

## Revisiting *Personal is Political*: Immigrant Women's Health Promotion Research Project Proposal

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### Summary of Research Proposal

Citizenship and Immigration Canada (1999) expected 200,000 to 225,000 immigrants and refugees to enter Canada in the year 2000. Becoming an immigrant is a process characterized by losses in socio-economic status and social networks. Although on arrival immigrants have a better health status than the average Canadian (Chen et al., 1996), after 10 years in the country they are in poorer health and have a higher prevalence of chronic health conditions (Dunn & Dyck, 2000). Immigrant women are particularly at risk for mental illness and other chronic diseases. They also lack access to health care services. This data reveals the urgent need to learn how to prevent illnesses and promote the health of Canadian immigrants. For instance, very little is known about immigrant women's strengths and their health promotion strategies in everyday life. In this context, it is important to acquire new insights on how to promote immigrant women's health.

To date, the study of immigrant women's experiences of health has been divided by a myriad of ethno-cultural groups. This approach has failed to identify the common elements of the immigrant experience shared by women. The proposed project is guided by concepts that transcend country of origin, which are gender, place and displacement, and power relations in everyday living. This study will focus in the particular context of mental health promotion. The core concept in health promotion is empowerment, meaning that in order to achieve health and well-being individuals and communities should have control over their lives. In the proposed study empowerment will be problematised as a potential means for achieving better health, but also as a strategy to raise self-responsibility for health by governments of advanced liberal societies.

The objectives of this research are to: (1) illustrate the resources and strategies immigrant women employ in order to promote their own mental health; (2) explore how being an immigrant (being displaced) shapes the power relations in which these women are engaged in their everyday lives; (3) describe how gender roles and relations influence the degree of control immigrant women have over their lives; (4) examine the concepts of individual and collective empowerment as simultaneously key elements for health promotion and as a discourse for self-care and the care of others.

The proposed method is participatory to allow an in-depth exploration of issues of power relations, place and gender. In order to capture the participants' experiences and create space for them to be empowered, this project will employ two approaches to data collection in different languages: (1) diaries or video tapes to promote a critical analysis of everyday living and the factors that facilitate or impede women's health promotion; (2) collective meetings with all participants to discuss their diary/video production and reflect on the key topics of the study.

The potential results will: (a) illustrate the possibilities and limitations of health promotion activities for culturally diverse women centred on gender and immigration issues; (b) suggest priority issues and particular strategies for mental health promotion programs and policies, at local, national or international levels; (c) reveal the potential and limitations of individual and collective empowerment as strategies to promote the mental health of immigrant women; (d) contribute to theories on the contextuality of power relations in terms of place and gender; (e) provide a gendered-power account of health promotion. These results will be significant for a variety of groups. To disseminate our findings, we have collaborators, such as community groups, networks of health services, as well as provincial and national agencies to help us reach a broad public beyond the academic community.

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### 1. Objectives

The feminist movement coined the expression "personal is political" to warn women that discrimination and oppression are embedded in personal everyday experiences. By politicising and problematising the ordinary world, feminist thinkers explored, for instance, the relations between the micropolitics of power, place, and gender (Smith, 1987; WGSG, 1997; Blunt & Wills, 2000). This study will concentrate on the political dimensions of personal lives in the context of health promotion among immigrant women, taking into account that health promotion can only be achieved by those who have a certain degree of control (power) over their own lives (Naidoo & Wills, 2000).

We have chosen to approach our study by focusing on gender, place, and power relations instead of using the traditional approach of fragmenting the experience of health according to ethno-cultural groups (Anderson, 2000). The latter disempowers immigrant women by producing multiple stereotypical accounts of "needy" women. Rather, we propose that gender and (dis)placement are central concepts for understanding the immigrant experience. Gender provides sufficient unifying elements to allow personal and collective intercultural reflections regarding how to achieve greater control over one's own life and health (WHO, 1986; Meleis et al., 1998). The notion of place is helpful because immigrant women share distinctiveness (being from another place) but also sameness (sharing a common new place).

