compared to other African women (e.g., based on voluntary migration status, the education they had received, and the jobs they had secured, though not without struggle).

A number of common themes were raised between the African women and the service providers. Among these was the diversity of African women, and how different home country experiences, culture, languages, etc., contributed to varied reproductive health experiences in Canada. With this in mind, it is worth noting that the service providers seemed to draw strongly from experiences working with refugees, while it was immigrants who formed the majority of interviews for this case study area.

Perhaps reflective of this difference, the service providers spoke quite strongly about the effects of changes to Interim Federal Health at the time of data collection. The women I interviewed also discussed barriers to accessing the system, including financial ones. The themes that came across most strongly for the women, in that they were discussed often and

tied to many of the other themes, were those of family, social networks, and the financial and mental impact of struggles to find meaningful employment. Mental health itself was identified as an important area for future action by the service providers. Stress was present in a number of the interviews with African women, but mental health by name did not come through among their experiences and recommendations. This may be due to cultural norms around mental health as well as consciousness of families who may be suffering even more back in their countries of birth.

In the next and final chapter of this dissertation, I draw together and compare the findings from all of the case studies.

Chapter 8: Integrated Analysis, Recommendations & Future Directions

In the last three chapters, I presented results for each case study. The data I drew on included maps of reproductive health services in each area, the perspectives of reproductive health service providers, and the stories of African immigrant and refugee women who lived out their reproductive health in each of these areas. The purpose of this last chapter is to look across case studies to pull out broader implications for the research questions of this study. In doing so, I highlight links between the findings of each case study as well as areas of difference. While undertaking such comparisons, I was conscious of the tension described by Stake (2005, 2006) that can surface when doing analysis in multiple case study research. That is that intentions to identify overarching insights across case studies can sometimes compete with the desire to retain the detailed description and uniqueness of each individual case. With this in mind, it is still valuable to undertake comparison across cases. Such comparison encourages one to consider how an issue is influenced by different contexts. It may also bring to the surface social forces that exert an influence across contexts despite their differences (Herbert, 2010; Stake, 2005).

The integrated analysis that I present below is followed by recommendations for policy and practice. In addition, I discuss the strengths and limitations of this study and consider potential directions for future research.

Integrated Analysis Across Case Studies

The Context for African Women's Reproductive Health in Ottawa

In this first part of the integrated analysis, I consider the research sub-question: What context and perspectives do maps of reproductive health services and reproductive health service providers present regarding African immigrant and refugee women's reproductive health? To answer this question, I first examine and compare the local context of the case study areas. After doing so, I consider cross-cutting themes that I identified from interviews and focus groups with reproductive health service providers.

LOCAL CONTEXT

As a starting point for this discussion, I have summarized key characteristics of each of the three case study areas in Table 5 (below). These characteristics include general features, such as size and population, along with some indicators of socioeconomic status and diversity in each area. I have also included the number of services available to help meet basic settlement and reproductive health needs. In conjunction with the service maps for each case study, this information provides a sense of how one element of place, location, varied between the areas. The differences in where people and things were located shed some light on how the unique context of given neighbourhoods could facilitate or hinder reproductive health opportunities. They also began to point to the ways in which different places helped to structure social relations between people.

Table 5. Summary Characteristics of Case Study Areas*

CHARACTERISTICS	CASE STUDY AREA		
	Central	West	Southwest Suburban
Population	37,700	20,390	54,875
Area	5.2 km^2	4.5 km^2	31.9 km^2
Density of population	7,246 ppl/ km^2	4,531 ppl/ km^2	1,720 ppl/ km^2
Households spending >30% income on shelter	31.4%	33.3%	17.4%
Number of social housing units	4,095	549	211
% Population immigrants	24.7%	36.6%	25.3%
% Population recent immigrants	5%	10%	3.4%
Settlement agencies (#)	5	1	0
Density of immigrant population	1,791 imm/ km^2	1,658 imm/ km^2	435 imm/ km^2
Density of recent immigrant population	363 rec imm/ km^2	453 rec imm/ km^2	58 rec imm/ km^2
Community health centres (#)	2	1	1
Walk-in clinics (#)	4	3	3
Family physicians** (#)	47	5	41
Midwives (#)	17	0	0
Obstetricians/gynaecologists** (#)	0	0	0
Pharmacies (#)	15	7	10
Ultrasound clinics & laboratories (#)	3	3	1
Density of total # of reproductive health services	16.9 services/km^2	4.2 services/km^2	1.8 services/km^2

* The number of settlement and reproductive health services in each area was identified as part of the mapping process for this study. All other data were drawn from the Ottawa Neighbourhood Study (Ottawa Neighbourhood Study, 2011).

** Indicates family physicians or obstetricians/gynaecologists who were operating independently of either a community health centre or a walk-in clinic.

First, the density of each area differed with respect to population and reproductive health services. Whether or not people and resources are in close proximity to each other

affect the likelihood of informal social encounters, the distance to travel to access services, and the ease with which one is able to do so. A density of newcomer populations and people of diverse socioeconomic backgrounds may also foster what Iris Marion Young termed "unassimilated otherness" (Young, 1990, p. 251). That is, that differences between social groups are welcomed and viewed as an asset rather than as a basis for exclusion. The extent to which an area approaches such an ideal may play in to African immigrant and refugee women's sense of belonging and the extent to which they are able to build and leverage social networks in an area.

The central case study area was the most dense with respect to population generally and its overall immigrant population. It was also the best served by reproductive health services. Related to its long and strong history as an immigrant-receiving area, a number of settlement agencies were available. In contrast, the southwest suburban area was the largest in size with a population that was much more spread out and separated in relatively newer, detached homes. A number of reproductive health services were available, but the density of these services was low. No settlement agencies were present in the area to cater to the smaller but growing population of newcomers. The west end case study shared some characteristics with both the central and suburban areas. It approached the density of the central area in general population and immigrants, while exceeding the central area with respect to the density of recent immigrants. Such density was aided by the variety of apartment buildings and smaller, attached rental homes in the area. The west end case study area was the least well-served, however, in terms of both the overall number of reproductive health services and

reproductive health services per capita. As I discuss in the next point, the distribution of these services was much less dense than the central area and more characteristic of a suburban zone.

A second noticeable difference between the layouts of the respective areas was the relative segregation of residential from commercial areas. The ease of travel by public transit within and to and from the neighbourhoods in question was also relevant to this finding. Characteristic of urban neighbourhoods, the central case study area featured high-density housing that was interspersed with commercial services. A variety of public transit options were also readily available. In the west end and the southwest suburban areas the service maps showed a greater clustering of services away from residential zones. Such segregation is generally a feature of suburban areas despite evidence that mixed use developments can promote both healthier behaviours (e.g., walking) and more vibrant communities (Frank, et al., 2006; Grant & Perrott, 2011) . Areas that are designed for and which promote a reliance on cars raise issues of access to services for residents who must use other forms of transportation. The public transit map for the southwest suburban area in particular showed that this area was generally less well-served. Many of the public transit routes were structured to aid residents to travel out of the area during peak commuter hours rather than to provide easy access within the area itself.

A final point of local context that varied between the case study areas was socioeconomic profile and heterogeneity. Canada generally does not have the stark geographic segregation by socioeconomic status and 'race' as seen in parts of the United States. Nor does Ottawa, within the Canadian context, have the same degree of segregation as the larger metropolitan areas of Toronto and Montreal (Walks & Bourne, 2006). For these reasons, it may

be assumed that African immigrant and refugee women may be able to make social connections with diverse people within and beyond the bounds of their neighbourhoods. Differences in socioeconomic makeup, however, were still apparent between the three case study areas. The central area was one with significant socioeconomic variation, whereas the southwest suburban area had a population that was both higher income generally and more homogeneously so. Compared to the other two case study areas, the southwest suburban area had less than half the percentage of households who spent more than 30% of their income on housing in 2011 (Ottawa Neighbourhood Study, 2011). This measure is an important indicator of socioeconomic circumstances in population health research. It sheds light on the number of households who spend a disproportionate amount of income on housing, thus restricting funds that can be directed towards other necessities (e.g., healthy food, winter clothing) (CIHI, 2016).

These differences in local context between the case study areas were sometimes reflected in my discussions with service providers. They linked these topics to the reproductive health of the African immigrant and refugee women they served. For example, service providers in the southwest suburban case study area raised the challenge of building up health services and connections for community engagement in a rapidly growing and diversifying suburban area. The physical size of the southwest suburban area and its low-density housing were also raised in relation to challenges for health promotion and for locating services in easily accessible places in the area. The view of the southwest suburban area presented by the service providers was consistent with other literature that suggests that Canada's suburbs are more socioeconomically and ethnically diverse than stereotypes of these areas often suggest (Harris, 2015; Hiebert, 2010). Despite this diversity, Canadian research has highlighted a

continued centralization of services for newcomers that fails to keep pace with rapid growth in suburban areas. In the context of limited long-term funding for immigrant service agencies, those that are established in suburban areas may also face uncertain futures because they lack the longer histories and established infrastructures of services in older parts of the city (Lo, 2011).

In another example of differences between the case study areas, variations in the socioeconomic profiles of the areas were evident in some of the discussions of the service providers. Those in the central and west end case study areas spoke more frequently about the socioeconomic and settlement challenges faced by very new immigrant and refugees. Pressing and immediate needs related to finding housing went hand in hand with, and sometimes superseded, more direct reproductive health concerns. The service providers in these areas spoke often about the refugee populations with whom they worked and their particular needs and challenges. The clients of service providers in the suburban area, on the other hand, were generally perceived as more settled and better off financially. Although these issues still featured within the comments of service providers, the view of a population in a less precarious socioeconomic situation was evident.

Related to socioeconomic variations, the service providers demonstrated that they perceived differences in the social gathering points for African immigrant and refugee women in different case study areas. In the more dense and less affluent central and west end areas, the providers spoke about how African women would forge social connections grounded in the shelters, subsidized housing, and apartment buildings in which they lived. These connections could be the basis for sharing childcare and cooking responsibilities as well as providing

emotional support. The detached homes of the suburban area were perceived as potentially more isolating for African immigrant and refugee women. Instead, some service providers pointed to the need to look for social connections fostered through other places, such as parks and religious institutions.

Despite the differences between the case study areas, there were also strong similarities in the key issues that the service providers identified with respect to African immigrant and refugee women's reproductive health. In Table 6 (below) I have grouped the main themes from my interviews and focus groups into overarching categories. Within this figure, I have also highlighted the overlap between the specific themes and made note of links back to the theoretical framework that informed this research. Above, I have already addressed the first category of local context. In the sections that follow, I discuss in further detail each of the three remaining overarching categories outlined in Table 6.

Table 6. Key Themes from Interviews and Focus Groups with Service Providers

OVERARCHING CATEGORY 1: LOCAL CONTEXT			
Case Study Themes (Areas of overlap marked in green)	Central	West	Suburban
	Population mixed socioeconomically	Lower income migrant population	Large, low density area Growing & diversifying community Higher SES among population & migrants Moving up & out to the suburbs
	Diverse immigrant-receiving community	Diverse, immigrant-receiving community	
	Temporary/rental housing first stop for migrants	Pockets of migrant groups in rental/subsidized housing	
Links to Intersectionality & Place	• Location of people and services create unique local contexts • Availability of affordable housing and settlement services affect where newcomers first reside • Local context shapes opportunities for meaningful social connections		

OVERARCHING CATEGORY 2: FORCES & FACTORS BEYOND SERVICE PROVIDERS' CONTROL			
Case Study Themes (Areas of overlap marked in green)	Central	West	Suburban
	Different stories, different needs Expectations & past experiences	Different stories, different needs Past experiences with health & health care	Different needs & past experiences Challenges of preventative care
	Including & beyond reproductive health	Including & beyond reproductive health	Stress & other issues beyond reproductive health
	Social networks & support	Separated families	Social networks & support
	Laws & policies	Health care coverage	
Links to Intersectionality & Place	• Privilege and oppression are shaped by forces at the structural-level • Women in different social positions have different opportunities for reproductive health • Experience in place is affected by social position and relations at different scales • Places are not always grounded in physical structures, but may be constituted of out social relations		
OVERARCHING CATEGORY 3: CULTURAL COMPETENCY IN INTERACTIONS & INSTITUTIONS			
Case Study Themes (Areas of overlap marked in green)	Central	West	Suburban
	Languages, religions & cultures	Languages, religions & cultures	Languages & cultures
	Creating comfortable, accessible & respectful spaces		Comfortable & respectful spaces
Links to Intersectionality & Place	• Intersecting elements of social location (e.g., language, religion, culture) shape women's reproductive health access and experiences • Institutions and providers influence the social environment of health care spaces in a way that affects the extent to which they are welcoming and respectful of African immigrant and refugee women		
OVERARCHING CATEGORY 4: PRESENCE OF SERVICES IS NOT ENOUGH			
Case Study Themes (Areas of overlap marked in green)	Central	West	Suburban
	Linking into & navigating the system	Linking into & navigating the system	Engaging women & continuity of care
	Laws & policies	Health care coverage	
		Bringing services to the women	
Links to Intersectionality & Place	• Location is not sufficient for access, structural-level factors are at play • How women live in and navigate the system is affected by their social positions		

A GLIMPSE IN TIME – FORCES & FACTORS BEYOND SERVICE PROVIDERS' CONTROL

A consistent and overriding message that I drew from my discussions with service providers was that they were aware that their interactions with African immigrant and refugee women were but a tiny slice out of these women's lives. In the time that they shared with the women, the service providers I interviewed tried their best to address as many health issues as possible. This included attempts to understand some of the external forces and factors that affected African immigrant and refugee women's reproductive health. What was clear was the diversity and complexity the service providers encountered in their work. African women's reproductive health needs were enmeshed with: past experiences in their country of birth (e.g., lack of preventative care, violence and trauma); the migration trajectory (e.g., time spent in refugee camps); migration category and associated health coverage (e.g., Interim Federal Health for refugees, OHIP for voluntary migrants), and a host of settlement issues (e.g., finding stable and affordable housing and employment). Language and culture also featured strongly among these factors and is discussed in more detail under the next theme.

