Domestic/intimate partner violence in the lives of immigrant women: a New Brunswick response

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Abstract

Objectives This article highlights barriers in accessing public services for domestic and intimate partner violence (D/IPV) from the perspectives of immigrant women and service providers in the province of New Brunswick. Addressing these barriers can assist in building capacity among immigrant women to talk about D/IPV; increase awareness and facilitate the use of public services by immigrant women experiencing D/IPV; and improve collaboration among D/IPV service providers in different sectors.

Methods The study is based on social determinants of health and intersectional theoretical frameworks. Semi-structured interviews and focus group discussions were conducted with immigrant women and public service providers, representing the province's linguistic and geographic (rural/urban) diversity. Qualitative data were coded thematically. Common and disparate themes between immigrant women and service providers were identified.

Results Common themes include lack of understanding, the complexity of the intersection of D/IPV and Canada's immigration framework, and issues of trust. Disparate themes include differences in cultural values, the lack of collaboration between different types of service provision, and financial issues. Recommendations are made to mitigate structural barriers and increase collaboration.

Conclusion Acknowledgement and better understanding of the cultural differences between service providers and immigrant survivors of D/IPV would go a long way to improve trust and break down barriers in communication. Revision of the New Brunswick Woman Abuse Protocols will highlight the perspectives of immigrant women. Long-term and increased funding for D/IPV and settlement public services will ensure that women-centered programming and professional translation services are available and improved collaboration takes place.

Résumé

Objectifs Présenter les obstacles à l'accès aux services publics en lien avec la violence domestique et la violence envers la partenaire intime (VD/VPI) du point de vue des immigrantes et de celui des dispensateurs/trices de services dans la province du Nouveau-Brunswick. L'abolition de ces obstacles pourrait renforcer les capacités des immigrantes à parler de la VD/VPI, leur faire connaître les services publics en lien avec la VD/VPI et en faciliter l'utilisation, et améliorer la collaboration entre les dispensateurs/trices de services de VD/VPI de différents secteurs.

Méthode L'étude est fondée sur les cadres théoriques des déterminants sociaux de la santé et de l'intersectionnalité. Des entretiens semi-dirigés et des groupes de discussion ont été menés avec des immigrantes et des dispensateurs/trices de services publics représentatifs de la diversité linguistique et géographique (rurale/urbaine) de la province. Les données qualitatives ont été codées par thème. Les thèmes communs et divergents entre les immigrantes et les dispensateurs/trices ont été recensés.

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Résultats Les thèmes communs sont le manque de compréhension, la complexité de l'intersection entre la VD/VPI et le cadre d'immigration du Canada, et les problèmes de confiance. Les thèmes divergents sont les valeurs culturelles différentes, le manque de collaboration entre les différents modes de prestation de services et les questions financières. Nous formulons des recommandations pour atténuer les obstacles structurels et accroître la collaboration.

Conclusion Une reconnaissance et une meilleure compréhension des différences culturelles entre les dispensateurs/trices et les immigrantes ayant survécu à la VD/VPI contribueraient beaucoup à améliorer le lien de confiance et à abolir les obstacles sur le plan des communications. La révision des *Protocoles relatifs à la violence faite aux femmes* du Nouveau-Brunswick mettrait en lumière les perspectives des immigrantes. Le financement accru et à long terme des services publics d'établissement des immigrants et de lutte contre la VD/VPI assurerait la disponibilité de programmes axés sur les femmes et de services professionnels d'interprétation, ainsi que la mise en place d'une meilleure collaboration.

