



**GIVING BIRTH
IN A NEW LAND**

Strategies for
Service Providers Working
with Newcomers

*best start
meilleur départ*

by/par health **nexus** santé





TABLE OF CONTENTS

Acknowledgements	2
Introduction	3
Guide Overview	4
Section 1 – Overview of Literature	6
Section 2 – Perspectives and Approaches in Service Delivery ...	9
Section 3 – Individual Challenges and Successful Strategies	21
Section 4 – Organizations and Resources ...	44
Section 5 – Key Terms	47
Section 6 – References	48
Appendix 1 – Census Data	50
Appendix 2 – Demographic Projections	56

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Disclaimer

The resources and programs cited throughout this guide are not necessarily endorsed by the Best Start Resource Centre. While the participation of the advisory committee and key informants was critical to the development of this Best Start resource, final decisions about content were made by the Best Start Resource Centre.

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INTRODUCTION



This guide is for service providers who work with pregnant women who are new to Canada. It also includes information about care during the postpartum period. It is a response to the changing demographics in Ontario due to recent immigration trends (See Appendix 1 – Census Data and Appendix 2 – Demographic Projections). The information in this guide will be useful to a range of service providers who work with pregnant women, including physicians, midwives, nurse practitioners, nurses, public health workers, home visitors, support program staff, etc. The guide contains suggested guidelines that aim to be respectful of clients’ needs and appropriate for health professionals who may be of the same or different culture.

The purpose of this guide is to help service providers find ways to provide “culturally competent care,” which has been defined as *“the ability to provide care with a client-centered orientation, recognizing the significant impact of cultural values and beliefs as well as power and hierarchy often inherent in clinical interactions, particularly between clients from marginalized groups and health care organizations”* (see Section 5 – Key Terms, Zine).

In order to do this, the guide has the following objectives:

- to share information about the beliefs and practices of newcomer women in relation to prenatal and postnatal health care services;
- to assist service providers in helping newcomer women and their partners familiarize themselves with Ontario health practices related to pregnancy and the birth of their baby; and
- to suggest ways for service providers to accommodate the needs of newcomer women within their organizational mandate.

From Immigration Canada’s point of view, the term “newcomer” refers to people who have arrived in Canada within the last five years. For the purpose of our guide, the definition is broader and may also include women who have been here longer. Our definition also includes women who are temporary residents, refugees, refugee claimants, foreign students, permanent residents and new Canadian citizens. Some newcomers may not have government medical coverage such as Ontario Health Insurance Plan (OHIP). Women in each of these situations may have the need to access reproductive health services. While some newcomers adapt and integrate with ease, others may take a longer period given barriers such as language, migratory path, education, social support and other personal experiences. Our broader definition of “newcomers” takes into account the strong influences that extended families and community settings may have on women in their reproductive years.

GUIDE OVERVIEW

Content

The guide focuses on the following aspects of women's reproductive health:

- pregnancy;
- labour and birth; and
- postpartum.

It is important to note that this guide does not provide comprehensive coverage of all areas of women's sexual and reproductive health care. Hence, it does not cover reproductive choices, HIV, drug and alcohol abuse, violence against women, women with disabilities and issues pertaining to gynaecology such as sexuality, breast health, menopause and screening tests. The guide includes a list of additional organizations and resources that may be useful for service providers in the broader context of determinants of health.

The guide is divided into six sections:

- Section 1 provides an overview of the literature on the topic.
- Section 2 offers ways to provide services from the client's point of view. This section includes personal narratives that voice women's experiences pertaining to their cultural and religious values, beliefs and perceptions within the Ontario context. An assessment tool is provided for individuals and for workplaces.
- Section 3 identifies specific challenges that have an impact on access to reproductive services and shares successful strategies for providing culturally competent services. The section has three major components: pregnancy, labour and birth, postpartum.
- Section 4 contains a list of organizations and resources such as immigrant services and ethno-cultural and faith organizations, as well as links to multilingual resources.
- Section 5 contains a glossary of relevant terms.
- Section 6 contains a list of references and suggested readings.

Methodology

This guide evolved through the adaptation of a manual titled "Immigrant and Refugee Women's Cultural Health Practices: A guide for health care professionals," which was developed by Linda Kongnetiman from the Calgary Health Region in 2005 and which contains Alberta-specific information.

This guide, "Giving Birth in a New Land – Strategies for Service Providers Working with Newcomers," is a snapshot of barriers to the delivery of services that were identified by newcomers in Ontario. It shares associated strategies to assist service providers in addressing these barriers and focuses on Ontario-specific information. Although a large number of newcomers settle in the Greater Toronto Area, attention was also given to ensure input from other regions of the province.

The information for this guide was collected through:

- a literature update;
- four focus group consultations which included 37 newcomer women; and
- phone interviews with ten key informants who are health and social service professionals working with newcomers.

The literature update focused mainly on recent Canadian research related to reproductive health services for newcomer women. The following databases were searched: Cumulative Index of



Nursing and Allied Health Literature (CINAHL), Medline and Academic Search Premier.

Bibliographies of related research were also used as information sources.

When gathering information through focus groups, efforts were made to include newcomer women who reflected the demographic profile of urban Ontario, where a majority of newcomers settle. With a few exceptions, most of the participants had been in Canada for less than five years.

The newcomer women in the focus groups self-identified their countries of origin, languages spoken, faith/non faith affiliations and immigration status. Participants were assured that their personal information would remain confidential. The focus groups included newcomers from 11 countries (Afghanistan, China, Egypt, Ethiopia, Ghana, India, Indonesia, Kuwait, Pakistan, St. Vincent and the Grenadines, Sudan) and belonged to a variety of faith communities (Buddhist, Christian, Hindu, Muslim, Sikh or having no religious affiliation).

Although most of the participants could read English, they also read or spoke the following languages: Arabic, Cantonese, Chinese, French, Gujarati, Hindi, Kiganda, Mandarin, Punjabi, Russian, Spanish, Swahili, Tagalong, Tamil, Urdu, Vietnamese, and other African languages.

Two of the focus groups were comprised of Chinese, Urdu and Punjabi speakers and were conducted in the language of the participants. The transcriptions to English were careful attempts to capture the voices of the women. The other two focus groups were held in English.

The service providers interviewed included two obstetricians, a social worker, an executive director of a community agency, two family home visitors, a program manager of a health centre, a supervisor of family home visitors, a manager of health services and a labour and delivery nurse. The professionals themselves reflected diverse ethno-cultural, religious and racial profiles and all worked with a culturally diverse population. The majority worked in the Greater Toronto Area and three worked in the London and Hamilton areas.

Stereotyping and Generalizations

The information in this guide will not apply to all women who are newcomers to Canada and is not specific to individual ethno-cultural communities.

To avoid generalizations, the guide minimizes references to ethno-cultural background, and focuses instead on concerns that are common to newcomer women. The personal narratives portray a sample of experiences that women from many cultures may have during the prenatal and postnatal phases of pregnancy (e.g., concerns, challenges and beliefs around food, rest and bathing).

It is recommended that service providers use this guide as a starting point for engaging newcomer women in playing an active role in defining and determining their own health. The guide will help service providers ask relevant questions and to provide respectful and helpful information, support and referrals.

Human Rights

Under the *Ontario Human Rights Code*, discrimination is against the law. Everyone should have access to the same opportunities and benefits, and should be treated with equal dignity and respect.

The Code states that protection against discrimination applies in the following areas:

“Services, goods and facilities, including education, hospitals and health services, stores and restaurants, government programs, and public places and facilities.”

It doesn't matter whether or not discrimination is intentional: it is the effect of the behaviour that is important. Where a rule conflicts with a person's religious or cultural requirements, efforts should be made to accommodate the individual, unless doing so would cause undue hardship, create excessive costs, or pose a risk to health and safety.

Service providers should also be aware that, if they are collecting data on clients (i.e., race, place of origin, citizenship, etc.), it is important to make sure that the information collected is relevant to the delivery of the service (Ontario Human Rights Commission, 2008).

Terminology

Terminology is both fluid and evolving, and people within a group may choose to use different terms to describe themselves. A glossary of terms used is provided in Section 5.

In this guide, quotes from other documents are used and the original wording has been maintained, even if the wording may be viewed as stereotypical.

SECTION 1 – OVERVIEW OF LITERATURE

Upon arrival in Canada, most immigrant and refugee women face many challenges in adjusting to their new environment. These may include language, cultural and religious barriers; employment challenges; as well as assuming roles that may differ from their traditional roles.

Until recently, the experiences of newcomer women in accessing health services have been given limited attention. Access issues identified in immigration health literature include the different realities of immigrant sub-populations (e.g., women, low-income individuals and victims of torture); the lack of knowledge/responsiveness among health care providers in meeting the needs of those other than the mainstream population; and communication and literacy issues (Health Canada, 1999).

The health and well being of first generation immigrant and refugee women has become a growing area of concern among policy makers, researchers and health professionals. Research has shown that newcomer women and their infants may require additional support in order to address their health and social concerns (Gagnon et al, 2007).

Immigrants to Canada are generally in better health than Canadians upon arrival (Hyman, 2007). This is explained by stringent screening guidelines and by the fact that healthy people are more likely to emigrate (Oxman-Martinez et al, 2000).

Refugees, however, may be in a different situation. They are more likely than other newcomers to arrive without their immediate families, having been forced to separate in flight from persecution. They may have survived torture and trauma and often fear for the safety of those left behind. As a result, their mental health may be precarious (Canadian Council For Refugees, 1998). A Canadian research team is currently investigating the frequency and distribution of harmful health events during pregnancy, labour and birth, and the postpartum period, as well as related health care issues of refugee women in Canada (Gagnon et al, 2006).

It is difficult to assess the vulnerability of newcomer parents as each situation is different and the specific events related to immigration become



determinants of health. A research project from Québec has defined some general “risk categories” and clearly indicates the higher risks experienced by refugee or refugee claimant mothers. The research also highlights that it is sometimes difficult for service providers to correctly interpret the information they receive. For example, on the issue of partner involvement, there is sometimes a fine line between “support” and “control” and personal bias of service providers needs to be acknowledged and set aside (Battaglini, 2000).

The National Organization of Immigrant and Visible Minority Women of Canada notes that the main issues faced by immigrant and refugee women are:

- isolation from mainstream society;
- differing cultural values, cultural belief systems and practices that create serious barriers for women in their understanding, access and interaction with the health care system;
- lack of access to culturally sensitive health care services;

- the inability of large numbers of immigrant and refugee women to speak English or French; and
- compromised mental health due to the stigmatization of their immigration and socio-economic status, racism and general marginalization (Simms, 1996).

Service providers also identified food preference, the role of spouses and partners, the lack of control over reproduction, emotional health, female genital mutilation, stigma attached to HIV and religious underpinnings as practices that create serious barriers for immigrant and refugee women (Simms, 1996).

A Canadian study from 2006 included 1,250 women in their first four weeks following discharge from five hospitals. It compared immigrant women to women born in Canada. The study revealed that immigrant women were significantly more likely than Canadian-born women to have low family incomes, little social support, poor health, possible postpartum depression, learning needs that were unmet in hospital and a need for financial assistance. Although there were no differences between groups in ability to get care for health concerns, immigrant women were less likely to be able to get financial aid, household help and reassurance/support. The authors concluded that health care professionals should attend not only to the basic postpartum health needs of immigrant women, but also to their income and support needs by ensuring effective interventions and referral mechanisms are used (Sword, 2006).

A 2008 study of Muslim women accessing maternity health services in Newfoundland revealed that women experienced discrimination, insensitivity and lack of knowledge about their religious and cultural practices. Health information was limited or lacked the cultural and religious specificity to meet their needs during pregnancy, labour and delivery, and postpartum phases. There were also significant gaps between existing maternity health services and women's needs for emotional support and culturally and linguistically appropriate information. This gap was further complicated by the functional and cultural adjustments associated with immigration (Reitmanova, 2008).


A recent Canadian study indicated that immigrants, refugees and women seeking asylum in Canada are four to five times more likely to suffer from postpartum depression symptoms than women born in Canada.

This is largely due to the lack of social support for newly arrived women. Service providers should be prepared to provide referrals to appropriate services (Stewart, 2008).

Our understandings and experiences are often governed and conditioned through the cultural context in which we live. Culture affects immigrant and refugee women's ideas about health and their expectations of effective strategies for maintaining and promoting health (Kim-Godwin et al, 2001). The authors of this study propose a culturally competent community care model that assumes caring, cultural sensitivity, knowledge and skills can be distinguished from each other, and are all essential elements of culturally competent community care.

The information presented within the Canadian literature review, although limited, shows a link between the influence of cultural values, beliefs and perceptions and the experiences of newcomer women when accessing reproductive health services. This information corresponds to the data provided by the key informants and focus group participants reached in the production of this guide.





“I was a visitor when I arrived pregnant to Canada and did not have my permanent resident status. I was paying \$100 for each visit to the doctor. I went to a community clinic that assists people without status in Canada to receive free health care. This was good.”

“I felt rushed at the doctor’s office and my doctor did not give me enough information. Only two months ago, when I went on maternity leave, I found out about prenatal classes through my friends. No one asked about my cultural requirements.”