These findings showed that the service providers felt that the reproductive health of African immigrant and refugee women could not be separated from the broader lives of these women. This included consideration of the ongoing influence of the women's prior lives in their countries of birth as well as their positions as newcomers settling in Canada. Such findings are consistent with a wealth of literature that speaks to both the important influence of factors outside of health care on the health of populations (Braveman, Egerter, & Williams, 2011; WHO, 2008), and on the complexity of immigrant women's health needs (Spitzer, 2011b; Vissandjée, et al., 2007). To this last point, literature on women's health that discusses how

social, political, and economic systems vary by place and help to structure health experiences and opportunities are particularly salient (Dyck, et al., 2001; Kerner, et al., 2001). Region of birth, ethnicity, gender, and socioeconomic standing, for instance, may all influence the likelihood that a woman has pursued postsecondary education in her home country or whether she has experienced war or environmental disaster. Such experiences are considered as part of applications to migrate to Canada, which then influence migration category of entry (Smith, 1993; Statistics Canada, 2016a; Veronis & McLeman, 2014; Vissandjée, et al., 2007). In Canada, these women's positions as immigrants or refugees affect the types of health care coverage they receive. The nature of their health care coverage influences the health care spaces that are open to them. Additionally, their positions as women, as migrants, as English or French speakers or not, as racialized or non-racialized populations, as particular ethnicities and members of specific religions all play into their respective experiences settling into their communities, finding housing and employment, and feeling welcome. Directly, through particular vulnerabilities and risks, and indirectly, through stress and resources available to them, these factors combine to affect the health of immigrant and refugee women (Kériset, 2011; McKeary & Newbold, 2010; Oxman Martinez, et al., 2005; Spitzer, 2011b; Wayland, 2006).

To a certain extent, the professional roles of the service providers as well as the structures and places within which they operated influenced their ability to move beyond the treatment of reproductive health issues per se and delve into the overarching complexity of immigrant and refugee women's health. Midwives, some community health/social workers and some public health nurses, for example, had the flexibility to visit women in less formal

settings, such as their homes. This removed a barrier to access and provided the service providers with a deeper glimpse into the home life and associated needs of the women. The funding models that supported midwives and clinicians at community health centres allowed them more time to see patients and the ability to accept patients without OHIP. Some of these service providers, for instance, described how in-home experiences allowed them to observe whether or not a client had the material items (e.g., crib, car seat) to care for an infant. In the home setting, the service providers were also able to meet other family members and neighbours and assess whether or not the client had adequate social support for labour, delivery, and postpartum. In addition, service providers described how discussions they had with clients in the home or in the course of generous clinic appointment slots (e.g., 30-40 minutes) revealed issues related to finances, immigration papers, and school registration for children. A number of steps were taken by the service providers as a result of these encounters. Several community health/social workers and nurses described instances where they had sat with a client and helped them to make phone calls to official organizations (e.g., Revenue Canada, City of Ottawa, school boards). In addition, examples were shared in which service providers had advocated directly to the federal government on behalf of clients (e.g., to secure the right to travel internationally to see family to help alleviate postpartum depression and isolation). Other service providers discussed how, as a result of their observations, they encouraged women to think through social connections to identify potential support people (e.g., to babysit older children during labour and delivery). A public health nurse shared an example in which she had helped to assemble a crib and install a car seat for a client during a home visit. Service providers who worked in community health centres and who saw clients

without health insurance and/or drug coverage were able to refer those in need to on-site resources (e.g., food cupboard, social worker) and to provide medications (e.g., birth control) for free or at a subsidized rate.

Policy, be it at the institutional or provincial level, thus affected professional roles and funding. In turn, these influenced the ability of the providers to cater to African women in different social locations and the places in which they were able to provide such care. All of the service providers seemed very passionate about helping their clients but they also strived for balance. Such balance entailed trying to assist their clients while working within their professional roles and the limits of what they could give in terms of their own emotional investment and personal time.

CULTURAL COMPETENCE IN INTERACTIONS & INSTITUTIONS

Across all of the case study areas, the service providers emphasized that they strove for cultural competency. This included respect for the religions, languages and particular circumstance of each individual African immigrant or refugee woman while they addressed her reproductive health needs. Within these discussions it was clear that service providers sought to achieve these goals within a Canadian society and health care system in which the dominant cultures and funding system restrictions were not always a good fit with the cultures, religions and languages the women brought from home.

Some of the service providers made it clear that they were aware of their own cultural beliefs and occasionally grappled with and negotiated differences between these beliefs and those of the African women with whom they worked. This particularly shone through in discussions related to issues of gender and with women whose cultures placed the husband as

the traditional decision-maker of the family. Some providers related the steps they took to try to ensure that they heard and acted upon a woman's own wishes. A few providers cited the specific example of female genital cutting. They discussed how they had learned how to examine women who had experienced female genital cutting and how they and their institutions had been required to consider how to handle potential requests from husbands for their wives to be re-sewn after giving birth.

This issue is worthy of note although it was raised by only a few of the service providers. It is, however, a key theme in the academic literature on African women's reproductive health. This literature ranges from consideration of the ethical and legal implications of the practice, to the challenges and concerns clinicians face when working with women who have undergone female genital cutting (Cook, Dickens, & Fathalla, 2002; Perron, Senikas, Burnett, Davis, & SOGC, 2013; Rouzi, 2015; Younger-Lewis, 1997). Taken together, these studies show how the diversification of migration streams to Canada has raised new issues for reproductive health service providers. As a result, they have grappled with their own cultural beliefs and concerns for the health and safety of the women they work with, as well as practical issues of treatment.

Despite the predominance of literature on female genital cutting, the service providers in my research discussed other issues under the realm of culture much more frequently and with more depth. These issues included, for example: cultural norms related to the use of preventative care and taboos related to the discussion of reproductive health issues; communication challenges for women who had not grown up speaking English or French; preferences among some women for a female health care provider. As with the last overarching category, the place in which a woman sought care seemed to partially influence

the flexibility that service providers felt they had to interact with African immigrant and refugee women in a sensitive and respectful way. Those who worked in community health centres, for instance, discussed how their particular model of care allowed them time to listen to women and their needs, work with interpretation services, and bring in other colleagues as necessary to try to respect wishes around the gender of the service provider. Some of the service providers pointed out that such flexibility was likely very different for a woman who presented at a hospital in mid-labour in the middle of the night. The availability of interpretation services and choice of health care providers was often much more limited under those circumstances.

The weight that the service providers placed on cultural competency is also echoed and built upon in research that had been conducted with African women in Canada in relation to their childbirth experiences (Etowa, 2012; Etowa & Adongo, 2010). In particular, Etowa and Adongo (2010) argue that cultural sensitivity is only the beginning of a continuum towards true cultural competence in health care. This competence includes not only a willingness to understand varying cultures of individual clients, but also the awareness, knowledge, and skills to accommodate these cultures. These actions implicate not only individual care providers but also the institutions within which they work.

As other authors point out, we must also be cautious with interventions focused on cultural competence in care. There is a tendency for such efforts to present cultures as fixed and to homogenize groups into a singular, unchanging culture (Kleinman & Benson, 2006). There is diversity within cultural groups, and a given interpretation and lived experience of culture is unique in time and place. Cultures are constantly changing because they are the result of human interactions (Dyck, 2004; Viruell-Fuentesa, et al., 2012). In addition, an

emphasis on cultural competence often places the locus of action, and potentially blame, at the level of interpersonal interactions. Inequities may be attributed to cultural practices rather than structural barriers (Abrams & Moio, 2009). These may include, for instance, the position of racialized newcomer women in the labour market. That is, their increased likelihood to work in unstable, poorly paid work while potentially shouldering the burden of domestic responsibilities in their home lives.

THE PRESENCE OF SERVICES IS NOT ENOUGH

The final overarching theme that I identified from discussions with service providers was that the mere presence of reproductive health services was not enough to ensure their accessibility and acceptability for African immigrant and refugee women. The two themes previously discussed in this section are also related to this final theme. African immigrant and refugee women have different past and current circumstances that affect their ability to use services (e.g., past traumas may affect trust in the system, lack of familiarity with the system causes confusion and accessibility barriers). Their particular cultures, languages, and religions may also play a role. African women who enter Canada with the ability to speak English or French, for example, will have a much easier time navigating and communicating their needs than those who do not have capabilities in these languages. Despite the official bilingualism of Canada, research has found that francophone populations outside of Quebec, newcomers included, have difficulties finding consistent access to service available in French (Bouchard & Desmeules, 2013; Kériset, 2011).

The system of publicly-funded health care laid out in the *Canada Health Act* includes accessibility among its key principles. The reality is, however, that newcomers to Canada

encounter a number of barriers to accessing and using the existing system. Those factors identified by the service providers in this study are echoed in the literature. These include lack of trust in or knowledge about the system and how it works, language barriers, and encounters with culturally inappropriate or insensitive services (Gagnon, 2002). The literature also deepens our understanding of such barriers by highlighting how some newcomer women, particularly those who are racialized, do not speak English or French, and/or have a precarious migration status, experience heightened barriers. These women are more likely to face discrimination in their encounters, have difficulty communicating, live in poverty, and work in precarious employment situations that limit their time and ability to address health concerns (Johnson, et al., 2004; Oxman Martinez, et al., 2005; Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008).

As mentioned above structural-level forces related to, for instance, institutional policies that govern hours of operation and the mobility of practitioners effectively mean that African women have different levels of access to services depending on their own time limitations (e.g., due to employment and/or childcare responsibilities) as well as their ability to travel to services. Additionally, the types of health coverage offered to different categories of newcomers affect access. The service providers I interviewed repeatedly raised concerns related to policy changes to the Interim Federal Health Program for refugees, and health care services that barred or imposed additional fees for refugees as a result.

During the period of data collection for this study, the federal government was in the process of introducing changes to the Interim Federal Health Program to create different levels of coverage rather than a single program (Sheikh, Rashid, Berger, & Hulme, 2013). Confusion related to these changes was well-documented in the academic literature as well as the media

(Ruiz-Casares, Cleveland, Oulhote, Dunkley-Hickin, & Rousseau, 2016). Well-documented as well were the inequities foreseen and realized as a result of the changes, including cases of pregnant refugee women being refused care or asked to sign documents saying that they would personally pay for services (Arya, 2012; Barnes, 2013; Evans, Caudarella, Ratnapalan, & Chan, 2014).

The case of Interim Federal Health highlights the important interaction of time and place. Following data collection, the policy context in Canada shifted again. With the election of a new federal government in late 2015, further changes have been introduced that reverse those to the Interim Federal Health Program (IRCC, 2016). The reversal of the cutbacks does not entirely negate the concerns expressed by the service providers with regards to the Interim Federal Health Program. Even prior to the proposed changes, researchers identified challenges with the program. These include a lack of awareness among independent clinicians about how Interim Federal Health operates and an unwillingness of some to undertake the paperwork to process claims through the program (Gagnon, 2002; Miedema, Hamilton, & Easley, 2008).

SUMMARY

In this final portion of this section, I return to consider more specifically the research question that guided the discussion above. That is, what does the data collected from reproductive health service maps, and interviews and focus groups with service providers tell us about the context in which African immigrant and refugee women experience their reproductive health in Ottawa? The reproductive health service maps provided a basic view of the services available in each of the case study areas and showed that, although the areas varied in the number of services, all had a range from family physicians, to community health

centre(s), to pharmacies and walk-in clinics. The dispersion of these services and the populations suggested that local context may be relevant to the ability of African immigrant and refugee women to access care and to make meaningful social connections to support their reproductive health.