Keywords Domestic violence · Intimate partner violence · Immigrant women · Multicultural services · Social determinants of health

Mots-clés Violence domestique · Violence envers lepartenaire intime · Immigrantes · Services multiculturels · Déterminants sociaux de la santé

Introduction

In its Strategy on Crime Prevention and Reduction, the New Brunswick provincial government indicates that domestic and/or intimate partner violence (D/IPV) occurs “when a person who is currently or previously in an intimate personal relationship uses abusive, threatening, harassing or violent behaviour as a means to psychologically, physically, sexually or financially coerce, dominate and control the other member of the relationship” (Government of New Brunswick 2012). Data on police-reported violence against women shows that New Brunswick has the highest rate of police-reported violence against women in Atlantic Canada (45% of which is some form of D/IPV) (Sinha 2013). New Brunswick also has the highest rate of women killed by intimate partners of any other Atlantic province. Saint John and Moncton have the second and third highest rates of police-reported violence against women of all Canadian cities. However, D/IPV remains one of the most under-reported crimes.

D/IPV is one of three foci in the New Brunswick government's efforts to reduce and prevent crime and improve the quality of living for all. Members of the Violence against Immigrant and Visible Minority Women research team at the Muriel McQueen Fergusson Centre for Family Violence Research at the University of New Brunswick have identified some of the barriers that immigrant women living with D/IPV encounter when seeking help from public service providers. Addressing structural barriers in accessing public services for D/IPV can be one step towards ensuring that the province's strategic response to crime takes into account the particular public health needs of this growing minority.

Social determinants of health

In considering the issue of D/IPV as experienced by immigrant women in New Brunswick, we felt it important to look at those structural factors that may influence individual experiences. The social determinants of health “are the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole.” (Raphael 2009) The social determinants of health reflect the quantity and quality of resources made available by a society to its members (Raphael 2016). They help to predict outcomes, identify vulnerabilities, and provide a starting point for addressing health as a social concept. Based on qualitative data collected in New Brunswick, we focus on the following most salient determinants of health for immigrant women who have experienced D/IPV.

Gender When discussing D/IPV, it is common to assume that violence-based events affect only women, however we know that when D/IPV is present in a family, all members of that family can be adversely affected by the events. While women can be perpetrators of violence in families, they are far more likely than men to experience gender-based violence (UNWomen 2016). They are more likely to be economically dependent on men and have children who are dependent on them. Immigrant women are more likely to be isolated because of their role within the family, the cultural understanding of that role, the distance and access to family supports, and language barriers (Delara 2016). Immigrant men are provided with opportunities to integrate through school, work, and social activities with other men; many immigrant women, on the other hand, are isolated by virtue of their responsibilities in the home, dedication to their husbands' needs, and the lack of affordable childcare facilitating their becoming employed

(Sethi 2013). Immigrant women have been identified as an isolated population within Canadian health interventions (Oxman-Martinez et al. 2000).

We do not have empirical evidence that immigrant women are more likely to experience D/IPV than non-immigrant women in Canada. In fact, based on the analysis of Statistics Canada self-report survey data on D/IPV, Brownridge suggests that immigrant women from industrialized countries may have lower rates of D/IPV compared to Canadian-born women and women from developing countries (Brownridge 2009). In analyzing data from the 2009 General Social Survey on Victimization, Du Mont and Forte found that immigrant women who have already spent more than 20 years in Canada are significantly more likely to report an experience of abuse than either immigrant women who have spent less than 20 years in Canada or Canadian-born women (Du Mont & Forte 2012). Given these contrasting findings, it is unclear which factors distinguish immigrant women's experiences of D/IPV from those of non-immigrant women.

Qualitative research has identified some of the unique vulnerabilities that immigrant women face in situations of D/IPV. Canadian immigration policies concerning principal applicants can force immigrant women into positions of social dependency on their husbands (Mosher 2009). Policies concerning family member sponsorship also exacerbate vulnerabilities. Abusive husbands can threaten to withdraw sponsorship of their wives—a tactic used to force them to stay in an abusive relationship even though this not legally possible (Canadian Council for Refugees 2016). While victimized refugee claimants and women with precarious status have the right to apply to remain in the country on humanitarian and compassionate grounds, they often need legal assistance in gathering evidence for their application and the process is lengthy and costly (Mosher 2009). Language barriers, a mistrust of police (originating in the country of origin), and racism among public service providers (Fong 2010) can prevent immigrants from seeking help and safety when D/IPV occurs.