“I was frustrated because some tests needed to be done at certain times and I missed them because I was waiting for an appointment with my doctor.”

SECTION 2 – PERSPECTIVES AND APPROACHES IN SERVICE DELIVERY

Newcomers to Canada are faced with the daunting task of resettling in a new land. This may require finding employment; having their credentials recognized; finding a home; learning about the legal, educational and financial systems; learning a language and becoming acclimatized to a new climate.

Newcomers face systemic and individual barriers as they navigate many institutions and organizations. The need to access critical reproductive health services during the resettlement process adds a level of complexity.

This section lists some general barriers to accessing services and suggests successful strategies for delivering sensitive services. It is not possible for service providers to know all of the values, beliefs, perceptions and practices surrounding women's reproductive health; however, this guide will draw attention to some of the barriers to accessing prenatal health services in Ontario and will outline strategies for improving newcomers' reproductive health.

It is important to note that there is a wide range of practices between individuals and within cultural communities. This guide raises awareness about systemic barriers and shares information about the impact of cultural practices on access to services and on service delivery. Service providers should ask questions to determine the woman's and her family's cultural practices, even if they are from the same culture.

In addition, individual services providers may not be able to address all the needs by themselves. A community approach is required and they should make use of existing local networks and agencies such as local cultural organizations, public health units, community health centres, Best Start networks, Early Years Centres, etc.



This section uses personal narratives to provide insights into the beliefs, perceptions and practices of newcomer women from diverse ethno-cultural and faith communities. The narratives are interspersed throughout the section to illustrate the broad themes that emerged during the focus groups. It should be pointed out that some of these issues may not be specific to newcomer women; for example, it is not only newcomer women who may have difficulty finding a family doctor or who may feel rushed through their prenatal care visit. Some of the issues may be felt more intensely by newcomer women given their immigration circumstances.

The quotes found throughout this section have been collected from focus groups with women who are newcomers to Canada. To reduce stereotyping, the countries of origin of the women are not indicated.



”

“



“I called my mother and asked her a lot of questions because my doctor did not have time to answer. The doctor is too busy and rushed. Most of the information I receive is from friends. I needed circumcision to be done in a specific way for my son because of my religion.”

“I received much more information through the community centre for this pregnancy than I had received back home for my first pregnancy. Also, it was good that my husband was able to attend the birth. This was not possible for my first baby.”



PERSONAL REFLECTIONS FOR SERVICE PROVIDERS

The following is a tool that may help service providers to assess their own behaviour and knowledge regarding diversity issues.

Understanding Diversity and Avoiding Stereotyping

Do you:

- Consider the impact of immigration on the health and well being of newcomers to Canada?
- Recognize the influence of your own ethnicity and culture and their effects on your practice?
- Consider factors such as social class, religion, level of education, and area of origin (e.g., rural or urban)?
- Consider your power and position when engaging clients?
- Recognize the diversity of needs and experiences of those you serve?
- Allow for variations or differences in health beliefs and practices?
- Generalize about the beliefs and practices of people who dress differently (e.g., hijab, turban, etc.)?
- Obtain details based on personal information actually given by the client rather than making assumptions?
- Use simple language when discussing procedures?

Gender-related Issues

Do you:

- Understand that many women's choices are related to socio-economic status and do not necessarily result from their cultural and ethnic background?
- Explore what is acceptable and suited to the woman for her care?
- Understand the role that family members play when decisions are required about health?
- Understand that traditional medicine and other approaches may be used for well being?
- Involve family members with the consent of the client?
- Work out a mutually acceptable schedule of caring for the client or infant?

Personal and Professional Development

Do you:

- Attend in-service workshops and conferences and consult with colleagues about culturally competent care?
- Read books and articles to increase your understanding of, and sensitivity to, particular topics such as immigration issues?
- Familiarize yourself with the population you serve?



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“I feel lucky to have a doctor that speaks the same language as me but my doctor is too busy.”

“

“My doctor did not ask about my culture or my concerns.”

”

“Language was not a barrier as my husband spoke fluent English and was always with me to interpret.”

“I would be more comfortable having a female doctor as it is very important to me and my husband.”

Areas of Assessment

Do you:

- Ask about place of birth (e.g., the country, rural/urban) to ascertain a client's background?
- Ask about the length of time they've been in Canada and about family or friends as support measures?

The following are some questions you may consider asking a client:

- How is health care different in your homeland?
- What kinds of foods do you eat/drink during pregnancy, birthing, etc?
- What kind of grooming/bathing is practiced during this time?
- What cultural beliefs and faith rituals should I know about?
- What kinds of home remedies and foods are used during this time? Are these used or available here?
- Whom do you wish to involve in the decision making?
- Do you have beliefs about pregnancy, birthing and the postpartum period that I need to know about?
- Which members of your extended family are with you?
- Whom do you turn to for support?
- Do you have childcare?
- Do you have any unmet financial needs?
- Do you have transportation to attend prenatal and postnatal care?
- What other organizations have you been involved with for your social support and health needs?
- Do you have an interpreter you have been working with who could assist in prenatal and postnatal care?

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“The health beliefs and practices of the newcomers often differ markedly not only from the mainstream population but, also from the health professionals who provide care.”

(Waxler-Morrison et al, 2005).



“I was six months pregnant when I arrived in Canada and had difficulty in the language when dealing with the doctor and nurse. The doctors were very nice, but they didn’t give me any places that I could go for help. I now have a doctor who understands my culture. At times, I don’t listen to the doctor because of my culture, as long as the baby is safe. For example, back home, there is no showering until the 11th day after delivering the baby. Lots of herbs and leaves are used in the bath water and somebody helps to bathe you.”



“My depression was so bad that I was introduced to another nurse and met with a home visitor from my home country. That was very helpful.”

“My doctor doesn't speak my language, but she has a nurse who can translate for me.”



WORKPLACE ASSESSMENT TOOL: SUCCESSFUL PRACTICE GUIDELINES

The following checklist will help employees and managers assess their service delivery strategies for diverse communities and will assist them in identifying areas for improvement. You may want to discuss these at management and staff meetings.

Does your workplace environment:

- Reflect the demographic population you serve?
- Provide a welcoming and inclusive environment?
- Offer multilingual and culturally appropriate services?
- Support the clients' right to choose a service provider and approach that best meets their needs?
- Offer flexibility in services?
- Undertake outreach?
- Listen to the community and clients served?
- Offer service irrespective of immigration status or other criteria of eligibility?
- Respond to changing immigration trends?
- Provide a safe space for women?
- Offer childcare?
- Have a geographically accessible site?
- Address clients' need for transportation?
- Have a physically accessible site?
- Recognize the diversity of needs and experiences of those you serve?
- Offer anti-racist services?
- Ensure a non-sexist, non-discriminatory and non-judgmental environment?
- Recognize the importance of family in the life of the client?
- Determine if services continue to meet the client's needs?
- Involve users in the planning, implementation and evaluation of services?
- Let clients know their options?

Adapted with permission from: Best Settlement Practices, Settlement Services for Immigrant and Refugees, Canadian Council for Refugees.

GENERAL APPROACHES FOR SERVICE PROVIDERS

Service providers, including those that are immigrants to Canada, may not realize how different their reality is from that of a newcomer who has experienced a very different health care system and cultural practices. The following general suggestions will assist service providers in reaching out to newcomer women and forms the basis for the specific reproductive health suggestions provided later on in this document.

Approaches	General Examples of Appropriate Practices
Ensure that women have an opportunity to express their needs.	<ul style="list-style-type: none"> • Ask women about their immigration experiences. • Discuss their goals and dreams.
Ask about cultural practices.	<ul style="list-style-type: none"> • Find out if they have specific religious or cultural practices during pregnancy, labour and birth, and postpartum. Discuss options.
Inform women of local health practices and services.	<ul style="list-style-type: none"> • Inform women about hospital practices, prenatal classes, postpartum services, childcare options, etc.
Encourage the building of a social network.	<ul style="list-style-type: none"> • Find out if the women are already linked to an organization or network. • Link women with local services and inform them of relevant social supports.
Understand your own cultural values.	<ul style="list-style-type: none"> • Realize that local customs and practices have changed over time and are not universal.

Adapted from: Ministère de la Santé et des Services sociaux – Gouvernement du Québec – Naître ici et venir d'ailleurs

SYSTEMIC CHALLENGES AND SUCCESSFUL STRATEGIES FOR SERVICE DELIVERY

The following chart summarizes broad systemic barriers that have an impact on newcomer women’s access to services. These barriers affect access to all services, including reproductive health, and are related to the determinants of health.

The chart also includes suggested strategies for improving service delivery. Some strategies need to be addressed at an organizational level, while other activities can be implemented by front-line staff. While the list of strategies is lengthy, bear in mind that each individual change that you are able to make will potentially make a difference to newcomer women. Some suggestions on this list may go beyond the scope of your particular service or organization.

Information in this section focuses broadly on care of diverse populations. Information that is specific to prenatal care is provided in later sections.

Challenges	Strategies to Improve Access to Services
Beliefs/Faith/Spirituality	<ul style="list-style-type: none"> • Familiarize yourself with clients’ ethno-cultural and faith perspectives by asking open-ended questions (e.g., Do you have any specific requirements such as dietary needs?). • Consult with colleagues, community members and faith leaders. • Create partnerships with faith communities. • Provide a private space for meditation, prayer and reflection. If this is not possible, as an organization, identify a room which could be used such as a Breastfeeding/Family Friendly Room if it is not busy. • Provide essential resources (e.g., prayer mats, sacred texts, statues or photos of deities, inspirational readings, etc.). If this is not possible, encourage clients to bring their own. • Mark the compass direction within any space set aside for prayer, as some worshippers may wish to face a specific direction. • Train staff about multi-faith requirements (e.g., provide panel speakers, lunch and learns, etc.). • If very few newcomers are present in the community, it may be useful to have some contacts in other, larger communities, to use as resource people. Access to key multicultural websites and organizations may be helpful to service providers in rural areas.
Childcare	<ul style="list-style-type: none"> • Provide on-site childcare. • Link with multicultural associations to find out where childcare may be offered when needed.
Communication & Outreach	<ul style="list-style-type: none"> • Clarify the respective roles of public health, hospital, immigration, Children’s Aid Society, etc. • Provide education about free services within the community. • Provide posters, brochures, etc. which are user-friendly and translated into various languages. • Use simplified diagrams, posters and signage.

Challenges	Strategies to Improve Access to Services
Communication & Outreach (continued)	<ul style="list-style-type: none"> • Partner with settlement services and multicultural organizations to provide multilingual service delivery. • Develop a website in simplified English and in other languages. • Use informal networks for information dissemination on program delivery (i.e., word of mouth, religious organizations). • Use ethnic media. • Post ads on subways, buses and billboards.
Confidentiality	<ul style="list-style-type: none"> • Use staff interpreters. Avoid using family members whenever possible as they may select what information they want the woman to hear.
Food	<ul style="list-style-type: none"> • Find out about what type of diet and food they are used to eating. Accessing foods that are familiar to newcomers may be difficult for financial reasons or due to lack of local availability. • Work with the local food security groups to find out where certain types of food can be purchased. • If familiar foods are not available, suggest alternatives and show ways to prepare locally available foods. Refer the women to a local dietitian if needed. • In smaller and rural communities, see if a program such as the local Good Food Box could offer a personalized service for some newcomers.
Housing	<ul style="list-style-type: none"> • Recognize that some clients live in shelters or are homeless. Hand-deliver information rather than mailing it. • Acknowledge that many newcomers may be living in a dwelling with multiple families and generations and that suggestions related to cooking and sleeping arrangements need to take this into consideration.
General Accessibility of Organization's Services	<ul style="list-style-type: none"> • Offer access outside core business hours. • Hire staff from diverse backgrounds representative of your population. • Provide staff with cross-cultural training. • Develop a "tip sheet" on ethno-cultural communities with items such as religious holidays, etc. • Develop a diversity committee. • Develop a "tip sheet" for staff with key terms (e.g., push, breathe) in various languages. • Review policies and procedures on a regular basis to reduce institutional and systemic discrimination (e.g. only two visitors allowed in hospital room).
Medical Coverage	<ul style="list-style-type: none"> • Refer women without formal status in Canada, or who are waiting for Ontario Health Insurance coverage, to the nearest community health centre or midwife collective. • As an organization, advocate for more access to clinics for the uninsured.

Challenges	Strategies to Improve Access to Services
Role of Partner and Extended Family	<ul style="list-style-type: none"> • Communicate with the women directly. If possible, request a private interview with her. • Find out what the expectations of the woman and her family are related to parenting, especially the role of the father, mother, mother-in-law and extended family. • With clients' permission, include spouses/partners and extended family in all decision making.
Settlement Issues	<ul style="list-style-type: none"> • Partner with settlement agencies and multicultural associations. • Encourage the women to participate in local culture and systems. • Establish a settlement community display board or partner with your local multicultural association to find out about settlement issues and programs which can be displayed at your agency. • Distribute information about legal aid. • Provide information regarding English as Second Language (ESL) and Language Instruction for Newcomers to Canada (LINC) programs (federal program). These may be available through a local literacy organization or through continuing education classes at high schools or community colleges.
Socio-economic Issues	<ul style="list-style-type: none"> • Connect clients with appropriate social service agencies. Use or develop a list of community services or refer clients to public health to access the Healthy Babies Healthy Children Program (prenatal to age 6). • Refer clients to public health for additional reproductive health services (e.g., condoms, oral contraceptives). • Provide vouchers/gifts/incentives as part of all service delivery. • Connect clients with employment offices and opportunities. • Tell clients about the use of free computers in libraries, places for inexpensive shopping (e.g., second-hand shops), the cost of local telephone use (i.e., flat rate), Canada Prenatal Nutrition Programs and food bank locations.
Transportation	<ul style="list-style-type: none"> • Provide tickets/tokens for buses, subways or trains. • Take clients on a bus/subway/train tour to orient them to the neighbourhood. • Create partnerships with cab companies (specifically from ethno-specific communities).