Complexity was added to this context with the perspectives of the service providers. In their views, the accessibility of the services to African immigrant and refugee women varied significantly depending on the social positions of these women. The service providers made it clear that they viewed African immigrant and refugee women as an extremely diverse group with complex reproductive health needs that intersected with past circumstances and present settlement experiences. My discussions with the service providers showed that they made significant efforts to provide the best care they could. This included attention to reducing barriers to access and providing care in comfortable and respectful places and environments. These efforts, however, were carried out within the various opportunities and limitations presented by their professional roles, institutional regulations, and broader policies that governed different health care models and the health care coverage provided to immigrant and refugees in Canada. In sum, although the reproductive health service providers worked within the local context of Ottawa and focused on micro interactions with their clients, a local view was not enough to understand the full range of factors that influenced African immigrant and refugee women's health and care. In the views of the service providers, the actions that they took to serve African immigrant and refugee women, and the likelihood that these women accessed and continued to use various reproductive health services, were partially shaped by

factors that stretched from the country of birth of the women (e.g., cultures, languages, health care norms) to more macro-level policies and processes (e.g., immigration and health policies).

Immigrant Women's Experiences: Across Cases

In this next section I move from the context for African immigrant and refugee women's reproductive health experiences to consider these experiences themselves. I examine findings across cases, and draw out implications for two inter-related research sub-questions. These questions are as follows: (1) What aspects of place-based context do African immigrant and refugee women in the City of Ottawa feel are important to their reproductive health and impact their comfort and/or ability to seek reproductive health information, services, and support? (2) In what ways do these women actively construct places to facilitate their reproductive health and access to information, services, and support?

Before treating each of these questions in turn, I begin this integrated analysis by summarizing the main themes from interviews with African immigrant and refugee women in each case study areas (Table 7). I have grouped these themes into three different overarching categories: (1) migration and settlement; (2) accessing and using the health and social services system; (3) considerations outside of the formal system.

Table 7. Key Themes from Interviews with African Immigrant and Refugee Women

OVERARCHING CATEGORY 1: MIGRATION & SETTLEMENT			
Case Study Area Themes (Areas of overlap marked in green)	Central	West	Suburban
	Migrating & settling in	Migrating & settling in	Migration experiences & getting stuck Finding work & financial pressures
		Making a home in the west end	Settling in, then moving to the suburbs
Links to Intersectionality & Place	• Despite distance, home country experiences extend to current lived experiences • Different local contexts are accessible at different stages of the settlement process • Privilege and oppression are shaped by forces at the structural-level • Experience in place is affected by social position and relations at different scales		
OVERARCHING CATEGORY 2: ACCESSING & USING HEALTH & SOCIAL SERVICES SYSTEM			
Case Study Area Themes (Areas of overlap marked in green)	Central	West	Suburban
	Getting out, getting around	Finding & traveling to services	Finding & accessing services
	Interactions with the system	Interactions with the system	Interactions with the system
	Bodies in one place, minds in another	Learning how the system works	
Links to Intersectionality & Place	• Location is not sufficient for access, structural-level factors are at play • How women live in and navigate the system is affected by their social positions • Social interactions affect sense of place • Places may be both physical and imagined		
OVERARCHING CATEGORY 3: CONSIDERATIONS OUTSIDE OF THE FORMAL SYSTEM			
Case Study Area Themes (Areas of overlap marked in green)	Central	West	Suburban
	Repr health outside of the system		Repr health outside of the system
	Separated families, social support & isolation	Separated families Social networks & support	Separated families & social support
	Home country communities & cultures	Culture, language & religion	Repr health back home – cultural norms & past experiences African women are diverse
	Raising children	Raising children	Raising children

	Stress & mental health	Stress & mental health	
		Resilience & pride	Identity, social status & self-worth Strength amidst struggle
		Assumptions, judgment & discrimination	Stereotypes & assumptions
Links to Intersectionality & Place	• Meaningful places may be constructed out of temporary and fluid social connections • Health experiences occur within formal care setting as well as outside of these • Local context partially shapes opportunities for social interaction • Privilege and oppression are shaped by forces at the structural-level • Migration entails both physical and social mobility		

As I mentioned in the introductory chapters of this dissertation, as I progressed through my data collection and began to think about emerging themes by case study area and across them I increasingly drew upon an intersectional theoretical framework integrated with theories of place. I came to realize that salient differences between the experiences of the women did not seem to primarily revolve around their neighbourhoods. Some elements of local context such as the density and diversity of the people and services in the area, along with its general socioeconomic profile, affected the overall opportunities women had to make connections in support of their reproductive health. The intersecting social positions of the women and the changing and varied social places they occupied, however, seemed to be prominent elements of their reproductive health experiences. To some extent these reproductive health experiences occurred within their case study area at a different scale than that of the neighbourhood (e.g., in physical locations such as clinical offices and their homes). They also occurred in virtual spaces (e.g., in social support networks that sometimes stretched internationally). In the following two sections, each focused on a research sub-question, I explore these ideas further.

WHAT ASPECTS OF PLACE-BASED CONTEXT DO THE WOMEN FEEL ARE IMPORTANT TO THEIR REPRODUCTIVE HEALTH AND IMPACT THEIR COMFORT/ABILITY TO SEEK INFORMATION, SERVICES & SUPPORT?

Among the themes that I identified from interviews with African immigrant and refugee women, it was clear that a number of aspects of place-based context were important to their reproductive health experiences in Ottawa. The first of these aspects was the shifting locations of women, both in terms of physical spaces and social ones. All of the women I spoke to had migrated to Canada, which entailed the physical movement from their country of birth to a new country. This physical movement necessitated starting over in Canada, with all that that implied in terms of finding housing and employment, applying for and learning how health care services work, adjusting to potential language and cultural differences, and seeking to develop new sources of social support. In some cases, imagined social spaces were also evident in the discussions of the women. Women spoke about hopes of returning to their countries of birth, while still being physically present and tethered to their lives in Canada. In a more direct relationship to reproductive health, some women shared stories of giving birth in health care settings, while at the same time imagining what the experience would have been like back home. These themes link to a literature on the important role of the imagination in relation to globalization and migration (Appadurai, 1996; Mahler & Pessar, 2001). That is, that images and hopes (e.g., of life in a new land or of that back home) transcend national borders and occur alongside lived realities. The nature of these imaginings plays into agency and affects decision-making, interactions with communities, and the feelings one has with respect to the migration experience (Mahler & Pessar, 2001).

The women also spoke explicitly or implicitly about how they had undergone a change in social position from their country of birth. This was particularly evident in relation to attempts to find employment and have foreign credentials recognized, as well with respect to domestic help that some may have been able to afford "back home". Notions of class shone through particularly in some of the interviews I conducted in the southwest suburban area. This was an area where the population was more uniformly better off financially, with less of the socioeconomic heterogeneity of the other two areas. The women I spoke to were mostly voluntary immigrants and were settled into employment even if it did not match what they had attained in their countries of birth. At the same time as it seemed that these women made their most meaningful social connections with other African women all over the city (e.g., through churches) some also took care to distinguish themselves. That is, they made it clear that they were not like some newcomers who were reliant on the social support system. Perhaps due to their more elevated socioeconomic positions and/or greater length of time in the country, among these suburban women were also those who appeared to be leaders in their cultural communities (e.g., through the founding of home country organizations).

Gendered considerations were evident within these discussions of social position. Alongside the settlement challenges of being newcomers to Canada, as women they grappled with (re)establishing careers while they juggled the reproductive work of pregnancy and birth. They also bore the primary responsibility for childrearing, meal preparation, and housecleaning in most cases. These findings are consistent with the literature on migrant women's health that points to the struggle for newcomer women, particularly those who are racialized and/or part of language minorities, to find employment in Canada consistent with their training (Kériset,

2011; Yesufu, 2005). For many newcomers, demands for Canadian experience are a rude awakening compared to the vision of job prospects in Canada they had prior to migration (Dean & Wilson, 2009). De-skilling can have very real health impacts by affecting material resources as well as psychological ones. Spitzer (2011b) discusses this issue in detail as she examines how the paid and unpaid work carried out by migrant women, in addition to the burden of worry for their families and weariness as hopes and expectations are unrealized, are embodied to the detriment of migrant women's health.

All of the women I interviewed were positioned as part of a racialized group within Canada. The intersection of migration status and racialized identity sometimes played out in health care and community settings. Those who came from countries where they grew up speaking English seemed to have better, but not perfect, experiences advocating for themselves within Canada's unfamiliar health and social services system. The women I spoke to who seemed to have struggled the most added language barriers and histories of war or abuse to their stories.

A related element of place that emerged in my analysis was that of social networks and isolation. Social support networks are often disrupted in the process of migration and migrants in general are at risk of isolation. Layered on top of this risk of isolation for the women were other variables that could increase isolation (e.g., new motherhood, social stigma in relation to living with HIV/AIDS). A number of the women I spoke to were in Canada, and often parenting, alone. This was especially so, but not solely found, among the refugees I interviewed in the central case study area.

Finding and using sources of social support is important to immigrant women to ease integration, reduce this isolation, and facilitate access to information and services (Stewart, et al., 2008). Creating new social networks in Canada seemed extremely important to the women with whom I spoke. They discussed how family members and friends, particularly the women, would have provided significant support in terms of reducing the burden of childbirth, childcare, and household work. They discussed emotional pain and occasional guilt related to being separated from family members back home. Some of the women also identified how the social culture in their countries of birth was an essential means of transmitting information. Under the next research sub-question, I discuss social networks in more detail and consider the ways in which women successfully or unsuccessfully built social networks in Canada to replace these female-centred networks from their home countries.

A final key element of place that emerged from my interviews with African women was health care settings themselves. Although a number of women discussed their satisfaction with the system, others raised several frustrations. Some of these related to difficulties securing a family physician given their newness to the country. Despite the other options available for primary care in the province of the Ontario (e.g., nurse practitioners), physicians were the health care professionals with which the majority of the women I interviewed seemed most familiar. Only one of the women referred to her interactions with a nurse practitioner and none of the women had used midwifery care for the birth of their children. As a result of difficulties securing a primary care provider, women were forced to rely on walk-in clinics. This was true regardless of the density of independent physicians' offices in the case study area. If they had the means to do so, some women showed considerable mobility. They travelled

outside of their neighbourhoods in search of care or to maintain contact with service providers with whom they had formed relationships. Difficulties finding a family physician in Ontario are not unique to immigrant and refugee women. Challenges faced by newcomer women in terms of getting around, potentially having to wait for health care coverage, and language and cultural barriers, however, exacerbate these difficulties (Asanin & Willson, 2008).

Other women expressed anger and/or confusion at the way they were treated within health care settings. This finding speaks to what Agnew (1987) refers to as 'sense of place'. Places are not just about the location themselves, but also about the feelings that people attribute to them based on their experiences. Some of the women I spoke to did not have positive associations with formal health care spaces. They raised concerns in relation to the time and respect they felt they were given by health care providers. The culture of health care and how providers interacted with patients appeared to be very different for some of the women from what they were used in their countries of birth.

This finding is similar to other research on the health care experiences of immigrant women of African descent. Such studies have pointed to the more social interactions some women are used to in their home countries, in which clinicians ask about family and home life before delving into specific health concerns (Etowa, et al., 2010). A reliance on walk-in clinics if the women were unable to find a permanent care provider seemed to exacerbate these experiences for some women. Again, migration category and language intersected with these other considerations as some of the refugee women appeared too overwhelmed with the immediate daily considerations of living and settlement to engage with the health care system.

Other women discussed their relief that they could communicate in English in order to better advocate for themselves in the health care system.

IN WHAT WAYS DO THE WOMEN ACTIVELY CONSTRUCT PLACES THAT FACILITATE THEIR REPRODUCTIVE HEALTH AND ACCESS TO INFORMATION, SERVICES & SUPPORT?

Common across case study areas, the African women who had the resources available to do so actively constructed places to facilitate their reproductive health. That is, the women sought out places in which they felt comfortable, worked within existing health care places to have their needs met, and created their own places (e.g., social networks) to support their reproductive health. The extent to which women did so was influenced by a mix of factors that affected the time, resources, and power they had to carve out such places. These intersecting factors included: the length of time they had spent in Canada and the knowledge and confidence that came with this; points of entry to social networks, be it based on place of residence, home country community, culture, or language; education and language abilities; migration category of entry and the extent to which women had to deal with immediate settlement concerns or not.

The creation and use of social networks was the primary way that some of the women I spoke to actively constructed places to facilitate their reproductive health. For those who were able to access and use them, women-centred social networks were a source emotional support (e.g., in reducing isolation for mothers) as well as a practical one (e.g., in bringing food postpartum, sharing childcare, getting around the city). For some of the women, elements of the physical environment of their neighbourhoods helped to facilitate the creation of these social networks. This was particularly evident in the case of a number of women I spoke to who lived in apartment buildings in the west end case study area. These women benefitted from

their close proximity, the high density of newcomers in the area, and the fact that some services deliberately targeted these environments and populations (e.g., through a playgroup offered in the basement of one building). The home was an important site of gathering for these women and one in which they shared information and support related to childbirth, parenting, and domestic responsibilities. For other women, neighbourhood or area boundaries seemed less important and they were more mobile in their search for social networks. The foundation of their networks was around institutions such as home country organizations and/or church communities. These examples show how some of the women I spoke to sought out and actively built places outside of the formal health care system in Canada. These places were not necessarily permanent. They were the fluid and shifting places formed out of social encounters. Regardless, these were the places in which they felt comfortable and which were compatible with their languages, religions, and/or cultural beliefs.