From a health promotion perspective, mental health promotion is a vital issue for immigrant women (Meadows et al., 2001). Factors such as feeling displaced, isolated, responsible for the well-being of others (women's gender roles) and limited to change power relations (women's gender relations) interfere with immigrant women's mental health. Therefore, this study will discuss health promotion in the context of mental health and well-being for recently arrived refugee and immigrant women.

We will work with immigrant women to attain a better understanding of how gender, health, place and the politics of everyday life are interwoven and of how to use this knowledge to promote their health. The objectives of this research are to: (1) illustrate the resources and strategies immigrant women employ in order to promote their own mental health; (2) explore how being an immigrant (being displaced) shapes the power relations in which these women are engaged in their everyday lives; (3) describe how gender roles and relations influence the degree of control immigrant women have over their lives; (4) examine the concepts of individual and collective empowerment as simultaneously key elements for health promotion and as a discourse for self-care and the care of others.

### 2. Relevance of the Study

Canada has an official immigration policy that attracts people from all over the world. Since 1867, over 14 million people have immigrated to Canada. Citizenship and Immigration Canada (1999) expected 200,000 to 225,000 immigrants and refugees to enter Canada in the year 2000. Becoming an immigrant involves a process characterized by losses in socio-economic status and social networks, and it demands the negotiation of a new cultural identity (Anderson, 1991; Edwards et al., 1992; Tabora & Flaskerud, 1997; Murty, 1998; Anderson, 2000; Meadows et al., 2001). On arrival, immigrants have a better health status than the average Canadian individual, but after 10 years in the country they are in poorer health, for example, they are more likely to report chronic health conditions (Chen et al., 1996; Dunn & Dyck, 2000). Immigrant women remain at high risk for different mental and physical illnesses and have limited access to health care (Palacios & Sheps, 1992; Aday, 1993; Bolaria & Bolaria, 1994; Allotey, 1998; Anderson, 1998; Meleis et al., 1998; Meadows et al., 2001).

In response to challenges to provide health care to immigrants, multicultural service initiatives have been

implemented and researchers have studied the impact of immigration and cultural beliefs on health (Giger et al., 1997; Maltby, 1998; Chow, 1999; Higgins & Learn, 1999). Although important steps have been taken to create a more culturally sensitive health care system, little is known about immigrant women's strengths and the strategies they use to deal with the challenges of immigration while promoting their health as they are displaced into new environments and as power relations change in their lives (Fox et al., 1995; Giger et al., 1997; Meadows et al., 2001).

The proposed study is relevant for a variety of groups. As a participatory research this study will produce knowledge that is meaningful to the study's participants (Gatenby & Humphries, 2000; Im, 2000). Their input into the research process will assure that the study acknowledges the participants' own political and social agendas. We also expect this project to be relevant to immigrant women groups and associations who might profit from the findings to corroborate some of their claims or to question some of the strategies they currently support. The academic community would profit from this interdisciplinary, participatory perspective on immigration (Meleis, 1990; Skodra, 1992; Gibbs & Fuery, 1994; Culley, 1996; Ng, 1998; Ramirez-Valles, 1998; South Asian Community et al., 1999). Moreover, this project results will be relevant to health care providers, program developers, and policy makers working in highly culturally diverse communities, in Canada and internationally. The project will generate practical guides for developing programs for immigrant women's health promotion.

For the applicants, the proposed project represents a creative integration of academic and professional perspectives (Gastaldo, 1997; Khanlou & Hajdukowski-Ahmed, 1997; Gastaldo et al., 1998; Gastaldo & Holmes, 1999; Khanlou, 1999). The collective knowledge that the applicants have acquired through research, clinical, and personal experiences as immigrant and/or visible minority women represents a strong foundation from which to explore the social and political elements of health promotion for immigrant women.