Culture The hierarchical ordering of gender is a central feature of patriarchal societies and a variety of patriarchal structures exist among cultures which differ according to ideologies and values. Many immigrant women come from cultures in which collectivist values are supported by state, religious, and ethnic ideologies which privilege men's power. This is in contrast to Canadian society in which secular individualism tempers patriarchy. In Canada the value of the individual is promoted by state ideology, public policy is used to bolster women's agency, and the legal system can hold men accountable for the abuse of power in families. Many immigrant women obey male authority without question for the sake of the family (Kids new to Canada 2017). The cultural traditions of immigrant women

play a significant role in divergent perceptions of what behaviours are considered as constituting D/IPV. Cultural practices may be a source of empowerment and resiliency for immigrant women or they may increase vulnerability to abuse (LeBrun et al. 2015). Further, culture is central to the way that people communicate healthcare needs (Iwelunmor & Airhihenbuewa, 2017). Complications, such as lack of trust, arise when immigrant women experiencing D/IPV discuss their families with service providers due to the distinct difference in each other's understanding of domestic violence; ultimately becoming one of the barriers to accessing care.

Social exclusion According to the World Health Organization (Popay et al. 2008), social exclusion occurs when there are power differentials that cut across economic, political, social, and cultural factors. This power imbalance results in some people, in this case women, having less access to resources, capabilities, and rights. Social exclusion can eventually result in health inequities. For the women in this study, language barriers, cultural values based in patriarchy and collectivism, and not having their usual support system nearby, due to the migration experience, result in feelings of isolation and social exclusion.

Objectives of the project

A Community Coordinated Response to D/IPV Experienced by Immigrant and Newcomer Women in New Brunswick is a Status of Women Canada-funded project currently underway. We are seeking to enhance the capacity of New Brunswick immigrant women to share their stories about D/IPV and connect with each other; to build bridges of understanding and information sharing between D/IPV and immigrant service providers and immigrant women; to increase the understanding of the complex issues surrounding D/IPV among immigrants; and to produce coordinated community response tools to strengthen the collaborative work among stakeholders, ensuring coordination and sustainability after the project's completion. The outcomes of the project will respond directly to the objectives and contribute to improving immigrant women's health through better understanding of and responses to their experiences of D/IPV.

Methods

We used an intersectional theoretical framework to uncover the barriers to accessing and receiving public services when experiencing D/IPV as an immigrant woman in New Brunswick. Intersectionality is an approach based on feminist scholarship that recognizes the substantive threats of

discrimination based on overlapping identities. These identities influence the experiences of women in such a way that we must consider the role of gender, race, and class as the basic intersecting oppressions (Crenshaw 1989). Further, the intersectional approach reflects the simultaneous effects of these and other intersecting oppressions that compound the complexity of systemic barriers for abused immigrant women.

The project's activities are provincial in scope. Specific communities were selected as pilot sites that represent the diversity of the immigrant population in New Brunswick, a cross section of the province based on population density and language (urban vs. rural; English vs. French), and have existing capacity and relationships with the multicultural associations in the regions chosen.

We began the project with a needs assessment in the three pilot sites during which we gathered information from D/IPV and settlement service providers and immigrant women to help the project team better understand immigrant women's perceptions of D/IPV and to identify collaborative strategies to reduce and/or eliminate D/IPV against immigrant women. After obtaining approval from the Research Ethics Board at the University of New Brunswick, data were collected through interviews and focus groups with immigrant women and public service providers.

We conducted seven focus group discussions with administrators and service providers, totaling 54 individuals from 46 different organizations (18 Anglophone and 28 Francophone), one focus group with 12 immigrant women, and six individual interviews with immigrant women. The invitation to immigrant women did not focus solely on those who had experienced D/IPV but the sample includes survivors. The interviews took place at a location of the participant's choosing and were audio-recorded. An interview guide was used to help structure the discussions. Immigrant women were asked about their understanding of D/IPV, barriers to accessing help, services that they are aware of, and services that they would like to see available. Focus group discussions were organized to include as many immigrant and D/IPV service organizations in the pilot sites as possible and included questions about service providers' experiences working with immigrant women, their perceptions of barriers to services, opportunities and challenges for collaboration, and training needs.