The contribution of social support has emerged as an important aspect of understanding immigrant and refugee's health. In particular, researchers have pointed to the different meanings of social support for various cultural groups (Stewart, et al., 2008; Stewart, et al., 2010). These varied meanings have important implications for how different immigrants and refugees seek out information and services. In work with Somali immigrants, used to a social culture in their home country, Stewart et al. (2008) found these newcomers tended to seek out services through informal networks. This was a contrast to immigrants who were used to a heavier reliance on government services back home and who carried this through to the ways in which they sought out support in Canada. Following from these findings are questions regarding whether the places that the Canadian health and social services system uses to

deliver services are compatible with the diverse cultures and expectations of newcomers to the country. Ley (2008), for instance, identifies immigrant Christian churches in Vancouver as a source of both support and personal and social services for newcomers who identify with their beliefs.

In each of the case study areas I also interviewed women who spoke very differently about social support. Some of these women were refugees, who were newer to the country, had lived past traumas, moved between housing, and/or struggled with the day-to-day challenges of just getting by. These women did not appear to have had the opportunity to build strong social networks in Canada as of yet. Some were women who didn't feel as connected to home country community groups because of fear of or actual experiences of stigma. Another had a desire to move away from the more traditional beliefs and practices prevalent in her home country community group.

A group of women who were living with HIV/AIDS spoke of the "family" they had found within a local community health organization where they could feel comfortable in shared experiences and acceptance. These women benefitted from the more diverse array of services available in the central case study area as compared to the others. The presence of a local community health organization with a program targeted specifically at African women was unique to this area. Another example showed how women who felt stigmatized in the social networks used by others found alternatives of their own. The use of virtual networks was raised by one woman who was afraid of stigma due to her status as a single mother. She found online communities a desirable alternative source of support because of their anonymity. Places built through the use of technology may increase the virtual mobility and access to

information and service for those who may be otherwise isolated (Kenyon, Lyons, & Rafferty, 2002). In line with the experience of the woman cited above, virtual networks may also be a means for socially excluded groups to build community and find support (Chong, Zhang, Mak, & Pang, 2015).

Evident in these discussions were also the ways in which women's positions as immigrants and refugees helped to structure their ability to build social support. A number of the women discussed family members, including husbands, who they missed and who they hoped would be able to come to Canada one day. Some of these women explicitly pointed to their inability to sponsor family members or leave Canada because of their lack of permanent residence or because they were embroiled in a lengthy process of sponsorship. The result of these separations were that these women sometimes gave birth and parented, suffered illness, and worried about what would happen to their children if they fell sick, without those on whom they most wanted to rely for support. As another woman I spoke to pointed out, the economic position of some newcomers to Canada also limited the time and opportunities they had to seek out social support networks. Again, structural forces were at play as newcomers sometimes found that their education was unrecognized, and they were channelled into lower-paying, more irregular work while potentially also undertaking re-training programs.

A second key way in which the women actively constructed places to facilitate their reproductive health was to push back within the formal and informal systems. This seemed to be particularly the case for the women who had been in Canada longer, who spoke English, and who felt they had the confidence derived from educational and cultural upbringing to do so. These women spoke about how they asserted themselves with doctors in order to have their

needs heard, and how they worked with others from home country or cultural communities to encourage them to do the same. In sharp contrast to these success stories, other women I interviewed seemed weary and frustrated at a system in which they found it difficult to communicate and where no one seemed to understand their past lives and current needs.

Comparison Between Data Sources

In the section that follows, I consider another of the research questions of this study. This research question asks about convergences and divergences between the different data sources and implications for the different types of evidence to inform interventions to support African and refugee women's reproductive health.

The first type of data, maps of reproductive health services, presented a largely undifferentiated picture of the services that were and were not available in the case study areas. The maps allowed for an analysis of the number and density of services but, as pointed out by the service providers and evident in my interviews with African immigrant and refugee women, they left out much of the lived realities of navigating the service system. Such a simple representation did not speak to how accessible these services were to clients or to how service providers acted within them. In short, the maps lacked the dynamic elements that showed how people in different social positions lived in place and interacted within these places to help meet their needs.

The results from the service providers showed that much more complexity was involved in African immigrant and refugee women's reproductive health and the varied accessibility that these women experienced (e.g., based on their health care coverage, their ability to get around, experiences with cultural competency, and the relevance of the services to their needs). The

service providers leveraged the resources at their disposal, within their professional roles and institutions, to help the women they worked with to the best of their abilities. It was evident from these interviews and focus groups that the service providers would have painted a different map of reproductive health services with respect to African immigrant and refugee women in Ottawa. Such a map would have emphasized the professional service networks they strived to create with other providers who they considered to be friendly and accessible to immigrant and refugees. It would have also differentiated between health services based on what was available given a woman's migration category and associated health coverage. The service providers appeared to try to link women into these friendly and accessible networks as much as possible, while only veering outside of them when necessary. Clinics known to have refused refugee patients or counselling services that required private payment, for example, were avoided whenever possible.

The perspectives of the African women echoed some of the sentiments from the service providers. Similar concerns were raised between these two groups in relation to the important influence of the diversity of African women and their varied migration and settlement experiences, cultures, religions, and languages. Social networks were actively created and used by some women, as were attempts to assert themselves within a health and social services system that was not necessarily compatible with their health care norms and cultures. While, understandably, the service providers largely discussed their experiences within the health care system, the key themes identified from interviews with African women centered more strongly outside of the formal system. Although the maps showed a variety of services, the women seemed to focus on the basics. That is, for the most part, they seemed to access physicians and

hospitals when necessary. For instance, for care during pregnancy and birth, for regular check-ups for children, for pressing health care needs (e.g., for those living with HIV/AIDS). By and large, the women did not seem to access many of the other supportive resources that were available (e.g., prenatal classes, playgroups). Much more relevant to the experiences of the African immigrant and refugee women, were connections formed in other places. Social networks featured strongly among these, as the women appeared to be much more comfortable in spaces that were based in their homes or churches. These were ones with which they were already familiar and which were connected with people whom they knew and trusted.

The implications of these findings for the overall research question of this study are discussed in the next and concluding section of the integrated analysis. Briefly, however, these differences in the findings from different types of evidence suggest that focusing only on whether or not a reproductive health service is available in a given area of Ottawa is not enough. What is needed is an understanding of how professionals work within those services. Even more important, is to know how African immigrant and refugee women in different social positions use they system and feel that it responds to their needs.

Conclusion to the Integrated Analysis

The overarching question that I asked in this research was: How do African immigrant and refugee women experience, negotiate and construct place in relation to their reproductive health and as they seek reproductive health information, services, and support in the City of Ottawa? By using a multiple case study approach and applying theories of intersectionality in

conjunction with theories of place, I sought a highly-contextualized understanding of these women's experiences.

Although the case studies for this project were based around different geographic areas, my interviews with African immigrant and refugee women showed that their experiences of places with respect to their reproductive health were much more complicated than simple interaction with neighbourhood services. Consistent with the other literature on place and immigrant and refugee women's health, and feminist literature on migrant women's health (Anthias, 2012; Dyck, 2004; Massey, 1994b), I found that the experiences of the women in this study were highly affected by their social positions in Canadian society. Their category of migration, gender, prior education and languages, racialized identities, cultures, and religions all came into play in different ways for different women. These affected, for example, the types of health coverage they received, the settlement challenges they faced, and their roles as migrants, as women, and as mothers. They negotiated these social positions as they adjusted to their lives in Canada, attempted to access care for reproductive health needs, cared for their families, and sought to build social networks to provide support, share material goods for parenting, and start over in a new land.

Both the African women and the reproductive health service providers I interviewed raised similar issues related to access barriers, the importance of settlement issues (e.g., housing, employment), and the need to continue to build cultural sensitivity in health care. In the body of work on immigrant and refugee women's reproductive health, such issues are also consistently raised (Bollini, et al., 2009; Etowa & Adongo, 2010; Stewart, Makwarimba, et al., 2015). Where the views of the service providers and African women differed, however, was the

primary focus of the women on their lives outside of the health care system. Social networks based in places outside of the system, such as religious organizations, the houses of friends, or virtual spaces, seemed to be particularly important to constructing environments where they felt comfortable. Though not designed to address their reproductive health needs, these places were nonetheless extremely helpful for those women who were successful building such social networks. Women discussed the important emotional support of friends, the role that such networks played in helping postpartum, and their importance to breaking the isolation of parenting.

These findings make a number of contributions, first and foremost by adding to the growing body of literature on Canadian African immigrant and refugee women. This literature recognizes the diversity among immigrant and refugee women and, thus, the importance of considering the particular needs of African women in the Canadian context (Spitzer, 2006a). This current study helps to document the particular experiences and needs of African immigrant and refugee women with respect to their reproductive health. By merging theories of intersectionality with theories of place in my examination, I have also identified a number of interconnected factors that influence their reproductive health. These factors range from the global, to the national, to the local. The results of this research emphasize the importance of understanding how African women's reproductive health is contextualized outside of the health care system and influenced by their intersecting social positions.

Finally, this study also pushes for an expansion of the ways in which theories of place are used in population health research. Much work on place in population health has focused on neighbourhoods and the built environment. Researchers have examined how

neighbourhood characteristics correlate to patterns of inequalities as well as how the built environment affects access to health-promoting behaviours and resources (Bernard, et al., 2007; Gelormino, et al., 2015; Wasfi, et al., 2016). The results of my study suggest that, to better identify and address the health needs of African immigrant and refugee women, the field of population health would be well-served by drawing on definitions of place more in line with social geography and merged with intersectional theories. The reproductive health experiences of the women in my study were strongly influenced by factors far beyond neighbourhood characteristics and the distribution of services. More relevant, were their various positions within multi-level networks of social conditions and relations that interacted to structure or constrain their opportunities for reproductive health (Massey, 1994b). Home country experiences, for instance, influenced whether a woman migrated alone as she fled trauma with her children or with her spouse in search of new educational and job opportunities. Upon entering Canada, she was admitted into a migration category (e.g., refugee, economic immigrant) that structured the health insurance she received as well as settlement supports. Religion, cultural and racialized positions have been shown to play into experiences in the job market and of discrimination, as well as social networks available. All of these respective factors flowed down to influence African immigrant and refugee women's social support, stress, socioeconomic positions, and ability to access information and services in relation to their reproductive health. The implications of the above findings for policy and practice are captured in the recommendations I outline below.

Recommendations

In this section I summarize recommendations that emerged from the findings of this research. When asked, some of the service providers and African women made specific suggestions for ways to improve the reproductive health of African immigrant and refugee women. In Tables 8 and 9 below I summarize these recommendations, along with their potential cost implications.

What is evident in the recommendations is that place is salient in different ways that stretch beyond the number and placement of services. Service providers and African women both highlighted certain services that were lacking in their views (e.g., mental health services, child care, clinics for newcomer women). Importantly, their recommendations in this respect contained adjectives (e.g., affordable, accessible, comfortable) that highlighted that was it not the mere presence of these services that was needed. What was needed was for these services to be places that African immigrant and refugee women could easily access and where they felt safe and welcomed. Other recommendations focused on the need for increased support navigating the system, again showing that newcomer women's experiences of the service environment in a given place may be very different from that of someone born in Canada. Finally, another set of recommendations extended beyond health services into the realm of other factors related to the settlement experience (e.g., housing, employment) and immigration and health policy (e.g., drug and health insurance) that help to structure immigrant and refugee women's social positions in Canada and reproductive health experiences.

Table 8. Summary of Recommendations from Service Providers

Recommendations from Service Providers	Potential Cost Implications
Increase long-term funding for services targeted at immigrant and refugee populations, including settlement services and multicultural health care staff	New revenue required
Reverse cuts to the Interim Federal Health Program announced in 2012	N/A (cuts were reversed in 2016)
Address gaps in coverage for non-prescription medications important to maternal and newborn health (e.g., prenatal vitamins, vitamin D supplements)	New revenue required
Develop mechanisms to better help newcomer women navigate and feel comfortable within the health and social services systems (e.g., peer outreach workers)	Revenue neutral if carried out in partnership with volunteers. New revenue required if paid positions are offered.
Explore models to support the increased presence of reproductive health service providers in community spaces and/or spaces designed specifically for immigrant and refugee women	Revenue neutral if carried out in existing spaces and within the current scope of service providers
Increase affordable and accessible mental health services for immigrant and refugee women	New revenue required
Ensure consistent and comprehensive counselling is provided as part of HIV testing services	Revenue neutral if carried out within the scope of service providers who offer testing
Create a system of affordable, emergency child care for women with few social supports	New revenue required

Table 9. Summary of Recommendations from African Immigrant and Refugee Women

Recommendations from African Immigrant and Refugee Women	Potential Cost Implications
Increase settlement and employment support for newly-arrived immigrant and refugee women (e.g., language training, small loan programs, employment support, housing)	New revenue required
Within settlement services, provide specific help to orient and guide women through the health care system	Revenue neutral to increase the emphasis on health within current information and services
Treat women with respect in health care settings, particularly taking the time to let them speak, ask questions, and work with any language barriers that may be present	Revenue neutral to integrate within existing training and practices

Encourage clinicians treating children to ask women about their own health and whether they are seeking regular care	Revenue neutral to integrate within existing training and practices
Improve follow-up by health and social services so that women who are the most in need are not suffering in silence	Revenue neutral to integrate within existing training and practices
Develop clinics and outreach programs specifically for immigrant and refugee women, that are multicultural, travel to home and communities, and which provide a safe and comfortable space for these women	New revenue required
Increase efforts to connect pregnant women to community support organizations before they give birth	Revenue neutral to integrate within existing training and practices
Increase the number of affordable child care spaces available in Ottawa	New revenue required
Reduce wait times for specialist services for women living with HIV/AIDS	New revenue required
Increase community outreach (e.g., through African churches) to reduce stigmatization about reproductive health issues such as HIV/AIDS	Revenue neutral if developed within the current scope of community health workers

In addition to the above, I discuss in turn below four overarching recommendations that I have identified based on the results of this research. These recommendations are high level enough to be broadly relevant and transferable despite the heterogeneity of the African immigrant and refugee women who participated in this study. As discussed within each recommendation below, they are also strengthened through consideration of the findings within the context of previously published literature.