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“A nurse came to my house and advised me about prenatal classes.”

“In my culture, we avoid eating papaya and okra during pregnancy.”

“There was nobody here to help me. It was the holy month of Ramadan (Islamic month of fasting) and I have a child in junior kindergarten. I wanted a female doctor from the religious point of view but no question was asked about my religion or culture.”

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SECTION 3 – INDIVIDUAL CHALLENGES AND SUCCESSFUL STRATEGIES

The following section describes some of the challenges women and their families may encounter when accessing reproductive health services. The challenges are grouped under three main sections:

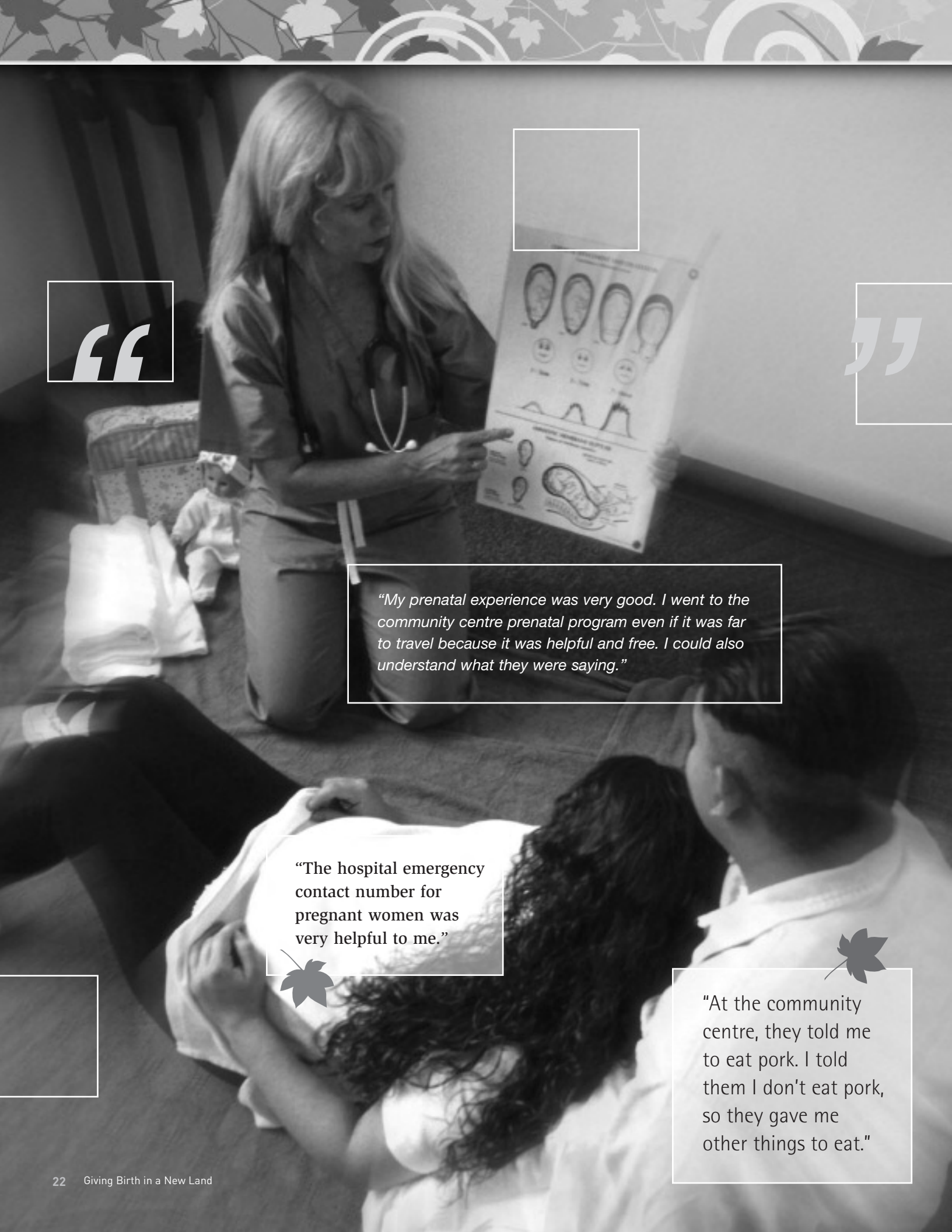
- pregnancy;
- labour and birth; and
- postpartum.

Some strategies are suggested to deal with these challenges. These strategies aim to help service providers view the issue from a client-centered point of view while taking into account Canadian practices and regulations.

PREGNANCY

This section will be particularly relevant to prenatal educators, professionals offering prenatal care services and service providers working with pregnant women.

Topics	Successful Strategies
<p>Decision Making</p> <ul style="list-style-type: none"> • Spouse/partner is sometimes the decision maker. • Health-related decisions are sometimes consultative (i.e., input is given by extended family, elder males). 	<ul style="list-style-type: none"> • Clarify the family structure and identify the roles of the family members in health-related decisions. • With the client's permission, inform and involve the partner, mother, mother-in-law, etc., during all consultations, but focus on the woman. • Create a "tip sheet" for the partner and for the extended family. • If needed, provide an interpreter. Do not rely solely on family members as they may select the information they interpret.
<p>Sexuality</p> <ul style="list-style-type: none"> • Women may abstain from sexual intercourse for two to six months prior to delivery, or they may abstain completely during pregnancy. • Spouses may sleep in separate beds. 	<ul style="list-style-type: none"> • Respect spousal intimacy as a private matter and be open to clarifying misinformation around sexuality.



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“My prenatal experience was very good. I went to the community centre prenatal program even if it was far to travel because it was helpful and free. I could also understand what they were saying.”

“The hospital emergency contact number for pregnant women was very helpful to me.”

“At the community centre, they told me to eat pork. I told them I don't eat pork, so they gave me other things to eat.”


Topics	Successful Strategies
<p>General Attitudes and Beliefs about Pregnancy</p> <ul style="list-style-type: none"> Depending on the immigration circumstances of the parents, the pregnancy may or may not be seen as a positive event. 	<ul style="list-style-type: none"> Ask questions to understand the family context in which the pregnancy is occurring. Assist through referrals to appropriate health, mental health or social service agencies if needed.
<ul style="list-style-type: none"> In some cultures, the announcement of the pregnancy may be done in a specific manner (e.g., by the father, by his brother or by the parents of the woman). The partner may not be the first person informed. 	<ul style="list-style-type: none"> Find out from the woman what her wishes are around the announcement of the pregnancy and respect these wishes.
<ul style="list-style-type: none"> Some women consider pregnancy a vulnerable time. They may avoid using sharp objects and scissors, taping or posting posters or pictures on the walls and/or working with adhesives and tools. They may also avoid the use of foul language and take precautions to prevent the evil eye. 	<ul style="list-style-type: none"> Begin by asking about beliefs and practices around health with each woman and acknowledge these without judging. Educate the woman about birthing in Ontario and the health care system to help alleviate anxiety.
<ul style="list-style-type: none"> Some women view pregnancy as a “hot” state or a time of increased body heat (e.g., morning sickness). Others may view pregnancy as a “cold” state. 	
<ul style="list-style-type: none"> Women may avoid emotional situations (e.g., funerals). 	
<ul style="list-style-type: none"> Women may be exempt from some religious rituals (e.g., fasting, going to places of worship, prayers). 	
<ul style="list-style-type: none"> Rituals may be performed to protect mother and child (e.g., reading from a sacred text, not going out at night, covering the head, wearing an amulet, giving to charity). 	
<ul style="list-style-type: none"> Some women may feel stigmatized by the mainstream culture regarding the number of children they are choosing to have. 	
<ul style="list-style-type: none"> Some women have very positive feelings about the high-tech hospital equipment and the well-trained health professionals available in Ontario and may feel that nothing can go wrong. 	<ul style="list-style-type: none"> While it is important to reinforce the positive aspects of our health care system, it is also necessary to mention that not all aspects of a pregnancy and birth can be controlled. Help the woman create a birth plan so she can be aware of what is available in her area and can have some control at birth.
<ul style="list-style-type: none"> Parents may not have the social support they would have had in their home country. 	<ul style="list-style-type: none"> Highlight the benefits of building social supports prior to the birth to reduce the risk of postpartum mood disorders and to facilitate breastfeeding, etc. Show the woman specific ways of doing this through community, cultural and religious groups, for example. Ensure the woman knows how to access services once the baby is born by providing her with local phone numbers and addresses and providing referrals as needed.

Topics	Successful Strategies
<p>Prenatal Classes</p> <ul style="list-style-type: none"> In many cultures, women learn what they will need for pregnancy and childbirth through their mothers, sisters and aunts. 	<ul style="list-style-type: none"> With the woman's permission, allow her partner, family, friends and elders to accompany her to classes. Try to specifically reach mothers and mothers-in-law. Involve health professionals who are familiar with the client's background. Consult with personnel from ethno-specific communities about curriculum and sensitive topics. In remote and northern communities it may be necessary to establish contact with a colleague from a community seeing large numbers of newcomers (i.e., Toronto). Ensure that the curriculum is client-driven and gender-specific, if required. Respect the possibility that the partner may choose not to attend prenatal classes and that a female family member will attend instead. During class, offer opportunities for participants to discuss their values and rituals related to pregnancy and birth as various topics come up. Ensure participants are comfortable sharing this information and that all participants are encouraged to be non-judgmental. Highlight local practices that may be different from those of the woman's home country and explain the purpose of these practices. Discuss the importance of breastfeeding, as the decision to breastfeed is generally made prior to pregnancy. Engage partner and family support on the issue. Clarify when the woman should come to the hospital and what she should bring. Assist the participants in developing a birth/ breastfeeding plan in class. Ensure that a supportive environment is created in the prenatal classes to help women build a social network. Use icebreakers, informal exchanges through refreshment breaks, etc. Consider offering separate classes for women and men. Assist men in adjusting their traditional roles to meet the needs of the family in the Canadian context. Teach them some basic skills they can use at home after the baby is born (e.g., cooking, cleaning, bathing, diapering, etc.). Respect their choices to take on new roles or to retain more traditional roles.

Topics	Successful Strategies
<p>Prenatal Classes (continued)</p> <ul style="list-style-type: none"> • It may be difficult for newcomers to attend classes due to systemic barriers. 	<ul style="list-style-type: none"> • Advocate for free prenatal classes. • Consider a variety of time slots for the program to accommodate part-time work and irregular work schedules. • Schedule classes around significant religious days. • Provide classes in a familiar space such as a cultural centre, a physician’s office or a faith location. • Partner with faith and cultural communities, physicians, etc. • Link with English as Second Language (ESL) classes, settlement services, multicultural organizations. • Since the women may already have children (i.e., children born in their country of origin), consider offering childcare. • As possible, provide free bus/taxi rides for those who do not have a vehicle. Find out from other participants if car pooling is possible. • Provide a list of contacts and support organizations early on (even at sign-up), in case some participants cannot attend classes.
<ul style="list-style-type: none"> • Language may be a barrier for some newcomers. 	<ul style="list-style-type: none"> • If possible, use prenatal educators from linguistic communities similar to those of clients. In smaller communities, contact a local multicultural association to see if there is an interpreter available. If that is not possible, try to at least provide some written materials in the woman’s language (these may be available through another agency). • Provide ESL programs for pregnant women. Such a program can integrate the learning of key terminology needed to navigate through the various steps of pregnancy, labour and birth, and newborn care. • Role-play situations regularly encountered by pregnant women when accessing the health care system. • Try to connect participants with new mothers and fathers from the same cultural/linguistic background who have experienced a birth in Ontario and who could help to reduce anxiety. In remote communities, this may be possible through a phone call or video conference.