The digital recordings were transcribed and the data coded individually by researchers on the project team who identified themes. Regular team meetings ensured that there was agreement about the themes. The themes were divided into two major groups: the common themes between immigrants and service providers and those that were clearly disparate. What follows is a description of the common and disparate themes followed by recommendations that can contribute to

improvements in community-coordinated responses to D/IPV among immigrants in New Brunswick.

Findings

Common barriers to a community-coordinated response to D/IPV identified by immigrant women and public service providers are differing understandings of the nature of D/IPV, the complexity of the intersection of D/IPV and Canada's immigration framework, and issues of trust.

Understanding between immigrant women and public service providers is an essential element of a community-coordinated response to D/IPV among immigrant women in New Brunswick. Due to cultural and religious differences, immigrant women have different understandings of what constitutes D/IPV than Canadian-born domestic violence service providers. The latter understand D/IPV as a public social problem and, working from a feminist framework, attribute the roots of D/IPV to male power and control, including structural gender inequalities. The majority of domestic service providers who participated in the research are Canadian-born and unfamiliar with the culturally diverse backgrounds of the newcomer population in the province. Immigrant women generally understand D/IPV as a private problem between a husband and wife that they would only talk about to close family members. D/IPV was usually described as physical violence, although emotional abuse was mentioned. If women speak to relatives about D/IPV, they are usually advised to endure, make sacrifices, and keep the family together for the sake of the children. There is also pressure from women in their cultural and religious social networks not to expose either their families to the stigma associated with D/IPV or the ethnocultural minority group to critique by the Canadian majority. Some women shared that they are using immigration to Canada for the purposes of furthering their children's education while their husbands remain abroad as a means of coping with D/IPV. Immigrant women want the violence and abuse to stop but they want to retain their cultural and religious identities and support networks. It will take patience and better understanding of the growing ethnocultural diversity on the part of domestic violence service providers to accompany immigrant women as they reshape their identities and practices in ways that can lead to safety.

The journey towards identifying and disclosing D/IPV in their families in a new society is hindered for immigrant women by language barriers. Disclosure of D/IPV and seeking help is a difficult process for any woman, a process which benefits enormously from conversations with other victims/survivors (Profitt 2000). However, this process is that much more challenging when immigrant women are learning to communicate

with one another and with service providers in a new language. A service provider shares her experience:

It was still another nationality and even their English was very heavily accented. I couldn't really tell if she understood. We had to really double-check words to make sure they understood. Sometimes the phrases aren't the same, the meaning of the word can be very different in their language. I discussed with the social workers and she said that in their culture, violence means something different. For them, doing [certain] things is trivial (French Focus Group #3, Participant #1).

In this quote, forms of emotional abuse are considered trivial by some immigrant women. Barriers to communication also make it difficult for domestic violence service providers to explain the range of behaviours that constitute abuse as well as the extent of the problem of D/IPV among Canadian-born women to immigrant women.

Furthermore, some immigrant women are unable to access government-funded language classes due to their responsibilities for young children, employment, or if their husband is an international student. Others are prevented from attending language classes by abusive husbands. Immigrant women survivors of D/IPV who seek public services, and those service providers who are trained to help them, need affordable access to professional interpreters. Interpreters also need training in the importance of maintaining confidentiality when working in situations of D/IPV, whether that work takes place in a hospital, shelter, or courtroom.

The reality of Canada's immigration framework is complex, to say the least. There has been a great deal of change to immigration policies in recent years, making it difficult for many immigrants to understand their status at particular points along the pathway towards citizenship. Federal, provincial, and territorial governments share the power for the selection and admission of immigrants (Baglay 2012). For example, the Provincial Nominee Program (PNP) enables provinces to select immigrant applications for nomination. Immigrants can apply for the PNP and permanent residency either from outside the country or from within after they have entered on a temporary permit, such as those granted to foreign workers or international students. The PNP principal applicants can include their spouses and children as dependents on the application to the provincial government. After selection for the PNP, nominated applicants then apply to the federal department of Immigrants, Refugees, and Citizenship Canada for a permanent resident visa. If granted, permanent residents have to live and pay taxes in Canada for at least 4 years and then pass a citizenship test before obtaining full citizenship.