### 3. Current Knowledge

Related research: The relationship between immigration and health has been studied extensively in the last two decades. The majority of the studies conducted analysed immigration from a cultural perspective. Multicultural health care was highlighted as essential in multicultural settings, particularly in the community (Waxler-Morrison et al., 1990; Meleis et al., 1992; Spector, 1995). Researchers concluded that health practices are influenced by cultural beliefs. Therefore, cultural sensitivity and cultural interpretation methods were vital tools for health workers (Kim & Rew, 1994; Pettaway et al., 1999; Sparks & Parks, 2000). Ethnic minority healthcare emerged as a new paradigm (Montes et al., 1995), encouraging multicultural communication and training (Canadian Task Force, 1988; Silka & Tip, 1994; DeSantis, 1997). The relationships among immigration, culture, and health have also been constant targets for researchers and health professionals examining the specific barriers and challenges for health care. Lack of language skills, the experience of racism, the need to balance two different cultures, the need to validate knowledge and experience, and the effort to make values understood and accepted have been the most explored issues (Meleis, 1990; Edwards et al., 1992; Ganguly, 1995; Liberman et al., 1997; Anderson, 1998; Maltby, 1998; Murty, 1998; Fong, 1999; Mohamed, 1999). Immigrant women in particular have been described as lacking access to health care services (Edwards et al., 1992; Lipson et al., 1995; Liberman et al., 1997; Anderson, 1998; Maltby, 1998; Meleis et al., 1998; Murty, 1998) and are considered a population at risk for physical and mental distress (Canadian Task Force, 1988; D'Avanzo, 1994; Sanders-Phillips, 1996; WHO, 1999; Meadows et al., 2001). Depression, stress, and chronic diseases were conditions researchers most frequently reported. In a 1999 study on counselling undertaken by our community partner, Women's Health in Women's Hands (WHIWH), practitioners identified depression among immigrants as the most prevalent diagnosis and related it to bereavement due to family disruption, frustration, low self-esteem, isolation, abuse, and racism.

Traditionally, the health sector and academics have focussed more attention on cultural differences and

communication problems in the provision of health care than on the similarities in immigrant experience related to gender, socio-economic and racial inequalities in health care (Anderson, 1998; 2000). Recently, critics have contested the at-risk, culturalist approach to immigration and health (Malterud, 1993; Culley, 1996; Ng, 1998). Others have argued that an empowering approach should not only acknowledge women's roles and dilemmas, but also raise consciousness, increase knowledge, and change power relations (Skodra, 1992; Gibbs & Fuery, 1994; Ramirez-Valles, 1998; South Asian Community et al., 1999). Several authors have pointed to the need for research that frames immigration and health using a social-critical health promotion perspective (Duffy & Hernandez, 1996; Giger et al., 1997; Murty, 1998). A few outstanding examples of this perspective suggest that a health promotion, participatory research project can validate immigrant women's knowledge and bring new insights into the health and immigration field (South Asian Community et al., 1999; Hajdokowski-Ahmed et al., 1999; Khanlou & Hajdokowski-Ahmed, 1999).