Support Women's Diverse and Complex Settlement Needs

Although this research focused on the reproductive health experiences of African immigrant and refugee women, my interviews with these women made it clear that their experiences were influenced by a web of interrelated factors related to their positions as newcomers and their settlement needs. In order to better support African immigrant and refugee women's reproductive health, it is necessary to recognize the diversity of this group of

women and work to address these factors. A central recommendation to this end is to provide stable and long-term support for settlement services, such as employment and training, language classes, housing, and orientation and guidance in using the health and social services system. Research has documented the cutbacks to a wealth of previously state-funded social services in Canada since the 1980's. These cutbacks have led to downsizing and downloading of health and social services to communities and homes. Given traditional gendered expectations related to child and family care, women have borne a disproportionate burden of these cutbacks. Immigrant and refugee women have faced particular challenges because the lack of adequate supports in realms such as childcare have intersected with cuts affecting affordable housing and the resources of settlement agencies (Man, 2002; Steele, Lemieux-Charles, Clark, & Glazier, 2002).

Increased support for settlement services, then, should take gendered considerations into account. The fact, for instance, that immigrant and refugee women may delay engaging with language classes and/or attempting to find formal employment due to immediate concerns related to childcare and household responsibilities (Man, 2002). Funding for settlement services should also take into account that settlement and integration are continuous processes that do not end after a pre-determined amount of time. Some of the women in this study who had been in Canada for years were still struggling to regain their former socioeconomic positions. Indeed, research shows that racialized newcomer populations, and racialized newcomer women in particular, may never regain their prior socioeconomic positions due to the persistent disadvantages they face in Canada's job market with respect to both employment opportunities and earnings (Block & Galabuzi, 2011). In

addition, some of the immigrant women I interviewed discussed their feelings of being left to fend for themselves once they had arrived as opposed to refugees who may be more directly linked to services due to their category of migration. While this finding does not diminish the significant needs of refugees, it does suggest the importance of recognizing the diversity of newcomers to Canada and supporting their different requirements.

Reduce Policy Barriers

Revealed through this research as well was that African immigrant and refugee women's local health care experiences were partially influenced by policies that positioned them in certain ways in Canadian society and within the health care system. The fact that refugee women may be excluded from certain health care services because some providers are either unaware of or unwilling to submit claims through the Interim Federal Health Program is unacceptable. The drastic cutbacks to the program announced in 2012 have been reversed, but research prior to the cutbacks suggests that the program's complexity will still likely present a barrier for some clinicians (Gagnon, 2002; Miedema, et al., 2008). This barrier needs to be addressed at two separate levels. These actions should require little to no new funding, but should be feasible within the scope of the current systems. Firstly, the federal government should review how claims are submitted and processed to ensure that it is as easy as possible for clinicians to receive payment for treating refugee clients. Secondly, training institutions should educate new clinicians on refugee health care and the Interim Federal Health Program.

Another structural barrier that requires action is immigration policy that may keep women separated from family members for extended periods of time. Such separation across countries can cause stress and worry, as well as placing strain on the important social networks

in women's lives (Rousseau, Rufagari, Bagilishya, Measham, & Aarabi, 2004; Spitzer, 2014). The African women I interviewed emphasized the important role that family members played in their social networks back home. The role of family included emotional and practical support through childbirth, parenting, and household responsibilities. One woman specifically discussed the marketing of Canada as a country with "family friendly" immigration policies. This marketing influenced her perceptions and expectations of life in Canada, which contrasted with her lived experience of facing repeated delays while trying to sponsor her spouse. Other women shared their sadness that they had given birth and were raising their children separated from their mothers and other family members. Financial concerns as well as policy restrictions (e.g., an inability to travel outside of Canada if not a permanent resident) were listed as barriers to visiting their countries of birth.

The service providers in this study identified services that they felt needed greater funding to increase their accessibility for immigrant and refugee women. Primary among these was a general lack of mental health services to address immigrant and refugee women's needs. The process of migration creates significant stress, particularly when combined with conditions that exacerbate risks to mental health such as poverty and past or current experiences of violence, trauma, and/or discrimination (Hyman, 2011). Although the mapping I undertook identified a number of mental health services, only a few targeted immigrant and refugee women. The majority of mental health services were also not free or covered by public health insurance. As identified by the Mental Health Commission of Canada, language and culture also play an important role in mental health care and the likelihood that services will meet the needs of the communities they aim to serve. Involving diverse immigrant and refugee

communities is an important part of developing and delivering mental health services to these groups (Hansson, Tuck, Lurie, & McKenzie, 2010).

Other gaps in coverage discussed by service providers included non-prescription supplements for maternal and newborn health, such as prenatal vitamins and vitamin D. Health promotion efforts aimed at supporting the use of these supplements may then produce inequitable results; women who can readily afford their purchase will be more likely to use them than women who spend the majority of their income on more pressing needs such as food and housing. Another final key service gap that was identified by both African women and service providers was a general lack of affordable child care. This included a dearth of temporary emergency or respite care for women who have few social supports, such as newcomers. A lack of affordable child care can present a barrier women's participation in the labour market. It may also make it difficult for them to find the time for and to move around to health and social services and (re-)training opportunities (Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002; Tastsoglou, 2005).

Increase Delivery of Services Outside of Institutions and Clinics

A central finding of this work was that many of the spaces and places women discussed with respect to their reproductive health resided outside of the institutions and clinics central to Canada's health care system. These alternative places were grounded in churches, home country or language groups, or residential buildings. In some cases, the service providers discussed their flexibility to travel outside of health care institutions. In these cases they established accessible and well-used services in apartment buildings, refugee shelters, and women's homes. For the most part, however, Canada's health care system is still designed

around the assumption that patients will travel to clinics and largely neglects to take into account the access barriers that this can present for immigrant and refugee women. Increasing the ability of service providers to build community partnerships to work within existing, but less formal places, should be feasible with no new funding.

Increased flexibility in delivery models for reproductive health care information and services would help to reduce some of these barriers. This would be particularly so is if such efforts were combined with partnerships with newcomer communities, along with programs to hire members of these communities to work as liaisons. Examples of such initiatives do exist. Research by Torres et al. (2014), identifies multicultural community health workers as a promising and underused resource in Canada for improving immigrant and refugee women's access to both health and social services. Ley (2008) documents the important role that some immigrant churches have started to play in building both the social capital of newcomers as well as providing services. Such examples are consistent with growing research that suggests that newcomers draw on different meanings and expectations of social support and that the service systems in Canada are not always compatible with these diverse views (Stewart, et al., 2008; Stewart, et al., 2010).

Engage Communities while Working Towards Culturally Competent Care

Although the service providers discussed their efforts to provide culturally competent care, it was clear from interviews with the African immigrant and refugee women that significant work in this area still needs to be done. These differences speak to the complexity of truly embedding culturally competent care into the work of health care providers and their institutions. It may also be expected that those service providers who responded to my

recruitment were among the most committed to working towards culturally competent reproductive health care for immigrant and refugee communities. Their efforts to this end should not be taken as representative of all of the reproductive health service providers in Canada.

While presenting this recommendation for culturally competent care, I acknowledge the critiques of such endeavours that I discussed earlier in this chapter (Abrams & Moio, 2009; Kleinman & Benson, 2006). To help address some of these critiques, this recommendation is made with community engagement and consultation as a key component. In addition, it is set alongside the other three overarching recommendations in this dissertation that focus more strongly on structural barriers faced by immigrant and refugee women.

Based on the findings of this current study as well as other research on the need for improvement in culturally competent health care (Etowa & Adongo, 2010; Reitmanova & Spitzer, 2014), health care institutions and providers should:

- Emphasize a commitment to cultural competency in the mission and vision statements of health care institutions.
- Undertake regular self-assessments of health care institutions, incorporating the perspectives of both providers and patients, to identify areas for improvement with respect to diversity inclusiveness and cultural competence.
- Increase training for staff on cultural competence. Such training should include critical self-reflection on the cultural beliefs and assumptions of their institutions and themselves. It should also include training on anti-discriminatory practice and on the potential needs of clients from different cultural groups.

- Build-in structures to facilitate the understanding of different clients' cultures and the accommodation of their needs. This may include the consistent provision of translation services, hiring a diverse and multicultural staff, engagement with different cultural communities to review institutional policies, and a commitment to fostering an environment where clients will have the time and opportunity to talk about their needs.
- Continuously evaluate progress towards culturally competent health care in consultation with patients and providers.

Limitations & Strengths

The African immigrant and refugee women who responded to recruitment for my study were those who had sufficient capabilities in English or French to be able to communicate with me and who felt comfortable and confident in doing so. Although these women shared extremely valuable experiences and opinions with me, I did not speak to many women who may be among the most vulnerable (e.g., those with past traumas that may decrease trust in formal institutions, those with strong language barriers). Challenges in recruiting marginalized populations is not uncommon in research (Ogilvie, Burgess-Pinto, & Caufield, 2008; Yancey, Ortega, & Kumanyika, 2006). Aware of this, I strived to recruit a diversity of African immigrant and refugee women and engaged with community organizations and hired cultural brokers from the communities themselves in order to do so. The knowledge derived from the stories of the African immigrant and refugee women in this study make a valuable contribution to increasing the representation of African migrant voices in Canadian literature on migrant women's health. It is important, however, to remember the incredible diversity among African

women and continuously encourage efforts to engage with those within these communities who may be in the most need.

This diversity of the women I spoke to may also be viewed as a limitation of this research. Diversity in recruitment was intended in order to explore how different African immigrant and refugee women experienced reproductive health in relation to place. As recruitment progressed slowly, even more diversity was introduced than originally intended in terms of length of time since migration, age, and case study areas. This was added to differences amongst the women in terms of source countries, native languages, migration categories, socioeconomic statuses, and reproductive health issues of most relevance to them. While this research is exploratory and this diversity enhanced the richness of the findings in ways, it also meant that I was only able to partially examine the implications for women in very different social positions (e.g., for a French-speaking new refugee women from the Congo who had fled conflict as compared to an English-speaking voluntary migrant from Nigeria who came with a job already secured).

Despite these limitations, this research surfaced a number of findings that are consistent with previously published literature on African immigrant and refugee women's reproductive health, as discussed earlier in this chapter. This lends strength to the results of this study. In addition, this study makes an important contribution of its own. I analyzed the reproductive health of African immigrant and refugee women in a highly contextualized way, merging theories of intersectionality and those of place. Place is one potential facet of intersectionality, but it is not as commonly included or theorized within that framework as other elements of social location (e.g., gender, class, 'race'). I, thus, expanded on the way in

which place is often used in population health (i.e., focusing on neighbourhood characteristics and built environment). The theoretical framework applied to this study was more inclusive of how immigrant and refugee women are positioned in given places as a result of structural factors that flow down from global to local. In doing so, I identified a range of important factors that influence the reproductive health of these women, both within and outside of the health care system. In addition, this research contributes to increasing the literature on African women as a diverse and distinct migrant group whose importance to the Canadian population has grown since migration policies have become more inclusive (Spitzer, 2006a). In addition, while recognizing the extremely valuable work on HIV/AIDS that has been carried out with African communities in Canada, this study embraces the fact that African women have reproductive concerns and experiences outside of the issue of HIV/AIDS. A final strength of this work is that it considers the experiences of African immigrant and refugee women in Ottawa. It, therefore, contributes to the literature on migrant health in a city outside of the Canada's largest urban centres, with its own unique context.

Future Research Directions

To conclude this dissertation, I turn my attention to four potential avenues for future research that I have identified based on the findings of this work. The first of these avenues stems from the finding that the African immigrant and refugee women identified places outside of the health care system as most relevant to their reproductive health and related social networks. For many of the women, religious organizations were a central piece of the social support systems they discussed. Community-based research that partners with religious organizations that serve as hubs for African communities in Ottawa would be valuable. Future

research could explore how some African women use these organizations to build social networks and support their reproductive health, along with how such organizations could be better partnered with to enhance such efforts. Included in such research should be consideration of which African women feel comfortable accessing and using such organizations, and who may be left out.