Topics	Successful Strategies
<p>Prenatal Care</p> <ul style="list-style-type: none"> Some women consider pregnancy a normal occurrence and a blessing and may not seek medical attention until labour. 	<ul style="list-style-type: none"> Ask about the woman's previous experience of perinatal care in Canada or in her country of origin. Conduct outreach and educate women about the benefits of prenatal care. Encourage the woman and her partner to attend prenatal classes.
<ul style="list-style-type: none"> Pregnancy information may be obtained from elders (e.g., mother, mother-in-law). 	<ul style="list-style-type: none"> Collaborate with elders, friends and relatives to educate the woman about the benefits of consistent medical check ups. Provide culturally appropriate, medically sound information about pregnancy.
<ul style="list-style-type: none"> Many prenatal tests, and the concept of regular prenatal appointments, may be unknown to the pregnant women. 	<ul style="list-style-type: none"> Explain the importance of prenatal care. Explain the relevance of tests clearly and make sure they are understood. Accommodate religious holidays when setting appointments.
<ul style="list-style-type: none"> Women may be encouraged to rest and not carry heavy loads or climb stairs. 	<ul style="list-style-type: none"> Educate the woman about the need for moderate exercise. Suggest walking, stretching, prenatal exercise classes, etc. Encourage the woman to complete the ParMedX for pregnancy form with her physician to identify the level of physical activity she is allowed to do. Encourage the woman to follow the advice of her physician or midwife.
<ul style="list-style-type: none"> In some cultures, weight gain during pregnancy is associated with difficult labour and birth. 	<ul style="list-style-type: none"> Reinforce the importance of an adequate weight gain for the health of the baby and explain why. Explain the recommendations of Canada's Food Guide to the woman. Refer her to a dietitian if needed.
<ul style="list-style-type: none"> Women may have uncertainties regarding breastfeeding. 	<ul style="list-style-type: none"> Ask open-ended questions about the woman's beliefs, knowledge and concerns about breastfeeding and make sure this information is in her files if it might have an impact on breastfeeding after the baby is born. The staff in birthing and postpartum will then be aware and can work with her toward successful breastfeeding. Give the woman information about where she can get help after baby is born (breastfeeding clinic, lactation consultant, public health nurse or breastfeeding peer mentor).
<ul style="list-style-type: none"> In some cultures, massages are used throughout pregnancy to reduce anxiety and to help with foetus positioning. 	<ul style="list-style-type: none"> Acknowledge the benefits of relaxation and check with professional organizations regarding appropriate practices.

Topics	Successful Strategies
<p>Hospital Tour</p> <ul style="list-style-type: none"> The hospital may be a very unfamiliar setting to many newcomers. In many countries, home births are the norm. 	<ul style="list-style-type: none"> As for all expectant parents, a tour of the hospital is important to increase comfort levels. Pay special attention to: food provided, clothing, blankets, postpartum care, access to fridge, access to hot water. Educate women about the birthing process and Canadian practices to avoid issues that may arise at the time of delivery concerning medications, episiotomy, immunizations, etc. During the discussion, use visual aids such as diagrams, pictures or videos. Rehearse/role-play what will happen during delivery. Empower clients to communicate their needs to the hospital staff. Having a birth plan written in English may be useful especially if language is an issue. If language is a barrier, use an interpreter to explain the labour and birthing process. Describe the roles and responsibilities of nurses and other staff during a hospital stay. With the women's permission, encourage mothers-in-law, friends and family to attend the hospital tour. If possible, have a newcomer mother who has recently given birth in that hospital say a few words regarding her experience and provide suggestions to future mothers. Inform women about the possibility of using a midwife for a home birth or a doula as a birth assistant in the hospital.
<ul style="list-style-type: none"> Some women believe in keeping themselves warm during the birthing process. 	<ul style="list-style-type: none"> Show women a hospital gown and suggest bringing alternate clothing for the hospital stay (e.g., warm gown, scarves, etc.).
<ul style="list-style-type: none"> Women may return to parental home for delivery. 	<ul style="list-style-type: none"> Let women know it is possible to have a home birth in Ontario and inform them of the pros and cons of such a decision. Educate women about the possibility of using a midwife for a home birth. Clarify that if there is a concern with the baby or pregnancy, the woman may not end up delivering at home but at the hospital, in the care of an obstetrician.



“I was seven months pregnant when I came to Canada and had a tracheotomy. I had a lot of questions regarding my physical health and my ability to deliver. I was provided with all of my prenatal information and directions for my medical condition but was not asked about my cultural needs regarding childbirth by the health care professional.”



“I enjoy the prenatal program provided in my area. Although the facilitator does not speak Chinese, they do provide an interpreter and all the written materials are available in Cantonese and Mandarin.”

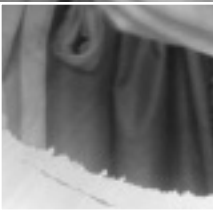


Topics	Successful Strategies
<p>Food</p> <ul style="list-style-type: none"> • Women may be held responsible by their families for not following dietary customs if they have a miscarriage or problems during birth. • Women may continue to adhere to dietary restrictions (e.g., will not eat pork, beef, or eggs or consume alcohol). • Women may adhere to the hot and cold principle associated with food (e.g., yin and yang). • Some women may not eat shellfish. Others may eat fish daily. • Women may not properly cut or mash food, and may avoid dark coloured foods. • Some women may avoid hot foods such as meats, eggs, nuts, herbs and spices and eat cool foods such as milk products, fruits and vegetables. • Some women may avoid spicy foods and sour edibles. • Some newcomers may have economic difficulty purchasing a variety of foods and may not be properly equipped to cook these foods. 	<ul style="list-style-type: none"> • Seek knowledge about the diverse faith communities and/or consult with faith leaders, dietitians, other professionals or family members regarding beliefs and dietary restrictions if they impinge on wellness. • Discuss nutrition with the woman, focusing on promoting a healthy pregnancy. Ensure the diet is not deficient. If needed, supplement the diet with traditional foods in keeping with Canada's Food Guide. Consult with a dietitian as needed. • Help the woman to become familiar with some of the foods commonly available in local grocery stores. Show her how to prepare simple meals with these foods or link her to an agency or home visitor that will. • Consult the local public health department to learn which fish are safe and healthy to eat during pregnancy. • Assist the woman in finding affordable sources of food to ensure basic nutritional requirements can be met and cooking is possible (i.e., Canada Prenatal Nutrition Programs, food banks, community kitchens). • Encourage the woman to take appropriate prenatal multi-vitamins and help her to get these vitamins.
<ul style="list-style-type: none"> • Women may use herbal remedies (e.g., drinking strong herbal teas or a hot mixture of flax seed and honey to ease labour pains, eating a special kind of clay to decrease nausea, avoiding cold water and drinking warm liquid). • Women may take certain vitamins and supplements. 	<ul style="list-style-type: none"> • Ask about herbal remedies and supplements. Learn about, and be open to discussions about, alternative medicine such as traditional Chinese and ancient Indian medicine (Ayurvedic medicine). Be aware of specific health contraindications with herbal and alternative medicines. Consult with appropriate professionals. • Reinforce the need for daily intake of folic acid.



“At home, a woman does not have a bath for seven days following a C-section. Here, the staff said to have one right away. I called my husband for guidance and decided to bathe as I did not have any elders to consult and if anything bad happened, at least I was in the hospital.”

“Back home, there is a room with lots of other women who are in labour, and women are not supposed to scream during labour-the quieter you are, the easier it is to deliver. During the birth of my first child, my mother-in-law put a towel in my mouth.”



“In my culture you don’t drink cold water during pregnancy and delivery, but I decided to drink it anyway in Canada.... I did not feel comfortable asking for warm water in the hospital.”



LABOUR AND BIRTH

This section includes suggestions that may be helpful to hospital staff who offer care during labour and delivery. The information may also be useful to prenatal educators who help to prepare women for labour and delivery.

Topics	Successful Strategies
<p>Hospital Intake</p> <ul style="list-style-type: none"> Some women may not have taken a hospital tour or may not be aware of hospital procedures. 	<ul style="list-style-type: none"> Give instruction using diagrams and demonstrations, and request feedback to ensure understanding. Use an interpreter to support the birthing process if language difficulties are anticipated. During the initial intake procedure, ask about the cultural/religious practices of the patient in terms of how to proceed with service provision. This may be particularly useful if a critical situation such as premature labour or death arises. Make the woman, partner and family members aware of the location of key items: blankets, showers, hot water, food, common areas, etc.
<ul style="list-style-type: none"> Some women go to the hospital at the first contraction. 	<ul style="list-style-type: none"> Ensure that the woman is aware of the signs of labour and that she understands when she should go to the hospital. Use diagrams or videos if needed.
<p>Labour</p> <ul style="list-style-type: none"> Some women facilitate labour by walking, drinking herbal medicines and being active. Women may assume a passive role, following instructions from a midwife or birthing attendant. In many cases, women will not openly contradict a health professional, even if it goes against their better judgement or their cultural practices. Some women deliver in silence and others may moan, groan or scream. 	<ul style="list-style-type: none"> Respect cultural practices displayed by the woman during the birthing process. Ask her what she feels like doing. Ensure the herbal medicines are not contraindicated for the mother and unborn baby.
<ul style="list-style-type: none"> Women may squat or sit to assist in the birthing process. 	<ul style="list-style-type: none"> Encourage the woman to use the most comfortable position for her during the birthing process.
<ul style="list-style-type: none"> Some women may avoid breathing techniques. 	<ul style="list-style-type: none"> Explain why breathing techniques may help through delivery, but don't insist on using them.
<p>Attitude Toward Pain</p> <ul style="list-style-type: none"> Some women might avoid pain relieving medications such as epidurals and spinal medication. 	<ul style="list-style-type: none"> Explain the procedures with diagrams and models. Simplify the language used. Use personnel from ethno-specific communities to explain procedures. Suggest non-intrusive alternatives (e.g., warm towel on the back, guided imagery). Ensure that the woman provides an informed consent.



“I asked my husband to bring warm water and food to the hospital.”

“In 2007, I had a C-section. When I came from the delivery room to the recovery room, within one hour, the nurse handed over the baby. I told her, 'Right now I'm not in the condition to handle her,' but she said, 'No! I wasn't even fully conscious and I had no one to help. I was alone. My husband was with me in the delivery room, but he was away at that time. I had to hold the baby for one hour. They said, 'Nobody can stay in the hospital!' ”



“My mother told me not to drink ‘thanda paani’ (cold water). In the hospital, they gave me cold water and ice. I took it, but my mother-in-law threw it outside.”



Topics	Successful Strategies
<p>Support</p> <ul style="list-style-type: none"> • Spouses may not be involved in the birthing process and, in some cases, are contributing through prayer. • Female relatives and friends may play a major role. 	<ul style="list-style-type: none"> • Recognize and accommodate the role of supports during labour and delivery and offer space for extended family members.
<ul style="list-style-type: none"> • In some cultures midwives are highly valued. 	<ul style="list-style-type: none"> • Encourage the use of a midwife or labour doula.

<p>Birth</p> <ul style="list-style-type: none"> • In some cultures, the gender of the child may not be announced until the father is present. 	<ul style="list-style-type: none"> • Prior to the birth, clarify any cultural and religious requirements. Include these in the birth plan.
<ul style="list-style-type: none"> • There may be a request to retain biological material (e.g., umbilical cord, placenta, hair, etc.) for burial. 	<ul style="list-style-type: none"> • Clarify the purpose for the request. Ask about the nature of the ritual. Explain infection control measures. Check for transmittable diseases (e.g., HIV, Hep. B.). Give any biological material to the parents in a sealed bag for burial, cremation, etc. Discuss this during the prenatal period and then reconfirm at the time of birth.
<ul style="list-style-type: none"> • There may be uncertainty around the timing of initiating breastfeeding. 	<ul style="list-style-type: none"> • Women should be given information on how to best facilitate successful breastfeeding and offered strategies for overcoming their cultural concerns (see Breastfeeding section).
<ul style="list-style-type: none"> • There may be specific rituals performed on the newborn, such as having the baby drink sacred water, putting tint in the baby's eyes, using black beads or thread on the baby's wrist or neck, wearing of a bracelet, having the baby taste honey, cutting of hair or nails, bathing with special ointments, having the grandmother give the first bath, etc. • There may be special ceremonies, such as a naming ceremony, baptism, reciting sacred text in child's ear, gift giving (e.g., eggs, soup, tea, sugar, milk) or animal sacrifices. 	<ul style="list-style-type: none"> • Clarify the purpose of the ritual. • Point out any potential child safety hazards such as lead in the black eye colouring, choking on beads, botulism associated with the use of honey. • Suggest safety measures. • Accommodate the rituals if possible, using an alternate space if necessary. • Keep in mind these rituals may be particularly important for couples who are isolated from their extended families and removed from their culture.

<p>Negative Outcomes</p> <ul style="list-style-type: none"> • In many religions, the outcome of the delivery (e.g., disability, Down's syndrome, birth defect) is seen to be determined by God. 	<ul style="list-style-type: none"> • These potential outcomes should be discussed during pregnancy. • Explain the short- and long-term consequences of the situation and the support options available.
<ul style="list-style-type: none"> • Women and families may avoid dealing with bad news. 	<ul style="list-style-type: none"> • Provide the family with time to deal with the situation.



"I had a C-section so I had stitches. The nurse said to shower, but my mother-in-law said, 'Don't bathe. Just wash the top and the bottom!' as this is what is done after giving birth in my country. I listened to the nurse."



"Back home, a woman must stay with her mother after delivering a baby. The mother must tell everyone when labour begins and likely over forty women will go to the hospital with her. No men are allowed."

"Back home we use hot water and ginger to bathe. When I was asked to shower at the hospital, I went and stood inside the shower and then just came outside." (She only pretended to shower.)