Theoretical framework: The nature of health promotion demands a theoretical perspective that addresses the intertextuality and interdependence of the processes that affect health (Webb & Wright, 2000). Health promotion theory has remained predominantly genderless and even though empowerment is a central concept to the health promotion movement, the power relations that characterize health promotion have rarely been explored (Gilbert, 1995; Hajdokowski-Ahmed et al., 1999; Naidoo & Wills, 2000; Holmes & Gastaldo, 2001). The theoretical underpinnings of this project draw from *cultural studies*. Among other contributions, cultural studies have advanced knowledge about feminism, ethnicity and race, identity, post-colonialism, and critical geography (Hall, 1986; 1989; 1992; Grossberg, 1996). Cultural studies are particularly appropriate for this project because they articulate post-structuralist and critical social perspectives (Morley & Chen, 1996). The post-structuralist framework supports the analysis of power relations in everyday life at the level of personal and collective experiences (Foucault, 1979, 1990; Lupton, 1995; Petersen & Lupton, 1996; Gastaldo, 1997). It can also address discourses embedded in historical, economic, and social contexts that explain broader issues, such as discourses about immigration and immigrants in a given society (Petersen & Bunton, 1997; Rose, 1998; Dean, 1999). In the proposed study, we will follow the tenets of post-structuralist feminist thinking, which bring the issue of gender into the analysis of power (Diamond & Quinby, 1988; Ramazanoglu, 1993; McNay, 1994; Sawicki, 1998). Gender is a crucial category of analysis for health promotion because traditionally women's domestic work has been taken for granted as free labour in the process of reducing risks (cooking healthy diets, promoting active lifestyle for children, providing emotional support) to increase the health of the nation (Holmes & Gastaldo, 2001). Women's subjectivities are constructed around discourses of health promotion (caring for others and oneself) internationally (Young, 1999), but there are important variations in what is expected from women in different places. Therefore, the event of moving to a new country re-shapes the meaning of what it means to be a woman based on local gender roles expectations and determines how relationships are established in a new place. Critical feminist geographers argue that displacement and the reconstruction of identity in a new place represent an opportunity to contest and transgress gender roles and relations (WGSG, 1997; Blunt & Wills, 2000). This does not mean that Canada, and Toronto in particular, offers a better standard of gender relations than other countries, but a different one. It is well known that many immigrant women who had full time jobs in their home countries are unemployed in Canada or have access to jobs with very poor working conditions (Gastaldo et al., 1999; Meadows et al., 2001). Finally, the process of empowerment, which has been argued from a critical social theory (Freire, 1981; 1994; hooks, 1990; Wallerstein, 1990; Figueiredo-Cowen & Gastaldo, 1995; Sparks & Park, 2000), offers critiques to post-structuralist thinking. These two streams of cultural studies, post-structuralism and critical social theory, will promote a thought-provoking tension between critiques of the discourse of empowerment and critiques of the deterministic nature of post-structuralist theory (Manias & Street, 2000). From a socio-political standpoint, empowerment is criticized as a new mode of governance for individuals and groups (Dean, 1999) that promotes

agency and activity as social norms in the production of subjectivity for self-regulated, enterprising individuals (Rose, 1998). Critical social theory, however, criticizes post-structuralist thinking because it is incapable of bridging the theory-practice gap, where power is disconnected from political intent (Manias and Street, 2000). Combining both perspectives of cultural studies is an attempt to generate new theoretical grounds in the understanding of health promotion.

#### 4. Methodology

Guiding Principles: (1) *Articulation theory-method:* Articulation is a central concept in cultural studies. Articulation works at the epistemological and political levels to challenge of what established theories already say about the subject under study and to re-work methods as tools that keep their relevance under new historical realities (Slack 1996). In other words, theory and method intersect each other creating an articulation that allows an in-depth exploration, in this case, of power relations, place and gender and which addresses the politics of knowledge production in a participatory research process (Slack, 1996; Kendall & Wickham, 1999; Banks-Wallace, 2000; Webb & Wright, 2000).

(2) *Participation:* A participatory framework promotes more balanced power relations between researchers and study participants by acknowledging that those involved in the study are knowledgeable individuals with diverse expertise. This principle is shared by our community partner and has been the basis of this project. The community health centre Women's Health in Women's Hands strongly believes that the power to shape women's health must be placed in the hands of those very women, who should envision and participate in the creation of health programs. WHIWH's multiprofessional team works from an inclusive, feminist, anti-racist, and anti-oppression framework. WHIWH has contributed in the development and supports the project here proposed because this participatory research provides the opportunity for women, who historically have been excluded from research, to bring their knowledge and experience to the centre of research practices (Clarke, 1992; Duffy & Hernandez, 1996). The immigrant women participating in this project will actively contribute to setting the research agenda, and they periodically will evaluate the research process (Denton et al., 1999). Although participatory research is known for its collaborative efforts between participants and researchers, the use of public funds to support the study demands that a basic structure be established to assure the achievement of the research goals. The plan that follows is meant to be flexible enough to respect participatory principles and structured enough to demonstrate how it will work (e.g., the number or duration of meetings can be adapted according to participants' suggestions).

(3) *Reflexivity:* Applying the notions of articulation and participation the research team combines professionals and academics. Throughout the research process, the researchers will employ a process of individual and collective reflexivity to operationalise the principles described above. The process values both experiential and scientific knowledge. The relationship with the participants will be based on this same reflexive process where similarities and differences between them will be explored. For example, as a starting point the researchers will reflect on their own experiences as women and as immigrants to establish a rapport with the participants.