This first strand of research could progress to a second, which develops and examines the effectiveness of interventions grounded in places outside of the health care system for delivering reproductive health information and services to African immigrant and refugee women (e.g., health promotion, anti-stigma campaigns, prenatal health check-ups and/or testing sites for sexually transmitted infections). Such research would be valuable for moving from describing the importance of such social spaces to African immigrant and refugee women, to testing ways to partner with and leverage these spaces to help improve their reproductive health. As with other population health intervention research, the focus would include not just the effectiveness of the intervention, but also its equitable or inequitable effects, and how such interventions could be scaled up if they should prove valuable (Hawe & Potvin, 2009).

Working as well with different cultural and linguistic groups of African immigrant and refugee women, I propose a third strand of research that would seek to develop training models to support culturally competent reproductive health care delivery. The development of such training models should engage these communities in discussion around key issues raised in this research and other studies. For instance, the different expectations about the time allocated to communicate with health care providers, gendered and cultural norms related to reproductive health issues, linguistic barriers, experiences of discrimination, and factors

influencing opportunities for reproductive health outside of the health care system. Training should also seek to raise awareness among service providers about the diversity of African immigrant and refugee women and how their different cultural, social, religious, racialized, linguistic, and economic positions may affect their needs and experiences.

The final avenue for future research that I propose relates to the ways in which reproductive health service providers interact with others in the health care system to facilitate the care of their immigrant and refugee clients. I suggest building on the findings of this study that showed that providers create their own professional networks of services known to be friendly to their clients. Working with these service providers, such professional networks could be mapped, along with surveys to identify which reproductive health services are welcoming to immigrant and refugee clients and which are not (i.e., which services accept Interim Federal Health clients, which services have explicit policies and training on cultural competency). The findings of such work would be useful for other service providers seeking to help immigrant and refugee clients. They would also serve as an advocacy tool to raise the awareness of institutional leads and policy makers about the realities of accessing reproductive health care as an immigrant or refugee woman.

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Appendices

Appendix 1. Recruitment Flyers - African Women

Are you a woman who has immigrated from Africa within the last 15 years?

Would you like to share your stories about seeking women's health information, services, and support?

Volunteers are needed for a PhD study that aims to learn about the experiences of immigrant women from Africa seeking women's health information, services, and support in Ottawa.

I am a PhD student in Population Health at the University of Ottawa. I am interested in talking to:

- Women who have immigrated to Canada from Africa within the last 15 years
  and
- Are between the ages of 18 and 45
  and
- Live in Ottawa in the Barrhaven, New Barrhaven-Stonebridge, Bayshore, Whitehaven-Queensway Terrace North, West Centretown, or Centretown neighbourhoods

To thank you for your time, we will provide you with compensation of $30. Interviews are confidential and anonymous, and will be held in a location that is convenient and secure for you.

I look forward to hearing from you soon!

For further information, please contact:
Heather Greenwood

uOttawa

Planned Parenthood Ottawa / Planning des naissances d'Ottawa

uOttawa

Êtes-vous une femme qui a immigré d'Afrique au cours des 15 dernières années?

Aimeriez-vous partager vos histoires de recherche d'information, de services ou de soutien en matière de santé des femmes?

Des volontaires sont recherchées pour participer à une étude doctorale dont l'objectif est de nous renseigner sur les expériences des femmes qui ont immigré au Canada venant d'Afrique qui recherchent des informations, des services ou un soutien en matière de santé des femmes à Ottawa.

Je suis une étudiante au doctorat en santé de la population à l'Université d'Ottawa.
J'aimerais parler aux :

- femmes qui ont immigré au Canada venant d'Afrique au cours des 15 dernières années
  et
- qui ont entre 18 et 45 ans
  et
- qui habitent à Ottawa dans les quartiers Barrhaven, Nouveau Barrhaven-Stonebridge, Bayshore, Whitehaven-Queensway Terrace Nord, Centre-ville ouest, ou Centre-ville

En guise de remerciement pour votre temps, nous vous fournirons une compensation de 30 $. Les entrevues sont confidentielles et anonymes, et auront lieu dans un endroit pratique et sécuritaire pour vous.

Je me réjouis d'avoir bientôt de vos nouvelles!

Pour obtenir de plus amples informations, veuillez contacter :
Heather Greenwood

uOttawa Planned Parenthood Ottawa Planning des naissances d'Ottawa uOttawa

Appendix 2. Recruitment Flyers - Service Providers

Are you a reproductive health/women's health service provider?

Do you work with immigrant women from Africa?

We need to learn from your knowledge & expertise to help improve reproductive/women's health services & access for African immigrant women in Ottawa

Volunteers are needed for a PhD study that aims to better understand the challenges African immigrant women face seeking and using reproductive/women's health services and how to improve their experiences.

I am a PhD student in Population Health at the University of Ottawa. I am interested in speaking to:

- Reproductive/women's health service providers (e.g. midwives, nurses, physicians, community outreach workers, pharmacists, doulas, lactation consultants),
- Who work with immigrant women from Africa,
  and
- Who work with clients from one of the following 3 Ottawa areas: Central (West Centretown); West (Bayshore & Whitehaven-Queensway Terrace); Suburban (Barrhaven & New Barrhaven).

I would like to invite you to participate in an individual interview or a group discussion with other service providers, as per your preference, to share your insight on key issues African immigrant women face in relation to reproductive/women's health and how to better address these.

For further information, please contact:
Heather Greenwood

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Êtes-vous un fournisseur de services de santé de la reproduction/ santé des femmes?

Travaillez-vous avec des immigrantes africaines?

Nous avons besoin d'avoir recours à vos connaissances et à votre compétence pour aider à améliorer les services de santé de la reproduction et l'accès à ces services pour les immigrantes africaines à Ottawa

Des volontaires sont recherchées pour participer à une étude doctorale dont l'objectif est mieux comprendre les défis que doivent relever les immigrantes africaines pour trouver et utiliser les services de santé des femmes, et pour savoir comment améliorer leurs expériences.

Je suis étudiante de doctorat en santé des populations à l'Université d'Ottawa. J'aimerais parler aux :

- fournisseurs de services de santé de la reproduction et services de santé des femmes (comme sages-femmes, médecins, travailleurs d'approche communautaire, pharmaciens et pharmaciennes, doulas, conseillères en lactation),
- qui travaillent avec des immigrantes africaines ***et***
- qui travaillent avec des clientes de l'un des trois quartiers suivants d'Ottawa : centre (Centre-Ville Ouest); ouest (Bayshore et Whitehaven-Queensway Terrace); faubourgs (Barrhaven et Nouveau Barrhaven).

Je voudrais vous inviter à participer à un entretien individuel ou à une discussion de groupe avec d'autres fournisseurs de services, selon votre préférence, pour discuter de votre compréhension des questions clés concernant les immigrantes africaines dans le domaine de la santé de la reproduction et de la santé des femmes, et comment mieux les résoudre.

Pour obtenir de plus amples informations, veuillez contacter :
Heather Greenwood

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Appendix 3. Interview Guide - African Women

Note: These questions are provided as a reference to ensure that key issues are discussed. However, interviews will proceed as a conversation between the researcher and the participants, and will adapt to focus on the views of the participants.

(1) Understanding their migration story & day-to-day life in Canada

- Would you please share with me the story of your migration to Canada?
    - Why did you come to Canada?
    - Did you come as a family class immigrant, economic class, or as a refugee?
    - How long have you been in Canada?

- Can you tell me a bit about your life now that you're in Canada?
    - What does a typical day in your life look like?
        - What are your primary responsibilities at home? At work?
        - For each place mentioned (e.g. home, work):
            - Do you generally feel comfortable or uncomfortable in this place?
            - Do you enjoy spending time there?
        - Do you spend a lot of time in your own neighbourhood or do you travel around the city? Why? (e.g. are there certain things you prefer to do or can only do at home vs. in other neighbourhoods?)
    - Do you have family here with you?
    - Are there any things you find particularly rewarding or challenging about being here?

(2) Understanding their experience of reproductive health

- When we think about reproductive health, one important issue is pregnancy and childbirth. Would you share with me the story of your first pregnancy in Canada?
    - What happened next?
    - What did you mean by that?
    - How did you feel in that situation (e.g. comfortable/uncomfortable)?
    - Can you tell me about the things that made this an easy or a difficult experience for you?
    - What is it about where you live or work that helps to access these services or not access these services?
    - Did the people around you have any effect on this experience? (e.g. family, community, reproductive health service providers)
    - Do you think living somewhere else would have made this experience easier?
    - How did you look for information/support (internet/networks)?
    - What services are you aware of to help you?

- If you had to look for this same information/service back in your home country, what would have been different?
- Can you tell me about any religious or cultural values/traditions that were important to you during this experience?
- What would you have wanted to be different about that experience?

- Another issue we often think about in relation to reproductive health is deciding how big a family to have. Would you share with me any stories you have of going to the doctor or looking for information on family planning/contraception/abortion?

- Another issue we often think about is keeping ourselves healthy by getting regular pap tests/cervical cancer screening. Would you share with me any stories you have of going to the doctor or looking for information on pap tests?

- Another issue we often think about is keeping ourselves healthy by protecting ourselves from infections such as STIs and HIV. Would you share with me any stories you have of going to the doctor or looking for information on preventing these infections?

- Are there any other issues related to reproductive health that have been important to you or that you see as being important to you in the future?

- Do you feel happy with your reproductive health here in Canada?
  - Do you feel that you have the time to take care of your reproductive health?
  - Do you see reproductive health as an important part of your overall health and life?

- Can you tell me about things that you do to make it easier to gain reproductive health information, services, and/or support (e.g. talk to friends? go to CHC?)?
  - Are there any specific stories or examples that you would be willing to share with me?

- Do you think that looking for reproductive health information, services, and support is different for women than for men?
  - Are there any specific stories or examples that you would be willing to share with me?

- Do you find that being a recent immigrant has any impact on the way in which you seek reproductive health information, services, and/or support?
  - Are there any specific stories or examples that you would be willing to share with me?

(4) Understanding more about their community context

- Would you tell me a bit more about where you live?
  - Is Ottawa the first city you settled in when you immigrated?

- Have you always lived in this neighbourhood?
- Why did you choose to live in this neighbourhood?
- Can you tell me about the neighbourhood you live in?
    - What are the people like?
    - Do you know a lot of people? How did you meet them?
    - Do you enjoy living here?
    - Do you feel comfortable?
    - Like you belong/fit in?
    - What's good about living here and what's more difficult?
    - If you have kids, do you like raising them in this neighbourhood?

- When you look for health services do you generally go to ones close to your home or somewhere else in the city? e.g. doctor, pharmacist, hospital, other (e.g. abortion)

- Is there anything else you'd like to share or anything important that you think we've missed in our conversation?

Appendix 4. Consent Form - African Women

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CONSENT FORM

AFRICAN IMMIGRANT WOMEN'S EXPERIENCES SEEKING REPRODUCTIVE HEALTH INFORMATION, SERVICES, AND SUPPORT

Principal Researcher: Heather Greenwood, Institute of Population Health, University of Ottawa
Research Supervisor: Dr. Denise Spitzer, Institute of Women's Studies & Institute of Population Health, University of Ottawa

We invite you to participate in a doctoral study entitled "African immigrant women's experiences seeking reproductive health information, services, and support" funded by the Canadian Institutes of Health Research. The purpose of this study is to learn about your experiences seeking reproductive health information, services, and support in Ottawa. There are no right or wrong answers; there are only your opinions and your story.

Your participation in this study will involve about 1-2 hours in an individual interview and will be held in a location convenient and secure to you. We will ask you to fill out a brief personal information form to verify the neighbourhood in which you live, and to provide summary statistics for the study. We will also ask you to fill out a brief address form to allow us to contact you if you wish to receive a copy of the transcript of our discussion or results of the study. Completion of the address form is optional, and all information provided will be kept strictly confidential.

The interview will be recorded and I may take notes for myself. Please let us know if you would prefer to give your consent to participate in this research verbally rather than in writing. When you are ready to do so, we will then ask you to say your name, the date, and that you understand and agree to participate in this research on the audio recording. Only the researcher and research supervisor will listen to the recording or read the transcripts of our interview. The tapes and transcripts will be kept in a locked cabinet in the principal researcher's office and stored for 15 years, after which time they will be destroyed.

We will randomly select a false name for you and will use this name on all material we keep and in any public presentations, written or oral, of this project. We may change some details of your life or position so that you will not be personally identifiable in any public presentation of the research, which may include conferences, public forums, academic publications, reports, and teaching materials. To thank you for your time, we will provide you with compensation of $30. You will be asked to sign a receipt when you receive payment; these receipts will be kept in a secure place.