The complex pathway towards citizenship is compounded in situations of D/IPV when an abusive husband uses his wife's immigration status as a means of control. For example, "That's the worst type of intimidation that can be used against women, by taking their documents, like passports" (Interview #2). Many domestic violence service providers in New Brunswick indicated that they do not know what to do in these cases. When immigrant women do not have documentation of their citizenship status, some domestic violence service providers are concerned that in providing shelter to potentially illegal immigrants they are breaking the law. This is not true but misinformation and mistrust remains. Immigrant settlement workers are much more familiar with the immigration policy landscape but are unsure of best practices in cases of family violence.

The lack of understanding between immigrant women and public service providers magnifies feelings of distrust. Because of experiences from their country of origin or from other public services they have accessed since arriving in Canada, abused immigrant women do not trust that their needs will be adequately addressed by D/IPV service providers. In a focus group discussion, an immigrant woman shared, "In my country many women can't call police. If police come, many times they just give them time, ok, 'You should understand each other, or you should sleep.' ...The police talk about what happened, but it's not real help" (Immigrant Focus Group #1, Participant #4).

Recent increases in the number of immigrants choosing to settle in New Brunswick has led many local-born citizens to fear that immigrants are taking away jobs. Anti-immigrant sentiments hover just below the surface of polite conversation. Structural racism influences the attitudes of public service providers. Domestic violence service providers lack an understanding of the vast range of cultural and religious practices and values of newcomer immigrant women. Unintentionally or intentionally, ignoring meaningful practices and values means failing to harness the potential resources that immigrant women could draw upon in the journey to well-being. Without trust on both sides, it is difficult to work towards improving services and ensuring the safety of immigrant women experiencing D/IPV. In contrast, immigrant women develop relationships of trust quite readily with immigrant settlement service workers, some of whom are from visible minority groups, as well as with other immigrants they meet when accessing language training or employment counseling. Trust is absolutely necessary for immigrant women to disclose situations of D/IPV outside the privacy of the family and seek help from those trained in best practices.

The disparate themes were identified by virtue of the stark differences found in the experiences of both the immigrant women and the various service organizations. The themes

include differences in cultural values, collaboration between different types of service provision, and financial issues. Women from different cultural backgrounds have different values. It seems ridiculous to have to say that not all immigrant women think alike or have the same values, religions, or cultural norms, but it is vitally important that people working with this population ensure that they consider this phenomenon. As new immigrants, women may not understand Canadian relationship ideals of autonomy and interdependency in the same way that non-immigrant Canadians do. These remain unrealized ideals given that Canadians continue to experience D/IPV at alarming rates (Sinha 2013). Immigrant women want to hold onto some of their cultural values as they transition to their new home. The values of motherhood and self-sacrifice play an important role in being able to understand how immigrant women make sense of D/IPV and why they may be hesitant to discuss, or even disclose incidents of D/IPV to service providers.

One example of differences in cultural values concerns women's identities. The importance of family and social networks emphasized by the immigrant women who took part in the needs assessment is an indication that their identities are primarily rooted in collectivist values. For many immigrant women, collective identities as mothers, wives, and daughters come before their individual identities. One woman described the reality of her collective identity, "My house was open... for... receptions; people every day for dinners—15 to 20 people, that is everyday" (Interview #1). In her home country she was able to rely on paid staff to meet her social obligations. The challenges of the immigration and settlement process increase immigrant women's dependence on the nuclear family. They are reluctant to focus on their personal well-being but put their efforts into keeping the family together. This phenomenon is in contrast to the emphasis on individual identity upon which the contemporary model of D/IPV service provision is based. D/IPV interventions which focus on dividing up the family or working with immigrant women in isolation from their families and networks are problematic. This situation challenges the prevailing models of D/IPV intervention in New Brunswick, which include safety planning that focuses on exiting the home and involving the police.