Topics	Successful Strategies
<p>Neonatal or Maternal Death</p> <ul style="list-style-type: none"> The death of the mother and/or child may be perceived as divine punishment. In the case of deaths, there may be some specific religious rituals the family wishes to perform, which may involve religious healers (e.g., for prayers, cleansing rituals). 	<ul style="list-style-type: none"> Involve faith practitioners for counselling/support around rituals of death specific to religion. Clarify family wishes around funeral visits. As much as possible, accommodate faith requests associated with death, such as immediate burial, and try to expedite documentation requirements. Find out from the family what should be done regarding photographs of dead infant, remnants of hair, nails, umbilical cord, etc.
<ul style="list-style-type: none"> The family may be reluctant to have an autopsy done on the infant. 	<ul style="list-style-type: none"> Explain legalities, consult with faith practitioners, and provide emotional and spiritual support.
<p>Female Genital Mutilation</p> <ul style="list-style-type: none"> In some cultures, female genital mutilation is a routine practice, involving the stitching of the inner layers of the labia minora or majora, and/or the removal of the clitoris or other parts of the genitalia. 	<ul style="list-style-type: none"> Educate yourself about the practice of female genital mutilation. Educate the woman and her partner about the myths and legal requirements. Suggest consultation with faith practitioners. If applicable, have the woman consult with a surgeon regarding reconstruction.
<p>Caesarean Section</p> <ul style="list-style-type: none"> Women may refuse this procedure. 	<ul style="list-style-type: none"> During pregnancy, educate the woman and her partner about the need for the procedure and the consequences of refusal. Ensure informed consent at birth.
<ul style="list-style-type: none"> Women who have undergone the procedure may restrict themselves to bed rest afterward. 	<ul style="list-style-type: none"> Consider this aspect when recommending a C-section. Educate the woman about the healing process following the procedure and offer alternative exercises.
<p>Modesty</p> <ul style="list-style-type: none"> Many women value privacy and being clothed at all times. 	<ul style="list-style-type: none"> Where possible and given medical insurance allowances, support a woman who has a preference for a semi-private or private room, or encourage the use of a curtain. Discuss her level of comfort around clothing (e.g., using a medical hat to cover her hair, wearing a gown over her hospital gown).
<ul style="list-style-type: none"> Women may prefer same-gender service providers. 	<ul style="list-style-type: none"> Incorporate patient preferences into health-related decisions where appropriate and possible. Ideally, refer to a female physician or include a female nurse or family member during examinations. Encourage working with a midwife or labour doula. Have an open dialogue with the patient to identify accommodation strategies. During pregnancy, let the woman know that it may not be possible to accommodate her preferences, depending on the staff on duty when she is admitted to the hospital.



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“A public health nurse came to my house to help me with breastfeeding and an interpreter came with her, which was very helpful.”



“In my culture, the grandmother gives a bracelet to the baby about one month after the birth.”

“I have been seeing a dietitian who knows the foods from my country, and this is very helpful. With my previous child, someone came to my home to help me with breastfeeding. Canada is a very special place for me.”

“In my culture, we do not shower for one month after delivering a baby. I waited to shower.”



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POSTPARTUM (BIRTH-FOUR MONTHS)

This section will be relevant to hospital staff, home visitors, lactation consultants and anyone offering postpartum services.

Topics	Successful Strategies
<p>Hospital Stay</p> <ul style="list-style-type: none"> • Women may expect nurses to do everything related to newborn care. 	<ul style="list-style-type: none"> • During the prenatal stage, educate the woman about the roles and responsibilities of health care professionals and other service providers in postpartum care. Encourage involvement of family members in caregiving after the birth.
<ul style="list-style-type: none"> • Women may have a greater need for privacy. 	<ul style="list-style-type: none"> • When possible, give the woman the bed farthest from the door. • Ensure the woman knows how to use the curtain provided.
<ul style="list-style-type: none"> • Women may have a large number of visitors. 	<ul style="list-style-type: none"> • Acknowledge the importance of a supportive social network. • Ensure that the woman and her family are aware of hospital policies well ahead of the birth. • Explain the importance of rest for the mother and other patients. • Encourage the use of common rooms.
<ul style="list-style-type: none"> • Women may not feel ready to care for their babies during their hospital stay. 	<ul style="list-style-type: none"> • Encourage the woman to arrange for assistance from family members or close friends during her hospital stay. • Try to facilitate the arrangements required to permit additional assistance during the hospital stay.
<p>Food</p> <ul style="list-style-type: none"> • Women may not eat raw or cold food. • Women may favour eating chicken, soups, lentils, fish, eggplant, greens (hot foods). • Women may wish to share food with friends and family. • Women may wish to drink warm water. • Women may want to eat special dishes. • Women may avoid foods that cause gas (e.g., cabbage, cauliflower, spicy foods). 	<ul style="list-style-type: none"> • Make women aware that it is acceptable for them to bring their traditional and religiously appropriate foods for their stay in the hospital. • Make women and their families aware of food safety policies at the hospital (e.g., no cooked leftovers can be kept in the room). • Consult with dietitians who are familiar with the woman's ethno-cultural community and ensure requirements of Canada's Food Guide are met.
<ul style="list-style-type: none"> • Women may wish to use herbal medicines. 	<ul style="list-style-type: none"> • Ensure herbal products are not contraindicated for breastfeeding. • Familiarize yourself with traditional medicine.

Topics	Successful Strategies
<p>Newborn Care</p> <ul style="list-style-type: none"> • Immunization may be refused. This may be because in their country of origin, equipment is not sterile and has caused deaths. It may also be because they fear other medication is added to the vaccines. They may also be concerned about the costs. 	<ul style="list-style-type: none"> • Explain long-term consequences of immunization choices (e.g., daycare and school requirements as per immunization legislation). Reassure the parents about the safety of the immunization equipment and the contents of the vaccines. Emphasize that the vaccines are covered under the Ontario Health Insurance Plan. This should be discussed during pregnancy and addressed again after the birth.
<ul style="list-style-type: none"> • The baby may require a longer hospital stay due to prematurity or other medical concerns. 	<ul style="list-style-type: none"> • Explain the situation clearly to the parents, clarifying their role during the hospital stay and discussing health care coverage of costs.
<ul style="list-style-type: none"> • Parents may wish to circumcise their baby for religious reasons. 	<ul style="list-style-type: none"> • Inform the parents of current guidelines and of the pros and cons of circumcision. • To facilitate the request, refer parents to a paediatrician or faith practitioner. • Ensure this information is discussed during pregnancy and made part of the birth plan.
<ul style="list-style-type: none"> • Parents may be reusing disposable diapers. 	<ul style="list-style-type: none"> • Educate the parents about hygiene issues. Discuss any economic challenges and refer the parents to social service agencies. Encourage the use of cloth diapers.
<ul style="list-style-type: none"> • Parents may leave the baby alone at home or with a young sibling. 	<ul style="list-style-type: none"> • Educate the parents about legal requirements of infant/child supervision as per child protection legislation.
<ul style="list-style-type: none"> • The baby may sleep with the mother in bed. 	<ul style="list-style-type: none"> • Educate the parents about safe sleeping guidelines.
<ul style="list-style-type: none"> • The father may bathe his baby with him. 	<ul style="list-style-type: none"> • This practice can help build attachment with the father. Ensure both parents know basic safety guidelines.
<ul style="list-style-type: none"> • The mother may perform regular massages on the baby, sometimes with unusual manipulations. 	<ul style="list-style-type: none"> • This practice can help build attachment. Assess safe techniques are used and that the baby's cues are taken into account.
<ul style="list-style-type: none"> • The parents may be overdressing/underdressing the baby. 	<ul style="list-style-type: none"> • Educate the parents about appropriate dressing for a child at different times of the year in Ontario. • Explain to the parents how they can tell if the baby is too warm or too cold. • Explain that babies have poor circulation (i.e., the hands and feet are usually colder). • Assist parents in getting free or inexpensive baby clothing.

Topics	Successful Strategies
<p>Newborn Care (continued)</p> <ul style="list-style-type: none"> The parents may demonstrate baby care behaviours that differ from mainstream habits. 	<ul style="list-style-type: none"> Show the parents videos about growth and development and caring for baby. Explain the benefits of promoting early attachment (e.g., talking to baby, responding to baby's cries, encouraging smiles). If you suspect that difficulties associated with the immigration experience of the parents may make the attachment process difficult (e.g., they are refugees or victims of torture, they are mourning the death of family members), refer them to a mental health agency or social service agency such as the Children's Aid Society, as appropriate, for additional support. Encourage traditional practices such as carrying the baby all the time, as they reinforce attachment. Ensure safe methods of transportation are used. Educate the parents about safety norms related to baby equipment (e.g., cribs, playpens, high chairs, carriers, car seats). Provide them with information on how to get safe and inexpensive equipment. This information should be available during pregnancy. Educate the parents about the safety of household products (e.g., cleaning products, plant care products, etc.) as they may not be familiar with the toxic nature of some of these products or may not have sufficient English or French to read the labels. Refer the mother, partner and extended family to local parenting programs for continued support related to parenting issues. Although in the home country the father's main role may have been as the family provider, adaptations are often made in the Canadian context. Efforts on the part of the father should be encouraged. Fathers may need to be taught some basic newborn care skills.
<ul style="list-style-type: none"> The parents may not be aware of legal requirements in registering their baby. 	<ul style="list-style-type: none"> Ensure that the parents have the required birth registration forms. If needed, assist them in filling out and mailing the forms. Inform the parents that online registration is now available. Link them to Service Canada.



"In my culture, we tie a black thread around the baby's wrist or neck to protect against the evil eye. Also, an iron bracelet is put around the baby's wrist. As the baby outgrows the iron bracelet, the mother replaces it with a bigger one. The doctor was against it, but we did it anyway."

"Back home, I would not leave the house for forty days after delivery. Back home, I would have a lot of people to help me."

"Although I did not have any family in Canada, I have had lots of good help from the family care centre and from my family doctor."



"In my culture, there is a naming ceremony after the baby is born. The baby is given a taste of honey from the finger of an elder, even though the doctor advised not to do so. The doctor in my country did not approve of this either but it is a traditional ritual and I wanted to do it. I did not discuss cultural rituals with my doctor as I suspected I would be advised not to do it."

Topics	Successful Strategies
<p>Mother Care</p> <ul style="list-style-type: none"> • Women may rest for a period of 10-40 days and, in some cases, may not leave the home for up to 40 days. They may choose not to visit anyone. • In some cases, women may not eat with family members. 	<ul style="list-style-type: none"> • Clarify with the woman during the prenatal stage her preferences about postnatal care and how she would like to be supported. • Discuss the possible negative consequences of isolation on mental health. • Refer the woman to a public health home visiting program if you feel isolation may be an issue (Healthy Babies Healthy Children program). Ideally, this should be done during pregnancy.
<ul style="list-style-type: none"> • Women may bind the abdomen to hasten uterine involution. 	<ul style="list-style-type: none"> • Discuss alternatives to hasten uterine involution, such as breastfeeding. • Accommodate as possible.
<ul style="list-style-type: none"> • Women may avoid walking and any other physical activity. • Some women believe that extended bed rest is important to straighten out the backbone. 	<ul style="list-style-type: none"> • Inform the woman and her family of the importance of a gradual return to physical activities. • Encourage the woman to not be in bed for extended periods of time to decrease the risk of blood clots, etc. • Encourage the partner and extended family to take walks with the new mother. • If appropriate and possible, suggest alternative health practices such as massage, acupuncture and acupressure.
<ul style="list-style-type: none"> • Personal hygiene practices may vary widely depending on culture and upbringing. Some women may not bathe or wash hair, or may bathe only once a week. Some may wash the perineal area with warm water and soap after urination and defecation. Others may bathe with salt sitz (crystals) to hasten healing. 	<ul style="list-style-type: none"> • Try to understand cultural hygiene practices. • Explain and negotiate what is preferred, such as sponge baths, the use of washcloths, etc. • Support and accommodate practices if possible. • Explain the signs and symptoms of infection and the importance of contacting a health care provider if this occurs.
<ul style="list-style-type: none"> • Some women may want to keep very warm at all times. 	<ul style="list-style-type: none"> • In the hospital setting, provide additional blankets or suggest bringing one from home. • Ask if the home provides an adequate room temperature.
<p>Contraception and Birth Spacing</p> <ul style="list-style-type: none"> • Women may not be aware of contraceptive choices. • Women may not be aware of birth spacing recommendations by health authorities. 	<ul style="list-style-type: none"> • Discuss reproductive choices with the woman and offer suggestions and resources. • Refer her to public health sexual health clinics. • If possible within your role, broaden the education around reproductive health in the ethno-specific community. • Make the woman aware of the recommendations from the World Health Organization on birth spacing to reduce health risks. • Stay open-minded about cultural/faith beliefs. • If the woman is planning a subsequent pregnancy, provide her with information on nutritional requirements, including folic acid.