We know that sometimes talking about these issues can be distressing or make you sad; should this occur, we can stop the interview, change topics, continue our conversation or take a break – the decision is yours. We hope that by sharing your

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perspectives and experiences with us, you can help us understand how to make it easier for immigrant women like yourself to access reproductive health information, services, and support.

At all times, you have the right to:

- Refuse to answer questions;
- Stop the interview at any point;
- Withdraw from the study at any time, in this case, we will only use the information you have given us with your permission. If you do not wish us to use this information, we will destroy it or give it to you; the compensation will be yours to keep should you withdraw;
- Ask any questions regarding the study.

If you have any further questions or concerns regarding this study please contact:
Heather Greenwood
Population Health PhD Program, University of Ottawa

This study received ethical approval from the Research Ethics Board at the University of Ottawa and Ottawa Public Health.
If you have any questions about the ethical conduct of this study please contact:
Protocol Officer for Ethics in Research
Tabaret Hall, University of Ottawa
550 Cumberland Street, Room 159
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Fax: 613-580-9601
Oph.ethics@ottawa.ca

I, _____ , voluntarily agree to participate in this study.
(Participant's Name)

_____

(Participant's Signature) (Date)

_____

(Researcher's Signature) (Date)

THERE ARE TWO COPIES OF THIS CONSENT FORM. PLEASE RETURN ONE COPY AND RETAIN ONE FOR YOUR FILES

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FORMULAIRE DE CONSENTEMENT

LES EXPÉRIENCES DES IMMIGRANTES AFRICAINES QUI RECHERCHENT DES INFORMATIONS, DES SERVICES ET UN SOUTIEN EN MATIÈRE DE SANTÉ DE LA REPRODUCTION

Chercheure principale : Heather Greenwood, Institut de recherche sur la santé des populations, Université d'Ottawa
Directrice de recherche : Dr. Denise Spitzer, Institut d'études des femmes et Institut de recherche sur la santé des populations, Université d'Ottawa

Nous vous invitons à participer à une étude doctorale intitulée : « Les expériences des immigrantes africaines qui recherchent des informations, des services et un soutien en matière de santé de la reproduction », subventionné par les Instituts de recherche en santé du Canada. L'objectif de cette étude est de mieux connaître vos expériences en matière de recherche d'information de services et de soutien pour la santé de la reproduction à Ottawa. Il n'y a pas de bonne ou de mauvaise réponse. Nous voulons connaître vos opinions et votre vécu.

Votre participation à cette étude implique une entrevue individuelle d'environ 1 à 2 heures qui aura lieu dans un endroit pratique et sécuritaire pour vous. Nous vous demanderons de remplir un bref questionnaire d'informations personnelles pour vérifier le quartier dans lequel vous vivez et pour fournir un résumé statistique de l'étude. Nous vous demanderons aussi de fournir vos coordonnées personnelles pour nous permettre de vous contacter si vous souhaitez recevoir une copie de la transcription de notre discussion ou des résultats de l'étude. Il est facultatif de remplir le formulaire d'adresse et toutes les informations fournies seront conservées de manière strictement confidentielle.

L'entrevue sera enregistrée et il se pourrait que je prenne des notes personnelles. Indique-nous s'il te plait si tu préfères donner ton consentement oralement plutôt que par écrit pour participer à cette recherche. On te demandera de donner ton nom, la date, et de dire que tu comprends et consens à participer à cette recherche sur enregistrement audio. Une interprète pourrait être présente durant l'entrevue pour faciliter les échanges et la communication. L'interprète a signée un accord de confidentialité. Seules la chercheure principale et la directrice de recherche pourront écouter les enregistrements ou lire les transcriptions de nos discussions. Les bandes magnétiques et les transcriptions seront conservées sous clé au bureau de la chercheure principale pendant 15 ans. Elles seront détruites après ce temps**.**

Nous allons choisir un nom fictif pour vous et nous utiliserons ce nom sur tous les documents que nous allons garder, et dans toutes présentations publiques, écrites, visuelles ou verbales, de ce projet. Nous pouvons modifier quelques détails de votre vie ou votre responsabilité de sorte que vous ne serez pas identifiable dans les présentations publiques de la recherche. Ceci pourrait inclure des conférences, des forums publics, des publications académiques, des rapports et du matériel d'enseignement. En guise de remerciement pour votre temps, nous vous fournirons une compensation de 30 $. On vous demandera de signer un reçu quand vous recevrez ce paiement. Les reçus seront conservés dans un lieu sécurisé.

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Nous savons que, parfois, parler de ces questions peut vous bouleverser ou vous rendre triste. Dans ce cas, nous pourrons arrêter l'entrevue, changer de sujet, continuer de parler, ou prendre une pause : à vous de décider. Nous espérons qu'en partageant vos perspectives et vos expériences avec nous, nous pourrons mieux comprendre comment faciliter l'accès des femmes immigrantes aux informations, aux services et au soutien en matière de santé de la reproduction.

En tout temps vous avez le droit de :

- Refuser de répondre à certaines questions
- Arrêter l'entrevue à n'importe quel moment
- Vous retirer de l'étude à tout moment. Dans ce cas, nous n'utiliserons que les informations que vous nous autoriserez à utiliser. Si vous ne souhaitez pas que nous utilisions ces informations, nous allons les détruire ou vous les remettre. Si vous vous retirez de l'étude, vous pourrez garder la compensation.
- Poser des questions sur cette étude

Si vous avez des questions ou inquiétudes additionnelles sur cette recherche, s'il vous plait vous adresser à :

Heather Greenwood
Institut d'études des femmes (Santé des populations), Université d'Ottawa

Ce projet a été approuvé par le Comité d'éthique en recherche de l'Université d'Ottawa et de Santé public Ottawa.
Si vous avez des questions sur la conduite éthique de cette recherche, veuillez vous adresser au :

Responsable de la déontologie en recherche, Université d'Ottawa
550, rue Cumberland, pièce 159,
Ottawa, Ontario, K1N 6N5
Tél : 613-562-5841
Courriel **:** ethics@uottawa.ca

Santé publique Ottawa
Comité d'éthique de la recherche, Secrétariat
100, croissant Constellation, 7e étage Ouest
Ottawa, Ontario K2B 2J1
Tél: 613-580-6477 poste 16543
Télécopieur: 613-580-9601
Courriel : Oph.ethics@ottawa.ca

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Je, _____ ,accepte de participer volontairement à cette étude
(Nom de la participante)

_____
__
Signature de la participante Date

_____
__
Signature de la chercheure Date

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Appendix 5. Demographic Questionnaire - African Women

AFRICAN IMMIGRANT WOMEN'S EXPERIENCES SEEKING REPRODUCTIVE HEALTH INFORMATION, SERVICES, AND SUPPORT

Personal Information Form for Immigrant Women

Contact information will be kept separately from this form. We will select a name for you (below) and use it on all transcripts and papers.

Pseudonym:_____(we will complete this)

Demographic Information

In order to provide summary statistics for our study, we would appreciate it if you could provide a few details about yourself. This information will be used for summary purposes only and will be kept strictly confidential.

1. Postal code: _____ (to verify the neighbourhood in which you live)

2. Date of Birth: _____ (Day) _____ (Month) _____ (Year)

3. Location and Country of Birth:

_____

Urban ☐ Rural ☐

4. Place of Residence before coming to Canada

_____

5. Year of Migration to Canada _____

6. Native Language _____

7. What other languages do you speak?

_____

8. What other languages do you write?

_____

9. What other languages do you understand?

_____

10. Religious Affiliation

_____

11. Current Marital Status

☐	Single
☐	Married /Common law
☐	Separated /Divorced/No longer with spouse
☐	Widowed

12. Number of Children (if any): ____

13. What is your highest level of education?

☐	Grade 9 or lower
☐	Grade 10-12 non-graduate
☐	High school diploma
☐	Some college or university courses
☐	Trade certificate or diploma
☐	University degree (Bachelor) _____ (specify area)
☐	University degree (Professional) _____ (specify area)
☐	University degree (Graduate) _____ (specify area)
☐	Other _____ (specify area)

14. Where did you complete this education? _____(country)

15. What was your occupation <u>before</u> coming to Canada

_____

16. Are you <u>currently</u> employed? Yes ☐ No ☐

Part time Yes ☐ No ☐

Full time Yes ☐ No ☐

17. What is your <u>current</u> occupation?

_____

_____

Thank you very much for taking the time to complete this information sheet. We greatly appreciate it.

LES EXPÉRIENCES DES IMMIGRANTES QUI RECHERCHENT DES INFORMATIONS, DES SERVICES ET UN SOUTIEN EN MATIÈRE DE SANTÉ DE LA REPRODUCTION

Questionnaire d'informations personnelles pour femmes immigrantes

Les informations pour le contact seront conservées séparément de ce formulaire. Nous choisirons un nom pour vous (ci-dessous) et l'utiliserons pour toutes les transcriptions et tous les documents.

Pseudonyme:_____(nous remplirons ceci)

Informations démographiques

Afin de nous fournir des statistiques de base pour notre étude, nous vous serions reconnaissants de bien vouloir fournir quelques détails vous concernant. Ces informations ne seront utilisées que pour le résumé et seront conservées de manière strictement confidentielle.

1. Code postal : _____ (pour vérifier le quartier dans lequel vous vivez)

2. Date de naissance: _____ (jour) _____ (mois) _____ (année)

3. Pays et lieu de naissance:

_____

Urbain ☐ Rural ☐

4. Lieu de résidence avant l'arrivée au Canada

_____

5. Année de l'immigration au Canada _____

6. Langue maternelle _____

7. Quelles autres langues parlez-vous?

_____

8. Quelles autres langues lisez-vous?

_____

9. Quelles autres langues comprenez-vous?

_____

10. Affiliation religieuse

_____

11. État civil actuel

☐ Célibataire
☐ Mariée / conjointe de fait
☐ Séparé(e)/ Divorcé(e)/Ne vit plus avec conjoint(e)
☐ Veuve

12. Nombre d'enfants (le cas échéant): ____

13. Quel est votre plus haut niveau d'éducation atteint?

☐ Neuvième année ou moins
☐ Dixième ou douzième année sans avoir terminé le secondaire
☐ Diplôme d'études secondaires
☐ Certains cours de collège ou d'université
☐ Certificat ou diplôme d'une école de métiers
☐ Grade universitaire (baccalauréat) _____ (spécifiez le domaine)
Grade universitaire (professionnel) _____ (spécifiez le domaine)
Grade universitaire (études supérieures)_____ (spécifiez le domaine)
☐ Autre _____ (spécifiez le domaine)

14. Où avez-vous terminé ce niveau d'éducation? _____(pays)

15. Quelle était votre profession <u>avant</u> de venir au Canada?

_____

16. Êtes-vous employé <u>actuellement</u>? Oui ☐ Non ☐
À temps partiel Oui ☐ Non ☐
À temps plein Oui ☐ Non ☐

17. Quelle est votre profession <u>actuelle</u>?

_____
_____

Merci beaucoup d'avoir pris le temps de remplir ce feuillet d'informations. Nous l'apprécions grandement.

Appendix 6. Consent Form - Service Providers

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CONSENT FORM

NEGOTIATING AND CONSTRUCTING PLACE: AFRICAN IMMIGRANT WOMEN'S EXPERIENCES SEEKING REPRODUCTIVE HEALTH INFORMATION, SERVICES, AND SUPPORT

Principal Researcher: Heather Greenwood, Institute of Population Health, University of Ottawa
Research Supervisor: Dr. Denise Spitzer, Institute of Women's Studies & Institute of Population Health, University of Ottawa

We invite you to participate in a doctoral study entitled "Negotiating and constructing place: African immigrant women's experiences seeking reproductive health information, services, and support" funded by the Canadian Institutes of Health Research. The purpose of this study is to learn about the experiences of immigrant women seeking reproductive health information, services, and support in Ottawa. As a service provider, you can help us understand the reproductive health service environment in your neighbourhood by sharing your knowledge and perspectives. There are no right or wrong answers; there are only your opinions.

Your participation in this study will involve about 1-2 hours in an individual interview and will be held in a location convenient and secure to you. We will ask you to fill out a brief personal information form to provide summary statistics for the study. We will also ask you to fill out a brief address form to allow us to contact you if you wish to receive a copy of the transcript of our discussion or results of the study. Completion of the address form is optional, and all information provided will be kept strictly confidential.

The discussion will be recorded and I may take notes for myself. Only the researcher and research supervisor will listen to the recording or read the transcripts of our interview. The tapes and transcripts will be kept in a locked cabinet in the principal researcher's office and stored for 15 years, after which time they will be destroyed.

We will randomly select a false name for you and will use this name on all material we keep and in any public presentations, written or oral, of this project. We may change some details of your life or position so that you will not be identifiable in any public presentation of the research, which may include conferences, public forums, academic publications, reports, and teaching materials. To thank you for your time, we will provide you with compensation of $30. You will be asked to sign a receipt when you receive payment; these receipts will be kept in a secure place.