The focus group sessions with service providers provided valuable information about the lack of collaboration between immigrant settlement services and domestic violence services. It is not due to a lack of desire on the part of agency workers, but more likely due to the fact that all public service agencies are under-resourced, staff feel over-worked, and there is a high turnover in agency staff. In some cases, the focus group sessions conducted by the project team constituted the first time that the workers from different service agencies in the same city had met. They were clearly interested in having an opportunity to get to know one another and obtaining information about the types of services their counterparts provided. In

meeting a woman from the multicultural agency in a rural region during the needs assessment, a domestic violence outreach worker said, "I had not been aware that [she] is the new ED of the Multicultural Centre and I thought, 'Oh, that's good, I wonder who she is?'" (English Focus Group #1, Participant #1). However, less than a year after the needs assessment was completed, we observed changes in staffing in many agencies. It is difficult to sustain coordination and collaboration with high rates of staff turnover.

Service providers indicated that real collaboration was important to practice, not just talk about. The director of a family crisis centre said, "I think everyone loves the idea of collaboration and we talk about it...but the challenge is how we can do that in a concrete way and in a trauma-informed way" (English Focus Group #3, Participant #2). Domestic violence workers emphasized that when an immigrant woman discloses a situation of D/IPV, it is important that she not have to repeat her story again and again to different public service providers—a suggestion that highlights the complications of maintaining confidentiality. Service providers want to work out the logistics of sharing confidential information between agencies in a city or region so that victims of D/IPV are not re-traumatized in the process of accessing multiple public services.

Both the immigrant women and public service providers involved in the needs assessment spoke about financial issues, but in different ways. Financial stability for immigrant families is a primary concern and access to the primary labour market in New Brunswick is important. Jobs in the primary labour market—those requiring higher skills and which result in higher wages—are very difficult for immigrant women to obtain, regardless of their credentials. Many immigrant women are pushed into the secondary labour market of precarious work with lower wages (Sethi 2013). Labour market segregation in New Brunswick is racialized and gendered, putting immigrant women at a distinct economic disadvantage (Holtmann & Theriault 2017). Financial dependency on their husbands can make immigrant women more vulnerable in situations of D/IPV. One immigrant woman shared that her ex-husband was not transparent about money and she did not know his salary, yet he insisted that she give him detailed information about her financial situation. She considered this a form of abuse (Interview #3).

The issue of the under-funding of public services is not a surprising finding. Staff in New Brunswick public service organizations and agencies in the immigrant settlement and domestic violence sectors have little core funding and feel that they are pushing current resources to the limit. They do not have funds for working on collaborative projects concerning immigrants and D/IPV. The need for gender-specific programming in immigrant settlement services in New Brunswick has been identified elsewhere (Theriault & Haan 2012); likewise, the need for cultural competency training for domestic

violence service providers has been addressed (Holtmann 2016). Increased collaboration between the two sectors makes perfect sense, but may require additional funding for coordination in the early stages.

When considering the issue of D/IPV and immigrant women, it is important to reflect on intersectionality theory and its relevant impact on the determinants of health. Intersectionality stemmed from the black feminist literature that pushed people to consider that it was one thing to be a woman and experience sexism but an entirely different thing to be both a woman and black (Viruell-Fuentes et al. 2012). These various identities create social locations for people that are additive in the layers of discrimination and oppression (McGibbon & McPherson 2011). The immigration process results in loss of social status by virtue of immigrant women not knowing anyone except their husbands. Immigrant women experience loss of income as a result of either not being able to work outside the house because of responsibilities for children or not being able to transfer professional credentials. These losses compound the stressors placed on the family. While domestic violence service organizations are fully aware of issues of sexism as experienced by clients, and multicultural service providers understand the effects of racism, what we are missing is the ability to collaborate in order to achieve a better understanding of the intersectionality of these disparate and important influences. As an example, domestic violence organizations need to understand that immigrant women do not want to jeopardize their immigration status by becoming a “bother” to the system, despite the fact that using the system will not impact immigration status. This study has highlighted how both gender and ethnicity impact the lives of immigrant women experiencing D/IPV. We believe that there are concrete ways to address these issues.