Location: This study will be carried out in Toronto, the most culturally diverse city in Canada and one of the most culturally diverse places in the world. Toronto is an ideal place to explore the notions of power, gender and place as mediators for women's health promotion because we will be able to recruit a highly diverse group of participants. Women's Health in Women's Hands serves predominantly but not exclusively clients from Africa, Latin America, Caribbean Islands, and South Asia; 37% have been in Canada for less than 5 years; they range in age from 19 to 51; and most have a high school education. In terms of annual income, 16% have no income, 27% earn up to \$15,000, 27% from \$15 to 40,000, and only 6% earn more than \$40,000. Their household compositions and living circumstances are very heterogeneous.

Sample: The participants will be refugee or landed immigrant women (but not undocumented immigrants) who have lived in Canada less than 3 years. The generic term "immigrant" refers to both groups of women. The participants will not have to be literate or English speakers. We will recruit 36 participants for the first phase of the study and 12 participants will be invited to phases 2 to 5. In these phases, we expect to have one third drop out due to life circumstances (we are considering here the average drop-out rate of WHIWH group activities with recently arrived immigrant women). The participants will be selected as an intentional and diversified sample of ethnic groups, social-economic status, and educational backgrounds based on the data described above.

Methods and Data Collection: There are health promotion and political reasons for choosing the methods that follow. Gendered social determinants of health have been taken into account in the selection of participatory and group methods for this study because these methods provide an opportunity for the participants to meet other immigrant women. The literature documents that there is a beneficial effect of emotional support on mental health among women and that women are more likely to provide support to their immediate network (Stansfeld, 1999). From a political perspective, in a participatory study, the participants' accounts need to be preserved in the construction of knowledge and in advocating for social change (Malterud, 1993). Hence, this project will employ a variety of approaches to data collection in different languages. The project is divided into concomitant collective and individual techniques. The collective activities consist of focus groups discussions (Morgan & Krueger, 1998; Barbour & Kitzinger, 1999). The principal investigator will moderate two-hour meetings (1:20 focus group, 40 minutes for arrival, snack and farewell) with approximately 12 participants, where the main themes of the study will be discussed. The meetings will take place at WHIWH, as presented in the timetable (see page 13). We expect to use a maximum of 3 languages in the discussions with the help of translators what has proven a successful strategy in previous focus groups conducted by the applicants (also, the researchers combined are fluent in 8 languages). The group meetings will be divided in 5 phases divided according to the research objectives. All phases will produce data pertaining to the four research objectives. The divisions created by the phases of the study, i.e. separate foci on place, gender, and power have been designed to help participants focus on particular elements of their experience. The 5 phases are:

*Phase 1 – Discussion focus: Activities immigrant women engage in promoting their own health* (addresses objective 1). In this phase, 3 focus groups with 12 women will take place. In total, 36 women will discuss how they perceive their health in the context of (dis)placement and gender, and the strategies and resources they employ to promote their own health. From the 36 participants, 12 will be invited to participate in the subsequent phases of the study based on their time availability, manifestation of interest, and their diversity of economic, educational and ethnic backgrounds.

*Phases 2, 3 and 4* – The following three phases will use a similar dynamic, that is the participants will receive few questions (elements generated in phase 1 and that should be discussed in greater depth) to orient their reflection prior to the focus group meetings. They will be given the choice of writing diaries, recording elements of their daily lives using video cameras or calling the research phone line to leave messages. We are taking into account the possibility that some participants may be illiterate, so they can leave messages on the research answering machine to record their comments to comprise an oral diary. Those participants who do not wish to present images of their homes or neighbourhoods will be encouraged to use oral or written diaries. In each focus group 3 participants will share their reflections with others; after these 3 brief presentations, the whole group will discuss commonalities and differences in their experiences. There will be a training session on making video and diary and on reporting to the group to prepare the participants to phases 2, 3, and 4.

*Phase 2 – Discussion focus: Being in a new place* (addresses objective 2). In this phase, 4 focus groups will be conducted to examine the influence of (dis)placement on mental health and well-being. Potential issues to be explored are: what health promotion meant before immigration and what does it mean now; how did they experience losing and recreating social networks; what is Toronto like as a place to live (language, social norms, etc); is there a common "language" shared by those who experienced recent displacement?