There are minimal risks associated with your participation in this study. We hope that by sharing your knowledge and perspectives with us, you can help us

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understand how to make it easier for immigrant women to access reproductive health information, services, and support

At all times, you have the right to:

- Refuse to answer questions;
- Stop the interview at any point;
- Withdraw from the study at any time, in this case, we will only use the information you have given us with your permission. If you do not wish us to use this information, we will destroy it or give it to you; the compensation will be yours to keep should you withdraw;
- Ask any questions regarding the study.

If you have any further questions or concerns regarding this study please contact:
Heather Greenwood
Population Health PhD Program, University of Ottawa

This study received ethical approval from the Research Ethics Board at the University of Ottawa.
If you have any questions about the ethical conduct of this study please contact:
Protocol Officer for Ethics in Research
Tabaret Hall, University of Ottawa
550 Cumberland Street, Room 159
Ottawa, Ontario K1N 6N5
Tel: 613-562-5841
Email: ethics@uottawa.ca

Ottawa Public Health
Research Ethics Board, Secretariat
100 Constellation Crescent, 7th Floor West
Ottawa, Ontario K2B 2J1
Tel: 613-580-6477 ext 16543
Fax: 613-580-9601
Email: Oph.ethics@ottawa.ca

I, _____, voluntarily agree to participate in this study.
(Participant's Name)

_____

(Participant's Signature) (Date)

_____

(Researcher's Signature) (Date)

THERE ARE TWO COPIES OF THIS CONSENT FORM. PLEASE RETURN ONE COPY AND RETAIN ONE FOR YOUR FILES

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FORMULAIRE DE CONSENTEMENT

NÉGOCIATION ET CONSTRUCTION DU LIEU DE VIE : LES EXPÉRIENCES DES IMMIGRANTES AFRICAINES QUI RECHERCHENT DES INFORMATIONS, DES SERVICES ET UN SOUTIEN EN MATIÈRE DE SANTÉ DE LA REPRODUCTION

Chercheure principale : Heather Greenwood, Institut de recherche sur la santé des populations, Université d'Ottawa
Directrice de recherche : Dr. Denise Spitzer, Institut d'études des femmes et Institut de recherche sur la santé des populations, Université d'Ottawa

Nous vous invitons à participer à une étude doctorale intitulée: « Négociation et construction du lieu de vie : les expériences des immigrantes africaines qui recherchent des informations, des services et un soutien en matière de santé de la reproduction », subventionné par les Instituts de recherche en santé du Canada. L'objectif de cette étude est de nous renseigner sur les expériences des immigrantes qui recherchent des informations, des services et un soutien en matière de santé de la reproduction à Ottawa. En tant que fournisseur de services de santé, vous pouvez nous aider à comprendre le milieu des services de santé de la reproduction dans votre quartier en partageant avec nous vos connaissances et vos perspectives. Il n'y a pas de bonne ou de mauvaise réponse. Nous voulons connaître vos opinions et votre vécu.

Votre participation à cette étude impliquera une entrevue individuelle d'environ 1 à 2 heures qui aura lieu dans un endroit pratique et sécuritaire pour vous. Nous vous demanderons de remplir un bref questionnaire d'informations personnelles pour fournir un résumé statistique de l'étude. Nous vous demanderons aussi de fournir vos coordonnées personnelles pour nous permettre de vous contacter si vous souhaitez recevoir une copie de la transcription de notre discussion ou des résultats de l'étude. Il est facultatif de remplir le formulaire d'adresse et toutes les informations fournies seront conservées de manière strictement confidentielle.

La discussion sera enregistrée et il se pourrait que je prenne des notes personnelles. Une interprète pourrait être présente durant l'entrevue pour faciliter les échanges et la communication. L'interprète a signée un accord de confidentialité. Seules la chercheure principale et la directrice de recherche pourront écouter les enregistrements ou lire les transcriptions de nos discussions. Les bandes magnétiques et les transcriptions seront conservées sous clé au bureau de la chercheure principale pendant 15 ans. Elles seront détruites après ce temps**.**

Nous allons choisir un nom fictif pour vous et nous utiliserons ce nom sur tous les documents que nous allons garder, et dans toutes présentations publiques, écrites, visuelles ou verbales, de ce projet. Nous pouvons modifier quelques détails de votre vie ou de vos responsabilités professionnelles de sorte que vous ne serez pas identifiable dans les présentations publiques de la recherche. Ceci pourrait inclure des conférences, des forums publics, des publications académiques, des rapports et du matériel d'enseignement. En guise de remerciement pour votre temps, nous vous fournirons une compensation de 30 $. On vous demandera de signer un reçu quand vous recevrez ce paiement. Les reçus seront conservés dans un lieu sécurisé.

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Il y a des risques minimes associés à votre participation à cette étude. Nous espérons qu'en partageant vos connaissances et vos perspectives avec nous, nous pourrons mieux comprendre comment faciliter l'accès des immigrantes aux informations, aux services et au soutien en matière de santé de la reproduction.

En tout temps vous avez le droit de :

- Refuser de répondre à certaines questions
- Arrêter l'entrevue à n'importe quel moment
- Vous retirer de l'étude à tout moment. Dans ce cas, nous n'utiliserons que les informations que vous nous autoriserez à utiliser. Si vous ne souhaitez pas que nous utilisions ces informations, nous allons les détruire ou vous les remettre. Si vous vous retirez de l'étude, vous pourrez garder la compensation.
- Poser des questions sur cette étude.

Si vous avez des questions ou inquiétudes additionnelles sur cette recherche, s'il vous plait vous adresser à :

Heather Greenwood
Institut d'études des femmes (Santé des populations), Université d'Ottawa

Ce projet a été approuvé par le Comité d'éthique en recherche de l'Université d'Ottawa.
Si vous avez de questions sur la conduite éthique de cette recherche, veuillez vous adresser au :

Responsable de la déontologie en recherche, Université d'Ottawa
550, rue Cumberland, pièce 159,
Ottawa, Ontario, K1N 6N5
Tél : 613-562-5841
Courriel : ethics@uottawa.ca

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Je, _____ accepte de participer volontairement à cette étude
(Nom de la participante)

_____

Signature de la participante Date

_____

Signature de la chercheure Date

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Appendix 7. Demographic Questionnaire - Service Providers

NEGOTIATING AND CONSTRUCTING PLACE: IMMIGRANT WOMEN'S EXPERIENCES SEEKING REPRODUCTIVE HEALTH INFORMATION, SERVICES, AND SUPPORT

Personal Information Form for Service Providers

Contact information will be kept separately from this form. We will select a name for you (below) and use it on all transcripts and papers.

Pseudonym:_____(we will complete this)

In order to provide summary statistics for our study, we would appreciate it if you could provide a few details about yourself. This information will be used for summary purposes only and will be kept strictly confidential.

1. Female ☐ **Male** ☐

2. Type of organization at which you primarily work:

- ☐ Community education and/or support organization
- ☐ Community health or resource centre
- ☐ Doctor's office/clinic
- ☐ Doula group
- ☐ Hospital
- ☐ Midwifery group
- ☐ Public health unit
- ☐ Other (please specify):_____

3. Type of reproductive health services offered by your organization (please select all that apply):

- ☐ Abortion services
- ☐ Cervical cancer screening
- ☐ Contraception
- ☐ General preventive reproductive health care
- ☐ Pregnancy/birth/postpartum care
- ☐ STI testing and/or treatment
- ☐ Support and/or counseling services
- ☐ Other (please specify):_____

4. Ottawa neighbourhood(s) served by your organization:

_____

5. Language(s) in which your organization offers its services:

- ☐ English
- ☐ French
- ☐ Other (please specify):_____

6. What population does your organization primarily target with its services?

_____

7. Does your organization offer services to support immigrant populations?

Yes ☐ **No** ☐

If yes, please specify:_____

Thank you very much for taking the time to complete this information sheet. We greatly appreciate it.

NÉGOCIATION ET CONSTRUCTION DU LIEU DE VIE : LES EXPÉRIENCES DES IMMIGRANTES QUI RECHERCHENT DES INFORMATIONS, DES SERVICES ET UN SOUTIEN EN MATIÈRE DE SANTÉ DE LA REPRODUCTION

Questionnaire d'informations personnelles pour fournisseurs de services de santé

Les informations pour le contact seront conservées séparément de ce formulaire. Nous choisirons un nom pour vous (ci-dessous) et l'utiliserons pour toutes les transcriptions et tous les documents.

Pseudonyme:_____(nous remplirons ceci)

Afin de nous fournir des statistiques de base pour notre étude, nous vous serions reconnaissants de bien vouloir fournir quelques détails vous concernant. Ces informations ne seront utilisées que pour le résumé et seront conservées de manière strictement confidentielle.

1. Femme ☐ Homme ☐

2. Type d'organisme dans lequel vous travaillez principalement:

- ☐ Cabinet de médecin/clinique
- ☐ Centre de santé ou de ressources communautaires
- ☐ Communauté d'éducation/organisme de soutien
- ☐ Groupe de doulas
- ☐ Groupe de sages-femmes
- ☐ Hôpital
- ☐ Service de santé public
- ☐ Autre (veuillez préciser):_____

3. Type de services santé de la reproduction que vous offrez dans votre organisme (cochez tout ce qui s'applique) :

- ☐ Contraception
- ☐ Dépistage du cancer du col
- ☐ Services d'avortement
- ☐ Services de soutien/counseling
- ☐ Services pendant la grossesse/à l'accouchement
- ☐ Soins généraux préventifs en matière de santé de la reproduction
- ☐ Tests et traitement pour les ITS
- ☐ Autre (veuillez préciser):_____

4. **Quartiers d'Ottawa desservis par votre organisme :**

_____

5. Langues dans lesquelles votre organisme offre ses services :

- ☐ Anglais
- ☐ Français
- ☐ Autre (veuillez préciser):_____

6. Quelle population est principalement visée par votre organisme?

_____

7. Votre organisme offre-t-il des services de soutien aux populations d'immigrants?

Oui ☐ **Non** ☐

Si oui, veuillez préciser :_____

Merci beaucoup d'avoir pris le temps de remplir ce feuillet d'informations. Nous l'apprécions grandement.

Appendix 8. Interview/Focus Group Guide - Service Providers

<u>Note</u>: These questions are provided as a reference to ensure that key issues are discussed. However, interviews will proceed as a conversation between the researcher and the participants, and will adapt to focus on the views of the participants.

(1) Understanding their Program/Service

- Would you tell me a little bit about the services you provide/programs you run?
  - What are they?
  - Where are they run?
  - What kind of work does this involve?
  - How long have you been engaged in this kind of work?

(2) Understanding the Population Served

- Who uses your services?
  - Are they targeted to a specific group? If yes, why?
- Do you encounter a lot of immigrant women? Immigrant women from Africa?
  - Which groups do you tend to see?
  - Has this changed at all over time (either # of African women seen, or subgroups)?
  - Can you paint me a picture of the social/demographic characteristics of these clients (may be diverse)?
    - Income, education, immigration class, yrs since immigration
    - Where do they settle in the city
    - Do you get the impression that they have a lot of support here?

(3) Understanding the Broader Community Context

- If you work in a specific catchment area/community would you tell me about the community you work in and the people you offer your services to?
  - How would you describe the general make-up of the community (e.g. diversity, income, education level, etc.)?
  - What can you tell me about African immigrant populations in this community and around the City?
    - Which groups? Where in the City? Timeline of arrival/why?
  - How would you describe how welcoming it is to immigrants (from Africa)? Has this changed at all over time?
    - Is it an older or newer immigrant receiving area?
    - Are there a lot of supports in this area for immigrants?
    - Why do you think immigrants choose or don't choose this area to settle in?
  - What's good for African immigrants about this community? What are the challenges?

(4) Perceptions of Women's Experiences

- Based on your experiences working with African immigrant women in this community:
  - What do you think are some of the main issues that your client base faces?
    - e.g., new moms, pregnant women, women looking for contraception, women looking for support?
  - Are these issues affected by other things in their life as immigrants (e.g. being new to the country, immigration or health policies, etc.)
  - How does your program/service help these women?
  - What do you observe or have heard about women doing to manage these issues or make things easier for themselves (e.g. talk to others, etc.)
- Are there certain groups of women that you think have an easier time finding and using your services? Why?
  - Who might be left out/missing and why? How does this make you feel as a service provider?
  - What do you think makes it easier or harder for them to do so?
- What else is needed to help your client base and support their health as women (e.g. new moms, pregnant women, etc.)?
- What other services/supports can you tell me about that your client base uses?

(5) Discussing/Reflecting On/Verifying the Reproductive Health Service Map

- When we consider the map of reproductive health services for this neighbourhood, is there any thing that I've missed?
  - That should be corrected or removed?
- Do you feel that this list provides an accurate picture of the reproductive health service environment in the neighbourhood?
- Based on your experience, do you feel that people are able to easily access these services?
  - Are there any reasons why people may be aware of these services but may not choose to use them?
  - Are there certain groups that you see more than others?
  - Are there certain groups that you feel cannot access these services?
- Do you think that the existence of these services is enough or do African immigrant women need more help from the perspective of supporting their reproductive health?

(6) Concluding Question

- Is there anything else you'd like to share or anything important that you think we've missed in our conversation?