Topics	Successful Strategies
<p>Sexuality</p> <ul style="list-style-type: none"> Sexuality may be viewed as a private matter, not to be discussed. Many women will not engage in sexual activity for up to 30-40 days, or until the cessation of bleeding. Some women may refrain from sexual activity for up to two years. 	<ul style="list-style-type: none"> Discuss this matter with the woman in private. Seek clarification about sexual practices. If the woman's wishes are not acknowledged by her partner, ask her if she would like additional assistance. With her consent, provide a referral to appropriate sexual assault services.
<p>Breastfeeding</p> <ul style="list-style-type: none"> Some women may not breastfeed for the first few days after giving birth and may believe that colostrum is harmful to the baby. 	<ul style="list-style-type: none"> Starting during pregnancy, educate the woman about breastfeeding, including the significance of early initiation of breastfeeding. As early as possible, educate and involve female family members and partners around breastfeeding.
<ul style="list-style-type: none"> Some women may hold the perception that formula is better than breast milk and may associate formula with the higher standard of living found in Canada. 	<ul style="list-style-type: none"> Educate the woman about the benefits of breastfeeding and the risks and financial costs of introducing formula. As early as possible, educate and involve female family members around breastfeeding.
<ul style="list-style-type: none"> Some women may not have a support system to support breastfeeding due to the work schedule of their partner or their own return to work. 	<ul style="list-style-type: none"> Inform the woman and family members about the importance of breastfeeding and provide strategies to facilitate breastfeeding. Teach strategies for pumping and storing breast milk. Refer the woman to a Public Health home visiting program (during pregnancy for higher risk situations) or La Leche League Canada for additional support.
<ul style="list-style-type: none"> Some women may think they will not have sufficient breast milk for their babies. 	<ul style="list-style-type: none"> Reassure the woman and concerned family members that the size of the breasts is not related to the quantity of milk produced and that most mothers produce sufficient milk for their babies. Remind the woman that frequent breastfeeding increases the breast milk supply.
<ul style="list-style-type: none"> Special foods may be eaten to stimulate milk production. 	<ul style="list-style-type: none"> Ensure an adequate diet that follows Canada's Food Guide.
<ul style="list-style-type: none"> Privacy may be required due to modesty. 	<ul style="list-style-type: none"> Try to accommodate privacy needs during breast education and feeding. Use models to explain breastfeeding rather than physically touching the woman. Suggest ways to breastfeed discreetly outside the home.
<ul style="list-style-type: none"> Women may not be aware of the recommended duration of breastfeeding. 	<ul style="list-style-type: none"> Starting in pregnancy, inform the woman and her partner of current breastfeeding recommendations.

Topics	Successful Strategies
<p>Post Partum Mood Disorders</p> <ul style="list-style-type: none"> • In the country of origin, postpartum mood disorders may not be recognized or may have a delayed onset due to the support and protection provided in the first few weeks. • This may be a taboo topic, as is the case with mental illness. 	<ul style="list-style-type: none"> • Ask questions around social support, settlement issues and family support. • Educate the woman and her extended family about the symptoms of postpartum mood disorders. • Suggest that the woman follow up with her physician if she experiences symptoms of post partum mood disorders. Ensure referral is carried out. • If a woman is perceived to be at a higher risk, indicate on the discharge sheet for the public health nurse that multiple visits may be required. • Ideally, this topic should be introduced during pregnancy in case there are signs and symptoms of depression during pregnancy. It should be discussed again at time of discharge.
<p>Support</p> <ul style="list-style-type: none"> • In many cultures, the parents, in-laws or female relatives assist in newborn care. In the case of new immigrants, extended family support may not be available. 	<ul style="list-style-type: none"> • Encourage partners, and family members who do live nearby, to offer support with care, such as changing the baby and assisting with household chores. • Assign a buddy and/or mentor, ideally from the same cultural community. • Inform parents and extended family of any community resources available, such as public health home visiting programs and volunteer associations.
<ul style="list-style-type: none"> • Women may be experiencing some tensions between the wishes of their extended families and their own choices regarding newborn care. 	<ul style="list-style-type: none"> • Within your professional guidelines, support the woman's choices and help her find compromises that are acceptable to her extended family. • Provide written documentation in the language of the extended family, to help them understand some of the health-related choices (i.e., baby sleeping on its back in a crib).

CONCLUSION

Providing culturally competent care is a difficult but rewarding task for service providers. Service providers in Ontario are already striving to provide quality services to diverse families.

A team approach is needed to build a circle of support around each newcomer woman and her family. Service providers need to assess which strategies may work well for them and build from that, involving others as needed.

This guide highlights some values, beliefs and practices that some immigrant and refugee women may demonstrate when accessing prenatal and postnatal services. By considering individual client needs, service providers can negotiate and personalize care for immigrant and refugee women ensuring that they “recognize the inherent dignity and worth of every person” (Ontario Human Rights Commission, 2005).

SECTION 4 – ORGANIZATIONS AND RESOURCES

This is a list of the organizations most commonly used by newcomer women. Inclusion in this guide does not imply endorsement. Service providers should also connect to their local services such as cultural organizations, public health units, community health centres, Best Start networks and Early Years Centres.

NATIONAL ORGANIZATIONS

Canadian Council for Refugees

An organization committed to the rights and protection of refugees in Canada and around the world and to the settlement of refugees and immigrants in Canada.

514-277-7223 • www.ccrweb.ca

Canadian Ethnocultural Council

A coalition of national ethnocultural umbrella organizations representing a cross-section of ethnocultural groups across Canada. Website has a comprehensive list of cultural groups.

613-230-3867 • www.ethnocultural.ca

Canadian Centre for Victims of Torture

A non-profit organization that helps survivors in overcoming the lasting effects of torture and war.

416-363-1066 • www.ccvt.org

Canadian Race Relations Foundation

An agency dedicated to the elimination of racism in Canada.

416-952-3500; 1-888-240-4936 • www.crr.ca

Centre for Faith and the Media

A non-profit organization that helps media and the general public achieve a stronger understanding of spiritual history, practices and values in Canadian society. Website offers contact information for a wide variety of religious organizations.

1-877-210-0077 • www.faihandmedia.org

Citizenship and Immigration Canada

A government department that assists people wishing to immigrate and newcomers to Canada. Services include immigration, citizenship registration and Language Instruction for Newcomers to Canada (LINC).

1-888-242-2100 • www.cic.gc.ca

La Leche League Canada

An organization that helps women to find answers to questions about breastfeeding or to locate a breastfeeding leader or group in their community.

1-800-665-4324 • www.lllc.ca

Public Health Agency of Canada

A government agency that seeks to promote and protect the health of Canadians through leadership, partnership, innovation and action in public health.

General: www.phac-aspc.gc.ca

Canada Prenatal National Program (CPNP):
www.phac-aspc.gc.ca/dca-dea/programs-mes/cpnp_main_e.html

Community Action Program for Children (CAPC):
www.phac-aspc.gc.ca/dca-dea/programs-mes/capc_main_e.html

Healthy Pregnancy: www.healthypregnancy.gc.ca

National Organization of Immigrant and Visible Minority Women of Canada

A not-for-profit organization that seeks to ensure equality for immigrant and visible minority women within an officially bilingual and multicultural Canada.

613-232-0689 • www.noivmwc.org

Service Canada

Offers access to a wide range of Government of Canada programs and services for citizens through more than 595 points of service located across the country, call centers, and the Internet.

1 800 O-Canada (1-800-622-6232)
www.servicecanada.gc.ca

PROVINCIAL ORGANIZATIONS

Assaulted Women's Helpline

A 24-hour crisis line for women in the province of Ontario.

416-863-0511; 1-866-863-0511;
#SAFE (#7233) using a mobile phone
www.awhl.org

Association of Ontario Health Centres

The policy and advocacy organization for non-profit, community-governed, multidisciplinary primary health care. Website has a list of all the health centres in Ontario.

416-236-2539 • www.aohc.org

Association of Local Public Health Agencies

A non-profit organization that represents public health units and boards of health in Ontario. Website has a list of all public health units in Ontario.

416-595-0006 • www.alphaweb.org

Landlord and Tenant Board

An independent agency that provides information about the Residential Tenancies Act and seeks to resolve disputes between residential landlords and tenants.

416-645-8080; 1-888-332-3234 • www.ltb.gov.on.ca

Legal Aid Ontario

An organization that provides legal aid to low income individuals and disadvantaged communities for a variety of legal problems, including immigration and refugee hearings.

416-979-1446; 1-800-668-8258
www.legalaid.on.ca

Ministry of Health and Long-Term Care

Ministry of the Ontario government offering provincial health services.

General Information on Services,
INFOline: 1-866-532-3161
Ontario Health Insurance Plan: 1-800-664-8988
Telehealth: 1-866-797-0000
www.health.gov.on.ca

Ministry of Community and Social Services

Ministry of the Ontario government offering services such as Social Assistance and Ontario Works.

416-325-5666; 1-888-789-4199
www.mcscs.gov.on.ca

Ministry of Children and Youth Services

Ministry of the Ontario government offering provincial services, such as Best Start, Healthy Babies Healthy Children, licensed childcare and Ontario Early Years Centres.

General: 1-866-821-7770; www.gov.on.ca/children
Ontario Early Years Centres; 1-866-821-7770;
www.ontarioearlyyears.ca

Motherisk

A clinical, research and teaching program of the Hospital for Sick Children dedicated to antenatal drug, chemical and disease risk counselling.

General: 416-813-6780
Alcohol and Substance: 1-877-327-4636
Morning Sickness: 1-800-436-8477
HIV and HIV Treatment: 1-888-246-5840
www.motherisk.org

Nutrition Resource Centre

A resource centre that aims to strengthen the capacity of nutrition practitioners in communities across Ontario. Website offers links to multilingual nutrition resources.

c/o Ontario Public Health Association
(416) 367-3313, ext. 222 • www.nutritionrc.ca

Office of the Registrar General

This website from Service Ontario provides online Ontario birth registration.

416-325-8305; 1-800-461-2156
https://www.orgforms.gov.on.ca

Ontario Council of Agencies Serving Immigrants

A non-profit organization that acts as a collective voice for immigrant-serving agencies and coordinates response to shared needs and concerns. Website offers a directory of member organizations for a wide variety of ethnic and cultural groups.

416-322-4950 • www.ocasi.org

Ontario Human Rights Commission

An independent statutory body that administers the Ontario Human Rights Code, which protects people in Ontario against discrimination in employment, accommodation, goods, services and facilities, and membership in vocational associations and trade unions.

General: 416-314-4500

Human Rights Inquiries:

416-326-9511; 1-800-387-9080

www.ohrc.on.ca

Ontario Immigration

An Ontario Government website designed for potential and new immigrants to Ontario. Provides information on procedures to follow and lists relevant links.

www.ontarioimmigration.ca

Ontario Multifaith Council on Spiritual and Religious Care

An organization dedicated to advocacy of spiritual care and the protection of religious rights.

(416) 422-1490; 1-888-837-0923

www.omc.ca

Settlement.org

A program of the Ontario Council of Agencies Serving Immigrants. Website offers settlement resources and information in more than 30 languages as well as links to regional resources including Newcomer Information Centres and Language Instruction for Newcomers to Canada (LINC).

www.settlement.org

TORONTO ORGANIZATIONS

Community Connection

This portal, also known as the “Blue Book,” has a list of all community, social and health agencies in Toronto. You can also dial 211 to get the service by phone.

www.211toronto.ca

Community Resource Connections of Toronto

A comprehensive source of information for mental health consumers/survivors, family members and service providers.

416-482-4103 • www.crct.org

MULTILINGUAL RESOURCES LINKS

Best Start Resource Centre

A provincial resource centre that supports service providers in implementing effective health promotion programs for expectant and new parents. A key program of Health Nexus.

For handouts on abuse in pregnancy:

www.beststart.org/resources/anti-violence/index.html

For handouts on Shaken Baby Syndrome:

www.beststart.org/resources/hlthy_chld_dev/index.html

Canadian Association of Family Resource Programs

An organization that promotes the well being of families by providing national leadership, consultation and resources to those who care for children and support families. The organization’s Welcome Here Website offers links to a variety of resources that may be useful to parents (e.g., nutrition, parenting, early childhood development, etc.).

www.welcomehere.ca

Calgary Health Region

Website offers the prenatal book “Best Beginning” for purchase in several languages.

www.calgaryhealthregion.ca/programs/maternalnewborn/bestbeginning.htm

Ministry of Health and Long-Term Care

Ministry of the Ontario government offering provincial health services. For fact sheets on newborn screening:

www.health.gov.on.ca/english/public/program/child/screening/fact_sheets.html

SECTION 5 –KEY TERMS

Access: The right to enter, and participate in, a program or service (Thesaurus. UK. English).

Asylum-seeker: See “Refugee claimant”

Barrier: an obstacle. In social justice, the concept includes obstacles to bias-free environments (Peel District School Board).

Culture: Ever-changing ideas, customs and art produced by a particular society that influences people’s behaviour. Culture is understood to mean a broad set of ideas that are learned and shared by members of a group. Culture organizes people’s behaviour and thoughts in the context of their societies, history and environment and shapes their identities, attitudes, beliefs and practices (Zine).

Cultural competence: A set of behaviours, attitudes and policies that come together in a system, agency, or among professionals and enables that system, agency or the professionals to work effectively in cross-cultural situations (Cross et al., 1989; Isaacs & Benjamin, 1991), (Zine).

Culturally competent care: The ability to provide care with a client-centered orientation, recognizing the significant impact of cultural values and beliefs as well as power and hierarchy often inherent in clinical interactions, particularly between clients from marginalized groups and health care organizations (Zine).