*Phase 3 – Discussion focus: Being a woman* (addresses objective 3). In this phase, 4 focus groups will be conducted to investigate the relationship between gender and mental health promotion. Some issues to be explored are: what are the commonalities and what are the differences in terms of gender roles and gender relations the participants identify among themselves; how being a women impacts on mental well-being; who are the ones involved in women's health promotion activities?

*Phase 4 – Discussion focus: Power to change?* (addresses objective 4). This phase brings together issues of power, place and gender to examine what women have attempted and/or successfully achieved in promoting their own mental health. Reflection is a powerful tool for empowerment (Johns, 1999) and, after the reflection done in the previous phases, the participants will discuss how power relations evolved since they immigrated and since they started participating in the focus groups and what was the impact of this reflection on their well-being. Elements of individual and collective empowerment will be discussed as well as the limits to attempting to improve the conditions that favour their mental well-being.

Phases 2, 3, and 4 will last 2 months each and will consist of a meeting every two weeks, with a month interval between the phases. The phases' duration and the intervals between them have taken into account the very demanding life styles of immigrant women in their first years after arrival in Canada (Hopps & Pinderhughes, 1999).

*Phase 5 – Evaluation and Opportunities for Dissemination.* This phase will consist of 2 focus groups for bringing closure to the project and to evaluate the participatory methods employed. The participants will be offered opportunities to contribute to the dissemination of the findings.

Analysis and Rigour: General principles of qualitative analysis will be employed to guide all the data analysis for the study (Denzin, 1998). The data consists of transcripts of all focus group meetings, a socio-demographic questionnaire for each participant, and the diaries and videos produced by the participants for phases 2,3, and 4. A preliminary analysis will be conducted between each phase of the study to inform the next phase.

The research questions will structure the analysis, however the final goal is to destabilize the central concepts of the study and recreate them in the context of health promotion for immigrant women. The analysis will avoid essentialising women or the immigration process; instead, it will highlight differences as much as the commonalities in the experience of gender and immigration.

The analysis will be conducted in two parts: a deductive process of coding based on the theoretical perspective followed by an inductive process to ensure that the analysis is comprehensive and can challenge current understandings. The focus group data will be analysed in terms of both process and content (Catterall & Maclaran, 1997), whilst video tapes and diaries will be analysed as visual and written narratives (Harper, 1998; Wang et al., 1998; Parker, 1999; Bresset, 2000; Pink, 2001). The software NVivo will be used to code, store, and manage all texts and images. A number of strategies will assure the rigour of the study. The researchers themselves will use diaries throughout the study for fieldnotes that will be explored in the confirmation of the findings. For reliability, the distinct sources of information collected will support the triangulation of the data and an academic external to the study will check the coding scheme (Chamberlain, 2000).

Ethics: The recruitment process will happen through posters and pamphlets in several languages placed at WHIWH. Those who would leave a contact phone in the centre will be informed in greater depth of the nature of the study, potential risks and benefits of participation and the right to withdraw at any time, among many other ethical considerations. Participants will volunteer to participate after obtaining information on the project. The same issues explained over the phone will be covered by the consent forms, which will be signed before the focus group meetings. Interpreters will make phone calls and provide information in the language preferred by the participants for informed consent. We are aware of the complexity of ethical issues that should be considered in participatory qualitative studies (Gastaldo & McKeever, 2000), such as authorship (using videos or diary quotes), addressing conflicting interests between the group members or the difficulty to ensure confidentiality when data are elicited in groups. These ethical concerns that the project raises will be carefully described and addressed in the ethical proposal to be submitted for approval at the University of Toronto and at WHIWH. The participants will be reminded of these issues in distinct moments of the study. After data collection, the use of particular elements of diaries and images in the dissemination of findings will be discussed with the participants for additional informed consent.