Recommendations for the future

As a result of analyzing the data collected from immigrant women and service providers around the province, we identified a number of areas where more work is needed to mitigate structural barriers and improve access to public services for immigrant women experiencing D/IPV in New Brunswick. The end goal of providing accessible services for immigrant women experiencing D/IPV is ultimately to improve the psychosocial and physical health and well-being of a growing component of our population. Recommendations include but are not limited to the following:

Coordination and collaboration of services among providers. A lack of coordination among organizations exists at the community level along with a lack of understanding about how to help women from diverse cultures. The divide between immigrant settlement agencies and

domestic violence serving agencies and the problem of securing resources, both financial and human, to provide effective assistance and interventions for immigrant women experiencing D/IPV in New Brunswick further compound the problem. With the advent of greater coordination and collaboration among these service organizations, we believe efficiencies will be identified. Increased awareness of each service organization’s mandate by providers may support greater opportunities to provide seamless, trauma-informed assistance without duplicating or having gaps in service, ultimately allowing greater numbers of immigrant women to access the services and meet their needs.

Revision of the New Brunswick Women Abuse Protocols. The provincial Protocols were last updated in 2014 and include only a half-page of information that addresses working with diverse populations of women, including immigrants. As a result of the rich information we have received from our consultations with immigrant women, immigrant serving agencies, and domestic violence resources, we feel strongly that the New Brunswick Women Abuse Protocols should be updated to include a chapter that is reflective of immigrant women’s unique perspectives and the socio-cultural context that creates the intersecting barriers when seeking assistance following D/IPV.

Operationalization of the Women Abuse Protocols at the local level. As a result of our many interactions with immigrant women and service providers, we recommend that the Women Abuse Protocols be developed for serving immigrant women in the project’s pilot sites, and to other immigrant serving sites along with settlement and D/IPV serving agencies around New Brunswick.

Core funding for service organizations. Public service organizations and agencies in the immigrant settlement and domestic violence sectors have little core funding, pushing current resources to the limit. They find themselves unable to properly attend to the complex needs of clients because of the lack of time and funding. We have identified the need for increased coordination and collaboration, which can only be realized with stable funding. Providing long-term funding (more than 3 years) acknowledges the complexity of the D/IPV situation and demonstrates a commitment to providing culturally sensitive services.

Women-centric focus on activities for immigrant women. A resounding message received in our conversations with immigrant women is that many of them are not comfortable in social situations that include men. They would be more likely to attend activities or support groups if they knew it was for women only. The activities must be focused on the needs of the women, driven by women, and attended by women.

Last, *professional interpretation services*. A crucial service that should be available to immigrant women seeking services related to D/IPV is confidential interpretation services. These services have to ensure that staff have been professionally trained to provide interpretation in complex, sensitive, and potentially volatile situations.

Conclusion

Through consultations with immigrant women from multiple cultural backgrounds and personnel from immigrant settlement organizations and D/IPV service agencies in New Brunswick, we have identified systemic and intersecting barriers. These barriers create unique vulnerabilities for immigrant women dealing with D/IPV. By participating in the interviews and focus groups, immigrant women have gained experience in articulating their understandings and experiences of D/IPV without stigma. As a result of the identification of structural barriers to coordinated public services, we can contribute to revisions of the New Brunswick Women Abuse Protocols and their operationalization at the local level. Improved communication, ensuring the development of trust, long-term funding for public service agencies and organizations, and culturally sensitive service provision addressing the unique needs of abused immigrant women are necessary in working towards structural change. Structural changes in responding to D/IPV among immigrant women can have a positive impact on health outcomes. A better coordinated response in New Brunswick by multicultural and D/IPV service organizations working together with immigrant women will further reduce barriers and improve the services available to immigrant women experiencing D/IPV.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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