Diversity: The term used to describe variation between people in terms of a range of factors such as ethnicity, national origin, gender, ability, age, physical characteristics, religion, values, sexual orientation, socio-economic class or life experiences (Zine).

Female Genital Mutilation: Comprises all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons (World Health Organization).

Immigrant: A person who is a landed immigrant in Canada. A landed immigrant is a person who has been granted the right to live in Canada permanently by immigration authorities. Some immigrants have resided in Canada for a number of years, while others are recent arrivals. Most immigrants are born outside Canada, but a small number were born in Canada (Statistics Canada, 2006 Census Dictionary).

Newcomer: A recent immigrant who has been in Canada for less than five years (OntarioImmigration.ca). For the purpose of this guide, the length of time may be longer as adaptation may take longer.

Permanent resident: A person who has been granted permanent resident status in Canada. The person may have come to Canada as an immigrant or as a refugee. Permanent residents who become Canadian citizens are no longer permanent residents (Canadian Council for Refugees).

Racialized person/Racialized group: The Ontario Human Rights Code states that: “When it is necessary to describe people collectively, the term ‘racialized person’ or ‘racialized group’ is preferred over ‘racial minority,’ ‘visible minority,’ ‘person of colour,’ or ‘non-White’ as it expresses race as a social construct” (Ontario Human Rights Commission, 2005).

Refugee: A person who is forced to flee from persecution (Canadian Council for Refugees).

Refugee claimant: A person who has made a claim for protection as a refugee. This term is more or less equivalent to asylum-seeker and is standard in Canada, while asylum-seeker is the term more often used internationally (Canadian Council for Refugees).

SECTION 6 - REFERENCES

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APPENDIX 1 - CENSUS DATA

HISTORICAL OVERVIEW

Over the past 100 years, more than 13 million immigrants have arrived in Canada. Most came from Europe during the first half of the twentieth century. Later on, non-Europeans started arriving in larger numbers as economic immigrants or refugees, or as family members of previous immigrants.

By 1970, half of the immigrants were coming from Caribbean nations, Asia and South America. In the 1980s, a growing number came from Africa. During the 1990s, Canada continued to receive immigrants from Asia, the Middle East, Europe, Central and South America, the Caribbean, sub-Saharan Africa and the United States (Statistics Canada - Ethnic diversity and immigration, 2006).

Canada's visible minority population is growing much faster than its total population. Canada experienced a 25% growth in visible minorities from 1996 to 2001 versus a 4% growth in the general population.

According to the 2006 Census data, 28% of Ontario's population are immigrants (Table 1) (Statistics Canada - Immigrant population by place of birth, 2006).

Table 1 Immigrant population by place of birth

	Ontario – Number	Ontario – Percentage
Total population of Ontario	12,028,895	100%
Total – Place of birth other than Canada	3,398,725	28%
United States	106,405	1%
Central and South America	216,640	2%
Caribbean and Bermuda	211,380	2%
Europe	1,307,885	11%
United Kingdom	321,650	3%
Other Northern and Western Europe	209,610	2%
Eastern Europe	304,495	3%
Southern Europe	472,130	4%
Africa	164,795	1%
Asia and the Middle East	1,376,595	11%
West Central Asia and the Middle East	213,980	2%
Eastern Asia	417,985	3%
Southeast Asia	270,710	2%
Southern Asia	473,915	4%
Oceania and other countries	15,025	< 1%

Derived from Statistics Canada, 2006 Census - Immigrant population by place of birth

Mother tongue

Over one quarter of the population of Ontario (26%) reports a language other than French or English as a mother tongue, as can be seen in Table 2. The Chinese languages currently dominate the list of non-official languages, with Italian ranked second.

Table 2 Population by mother tongue

	Ontario – Number	Ontario – Percentage
Total population	12,028,895	100%
Single responses	11,853,565	98.5%
English	8,230,705	68.4%
French	488,815	4%
Non-official languages	3,134,045	26%
Chinese	482,570	4%
Cantonese	181,820	1.5%
Mandarin	75,335	.6%
Chinese, other	215,345	1.8%
Italian	282,750	2.4%
German	158,000	1.3%
Polish	140,890	1.2%
Spanish	160,275	1.3%
Portuguese	155,310	1.3%
Punjabi	152,645	1.3%
Ukrainian	48,310	.4%
Arabic	114,730	1%
Dutch	68,180	.6%
Tagalog (Pilipino)	117,365	1%
Greek	61,330	.5%
Vietnamese	67,150	.5%
Cree	3,495	<.1%
Inuktitut (Eskimo)	390	<.1%
Other non-official languages	1,120,655	9.3%
Multiple responses	175,330	1.5%
English and French	32,690	.3%
English and non-official language	131,290	1.1%
French and non-official language	7,790	<.1%
English, French and non-official language	3,565	<.1%

Derived from Statistics Canada, 2006 Census - Population by mother tongue

Greater Toronto Area (GTA)

It is worth focusing more closely on the demographics of the GTA as they are quite different from those of the rest of the province. If we look specifically at the City of Toronto, we see that this city accounts for 42% of all visible minority persons in Ontario. In 2006, nearly half of Toronto's population (47%) were visible minorities, up from 42% in 2001. It is important to note that, although visible minorities may not be newcomers, they may have a cultural background quite different from Caucasians and this becomes relevant to service provision.

Regional municipalities in the rest of the GTA have seen sharp growth in visible minority populations, increasing by 122% over the past decade. Among regional municipalities, the largest number of visible minority persons lived in Peel Region, where visible minority populations account for 50% of the total population. This is followed by York region, where 37% of the population identified themselves as visible minorities in 2006.

Some interesting figures also include a 780% growth in visible minority population in the City of Milton and 122% in the City of Aurora from 2001 to 2006 (City of Toronto, 2008).

Areas other than Toronto Metropolitan Area

Immigrants make up a sizable percentage of the population in many urban areas outside the Toronto Metropolitan Area (see Figure 1) and one quarter of recent immigrants have settled outside Toronto. Figure 2 also shows that although the numbers are smaller, most areas outside Toronto showed a higher growth in number of immigrants.

Figure 1 Immigrants as Percent of Total Population - Census Metropolitan Areas

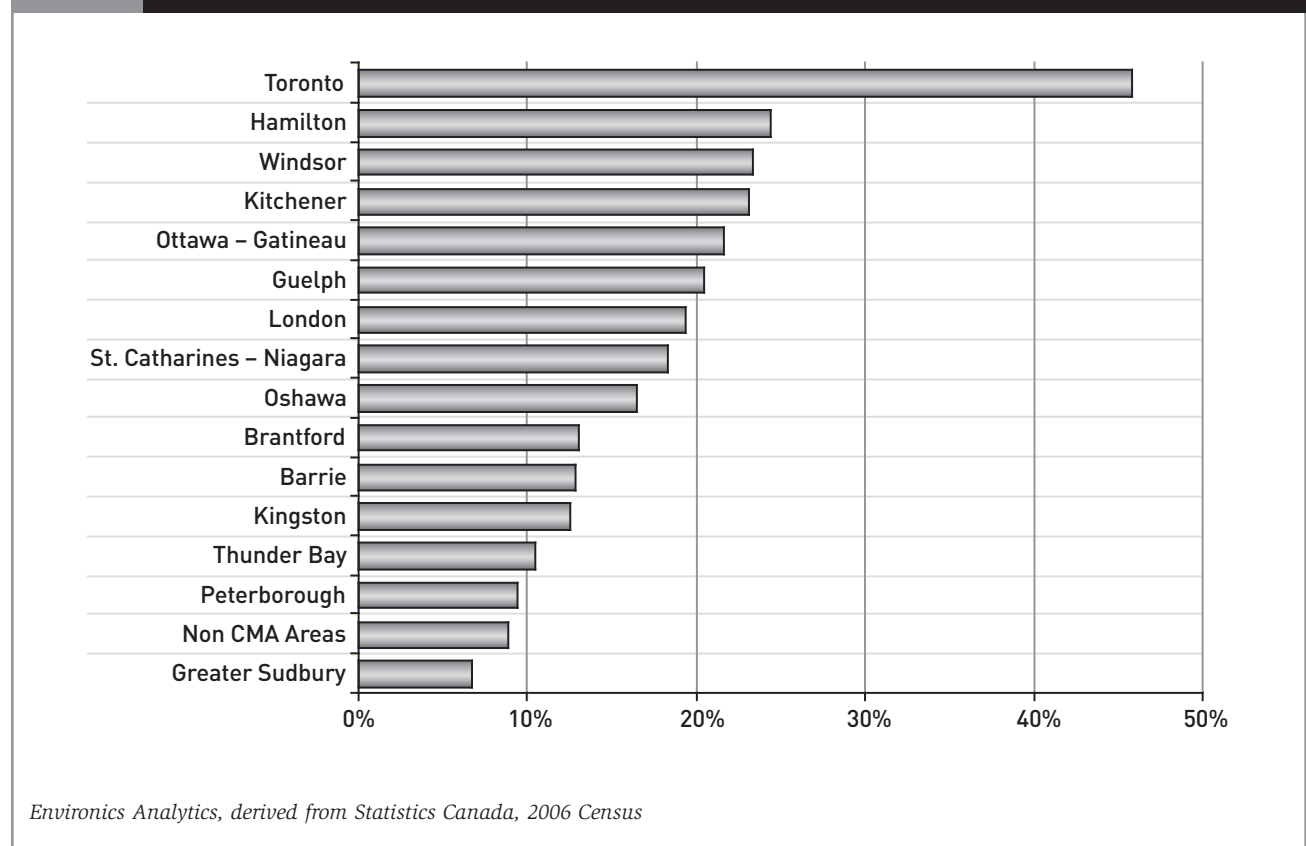
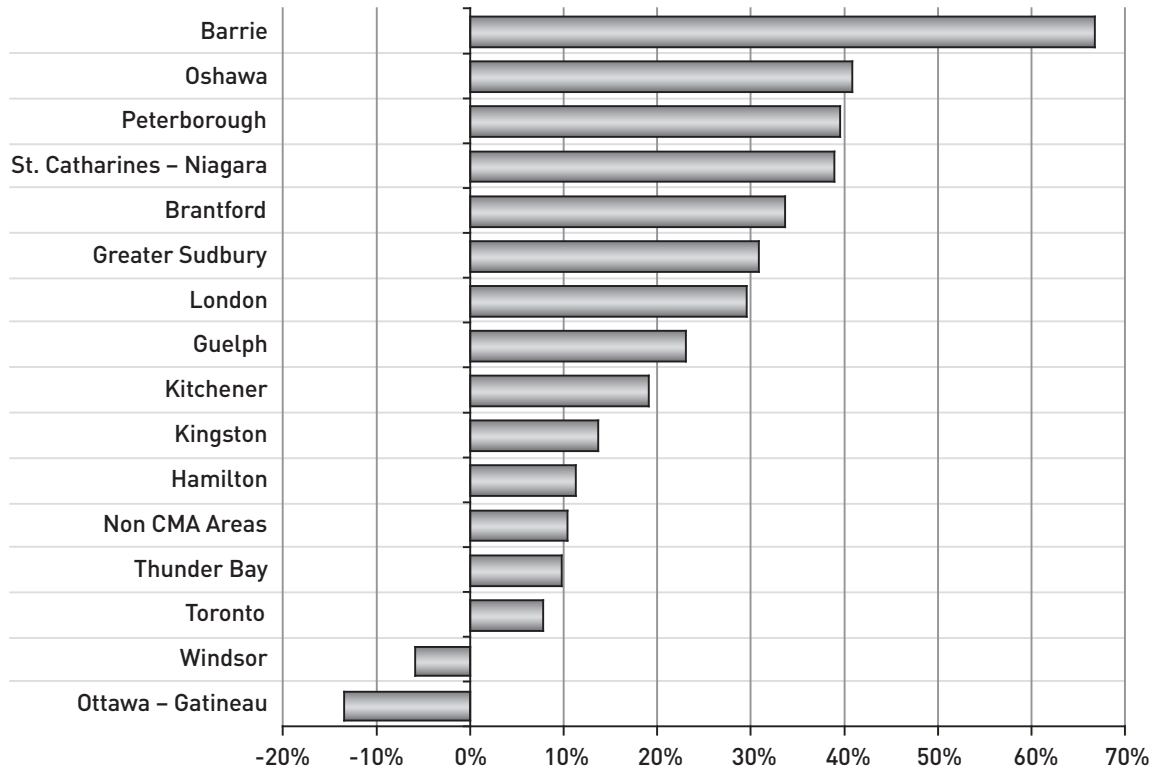


Figure 2 Percent Change in Number of Immigrants - 2001-2006 Compared to 1996-2001, Census Metropolitan Areas



Environics Analytics, derived from Statistics Canada, 2001 and 2006 Census

Religions

The main religions in Ontario are currently Catholic and Protestant, with approximately 10% of the population reporting belonging to non-Christian religions.