Acknowledging Women's Participation: The participants' collective effort in collaborating with the study will be acknowledged with educational workshops on topics they request to be held during the intervals, one between each phase. This initiative is based on research findings on immigrant women's interest in educational opportunities (Gastaldo et al., 1998) and on the experience of WHIWH. We anticipate workshops will be about how to get a job in Canada, immigration and legal concerns, resources available in the community, computer skills, and English language classes. The project will also provide the participants with childcare, transportation, refreshments, and compensation for the time spent on the research meetings.

## **5. Outcomes, Dissemination, Partnership, and Advisory Board**

Expected Outcomes: Through this project, we expect to generate knowledge based on the content and methodology employed in the study. The potential results will: (a) illustrate the possibilities and limitations of health promotion activities for culturally diverse women centred on gender and immigration issues; (b) suggest priority issues and particular strategies for mental health promotion programs and policies, at local, national or international levels; (c) reveal the potential and limitations of individual and collective empowerment as strategies to promote the mental health of immigrant women; (d) contribute to theories on the contextuality of power relations in terms of place and gender; (e) provide a gendered-power account of health promotion. These results will be significant for a variety of groups.

Dissemination: The research findings will be disseminated within four spheres: the academic community, non-governmental agencies and community groups, service providers, and the governmental sector (policy-makers and politicians). Once the results are ready, we will have a meeting with our collaborators for knowledge transfer to plan a detailed program of dissemination. The participants will be stimulated to be involved in the dissemination of findings.

What has been established thus far is that a one-day colloquium will be held for our four target groups. Another strategy of dissemination is to produce summary sheets that will be published in our collaborators' newsletters and on their web sites. A third approach will be to respond to invitations to present talks to community and health service groups. National and international audiences will be reached through academic publications and presentations at conferences by all researchers, the research coordinator, and students (12 presentations are

expected). To reach a broader audience, papers published in scientific journals will be sent to community, local, and national newspapers and magazines.

Collaboration to Transfer Knowledge: To receive advice on effective means of disseminating findings and to have access to a broad range of communication channels, we have chosen to work with the following partners: *Academic Collaborators:*(1) Centre for Health Promotion, University of Toronto (national and international academic leadership on health promotion; we will have access to their web site and newsletter which reach Affiliated Units, Canadian Consortium for Health Promotion Research and the International Union for Health Promotion and Education); (2) CERIS - Joint Centre of Excellence for Research on Immigration and Settlement, Toronto (a consortium of universities and community partners for the study of immigration with a wide network of policy-makers, academics, and community groups reached through their web site and newsletter); *Health Care Collaborators:* The Association of Ontario Healthcare Centres (A network of 225 health centres. Among other objectives, it aims at promoting healthy communities in Ontario; the centres will be reached through the Association's newsletter).

*Community Collaborators:* (1) National Action Committee on the Status of Women (NAC is the largest feminist organization in Canada, a coalition of more than 700 member groups. We will reach their members through their web site and newsletter); (2) North York Committee on Community, Race and Ethnicity Relations (a large number of community groups comprise the Committee, which has a web site and newsletter); (3) Jamaican Canadian Association (a social service agency for new immigrants, which reaches Black and Caribbean communities in Toronto through its newsletter);(4) Ethnoracial People with Disabilities Coalition of Ontario (cross disability provincial organization with a broad audience reached through web site and newsletter); (5) Ontario Council of Agencies Serving Immigrants (OCASI promotes information exchange among agencies and is involved in discussions with the federal government on programs and support to immigrant serving agencies).

Partnership Component: This research project was designed by the four researchers with the participation of UofT students doing practicum at WHIWH. The project has been conceived as a collaborative enterprise between the Faculty of Nursing, UofT and the Women's Health in Women's Hands community health centre. This is the first research project undertaken between these two institutions. This collaboration is very timely because the WHIWH has been searching for a greater involvement in research and the Faculty of Nursing has been expanding its educational opportunities for undergraduate and graduate students in the area of women's health and has recently been awarded a Chair in Women's Health by the Ontario Government. Our project will contribute offering four positions for students who would like to participate in the project as research assistants. Also, the project has been designed to allow academics and professionals to participate in all phases of the study by allocating a weekly number of hours that is compatible with their other activities. Both institutions will provide resources for the project, in addition to the researchers' time, and will share the equipment acquired through the study once the research is finished.

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