Table 3 Population by religion (2001 Census)		
	Ontario – Number	Ontario – Percentage
Total population	11,285,550	100%
Catholic	3,911,760	34.7%
Protestant	3,935,745	34.9%
Christian Orthodox	264,055	2.3%
Christian not included elsewhere	301,935	2.7%
Muslim	352,530	3.1%
Jewish	190,795	1.7%
Buddhist	128,320	1.1%
Hindu	217,555	1.9%
Sikh	104,785	.9%
Eastern religions	17,780	.2%
Other religions	18,985	.2%
No religious affiliation	1,841,290	16.3%

Derived from Statistics Canada, 2001 Census - Population by religion

Fertility Rates of Visible Minority Women

The following data from Statistics Canada, although national and not specific to Ontario, gives a snapshot of the fertility rates of visible minority women (Statistics Canada – The fertility of visible minority women in Canada, 2006).

In Canada, the fertility rate of visible minority women is higher than that of “White” women (Note: term used by authors; definition excludes First Nation, Metis and Inuit women). In 2000-2001, the rate was 1.70 for visible minorities and 1.51 for White women. Note that the total fertility rates of both groups are below the replacement level of 2.1.

It is interesting to note that there were larger fertility differences among the various visible minority groups than between total visible minority and White women (as depicted in Figure 3). The most fertile women were members of the Arab/West Asian and South Asian communities, with a rate of two or more children per woman. On the other hand, Korean, Chinese and Japanese women had lower total fertility rates than White women. Between the two different ends of fertility rates were Latin American, Black, Filipino and Southeast Asian women, whose fertility was close to the average for visible minority women.

Figure 3 Total fertility rate of visible minority groups, Canada, 2000-2001

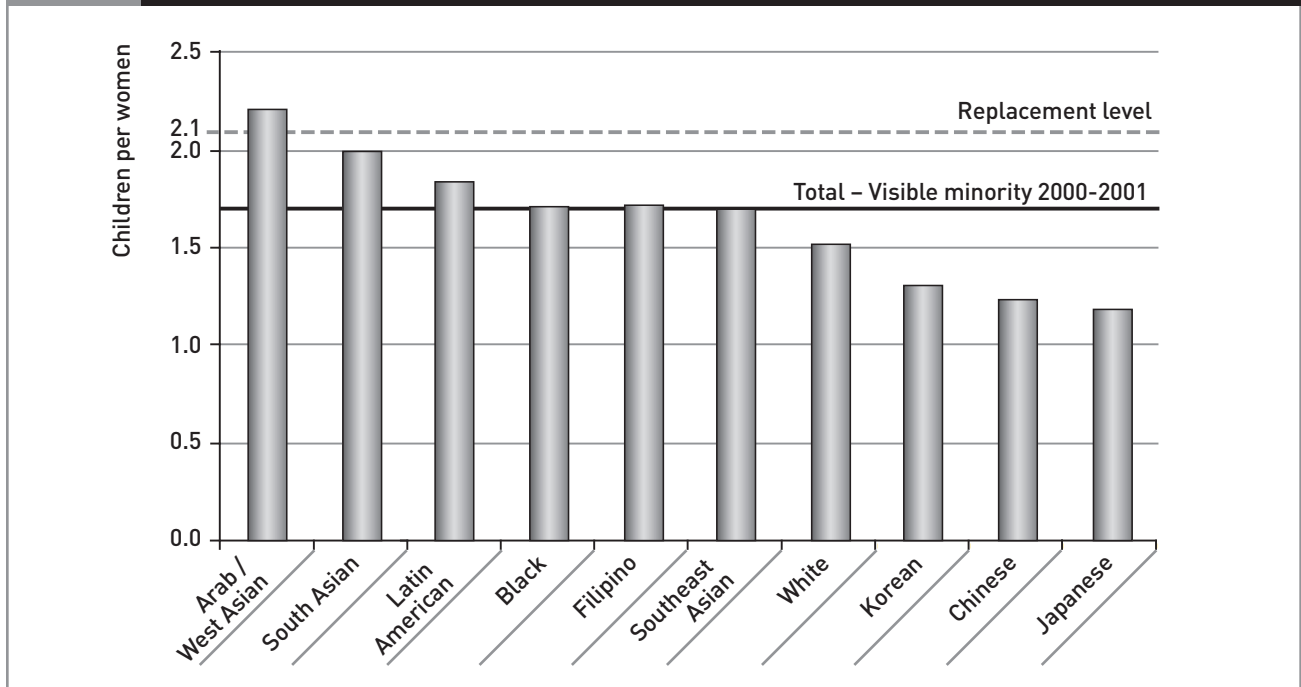
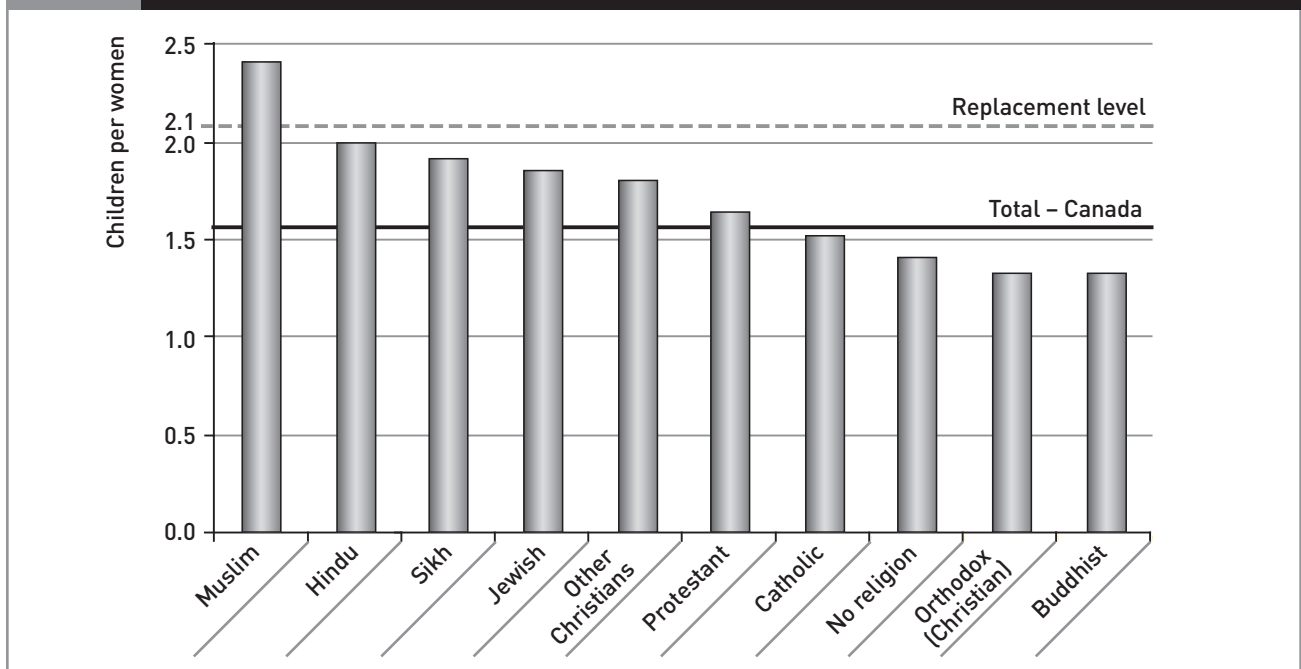


Figure 4 shows the fertility rates of major religious denominations in 2000-2001 and indicates that religious groups do differ in their fertility. The most fertile women were Muslims and Hindus, at 2.41 and 2.00 children per woman respectively. In contrast, Buddhists, Orthodox Christians and women with no religion had the lowest fertility rates at 1.34, 1.35 and 1.41 children per woman respectively.

Figure 4 Total fertility rate by religious denomination, Canada, 2000-2001

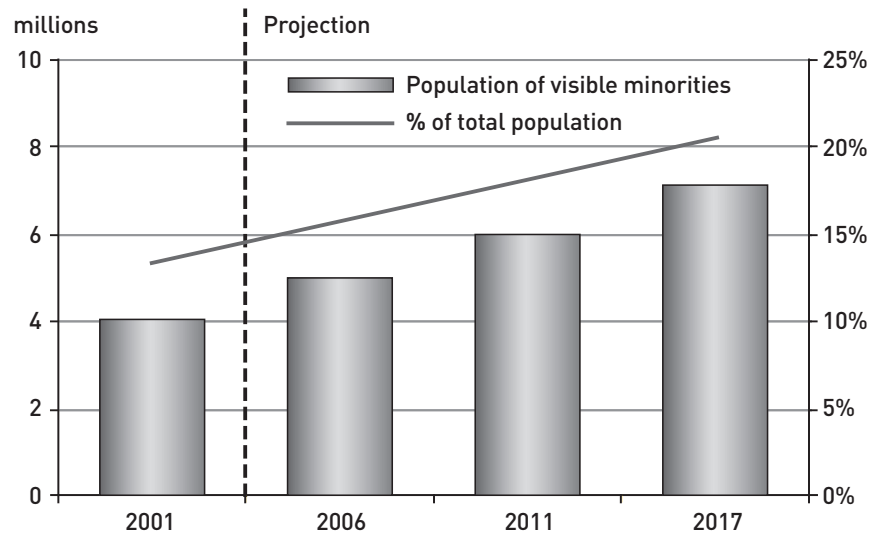


APPENDIX 2 - DEMOGRAPHIC PROJECTIONS

The following information is taken from Statistics Canada growth projections. In their report, various scenarios are explored, depending on the rate of immigration chosen by immigration authorities over time. A reference scenario is also described, which uses current trends (Statistics Canada – Population projections of visible minority groups, Canada, provinces and regions 2001-2017, 2005). It should be noted that visible minorities may not be newcomers; this information is helpful to give a sense of the different cultural backgrounds of the population.

Under the scenarios considered for these projections, Canada would have between 6,313,000 and 8,530,000 visible minority persons in 2017. This would be an increase of 56% to 111% from 2001, when their number was estimated at about 4,000,000. Under the various projection scenarios, roughly one Canadian in five (between 19% and 23%) would be a visible minority person (Figure 3). Under the reference scenario, Ontario would be the province with the fastest growing visible minority population in Canada, with an average annual growth rate of 4% between 2001 and 2017.

Figure 3 Growth of visible minorities in Canada

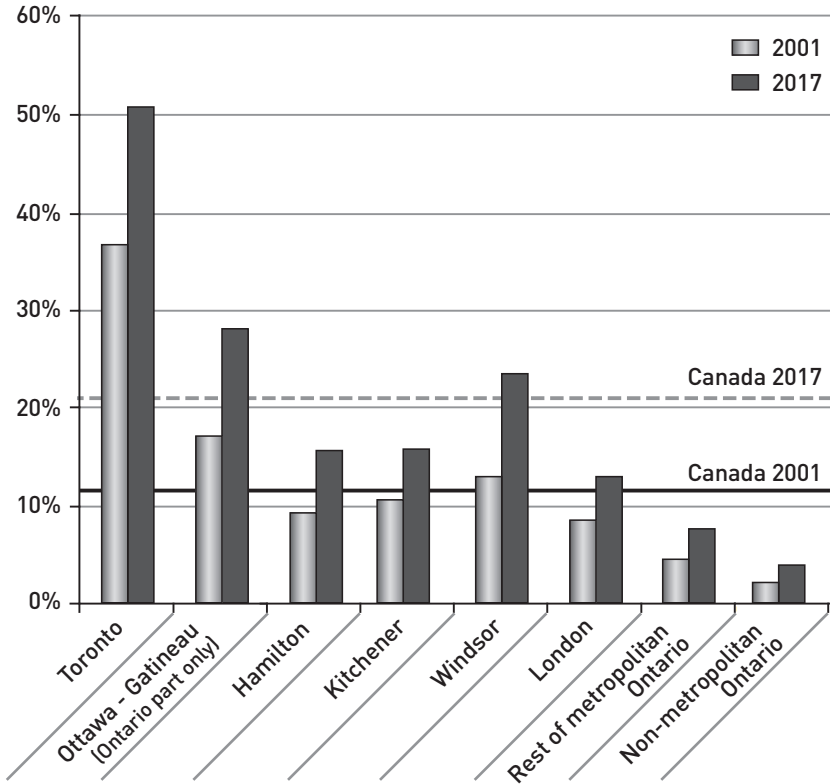


Note: Projections are based on a scenario that uses trends observed in the 2001 census and preceding years.

Source: Statistics Canada, Catalogue no. 91-541-XIE.

As seen in Figure 4, the following Ontario cities would have a higher percentage of visible minority persons than the national average: Toronto, Ottawa and Windsor. The cities of Hamilton, Kitchener and London would also have a high percentage of visible minorities. In 2017, more than half the population of the metropolitan Toronto area would belong to a visible minority group under four of the five scenarios.

Figure 4 Proportion (in percent) of visible minority population among the total population by region, Canada, 2001 and 2017, reference scenario



Statistics Canada, Demography Division

Under the reference scenario, by 2017, the largest ethnic communities in Ontario would be from the Chinese and South Asian communities who would comprise half of all the racialized groups. The Black (African/Caribbean) communities would form the third largest group.

The continued changing demographic necessitates that individual and collective participant perceptions and current policies, practices and procedures be reviewed with the goal of enhancing the inclusion and advancement of the health and presence of cultural/visible minorities in the health care system (The Montreal Children’s Hospital - McGill University Health Centre, 2007).

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