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Integration, Clarification, Substantiation: Sex, Gender, Ethnicity and Migration as Social Determinants of Women's Health

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Abstract

The aim of this paper was to examine, via a scoping review, how the literature focusing on immigrant women's health, based on selected criteria, has been able to capture not only sex and gender differences but also the other socially grounded determinants of health.

Using selected health databases as well as a diversity of keywords, a final sample of 59 was obtained after a number of steps to increase validity and credibility of the process were taken. Since "women" was one of the main keywords, all of the studies included women either by themselves (n=20/59) or along with men (n=39/59). In 34 (57.6%) of the papers reviewed, gender was defined above and beyond 'sex' (i.e. some discussion was provided regarding the social context of the study population prior to the presentation of the goal of the study). Ethnicity was merely mentioned without being expanded upon and at times being substituted with race in 26 (44%) of the papers reviewed. Migration was defined in 22 (37.2%) of the papers and was predominantly *operationalized* by length of stay in the country. While the concepts at hand represent important units of analysis within women's health research, most studies neglected to either capture gender specificities beyond sex as a biological variable, or to define migration experiences beyond ethnic identity.

Anchored within women's health scholarship seeking for conceptual clarity and accuracy, this paper pleads for an improved consideration of the multiple and interactive

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social and biological determinants of health, as well as structural conditions at the basis of structural inequities; If the production of socially grounded women's health research depends upon accurate, fully integrated and applied conceptualizations of relevant dimensions, how can this be facilitated by policy-makers, health research funding bodies, the researchers themselves and ultimately by health care practitioners?

Keywords: Gender, Ethnicity, Migration

Introduction

Many factors have been studied in terms of the influence they may have on health. These include economic, genetic and behavioural patterns, as well as physical and social environments and health systems (Adams, DeJesus, Trujillo & Cole, 1997; Agnew, 1996; Alexander, Patrick, Bovier, Gariaroo, Eytan & Loutan, 2003). Income, social support and housing, for example, have been shown to influence the physical and emotional well-being of individuals, neighbourhoods and communities (Allotey, 1998; Anand, 1999; Anand, Peter, & Sen, 2004; Blackford & Street, 2002; Boyd & Grieco, 2003). Such studies reveal a complex interrelationship between various factors that work together to determine health (Agnew, 1996; Allotey, 1998).

The concept of social determinants⁶ draws attention to social and economic circumstances which strongly affect the health of women, men, families, groups and populations. Hillary Graham argues that this concept should play a pivotal role in the development of programs and policies (Graham, 2004). Raphael (2004) also insists on health promotion programs and policies that move beyond biomedical and behavioural risk factor approaches, anchored in the perspective that the social gradient in health runs right across society. Such programs and policies should aim to decrease impairments in health while accounting for different levels of underlying social advantage.

A growing body of immigrant health research seeks to establish *sex, gender, ethnicity and migration* as social determinants of health (Aroian, 2001; Boyd & Grieco, 2003; Des Meules, Gold, Kazanjian, Manuel, Payne, Vissandjee, 2004; Dunn & Dyck, 2000; Dyck and McLaren, 2002; Hacking, 2005; Iglesias, 2003; Jolly, Reeves & Piper, 2003; Kazemipur, 2002; Krieger, 2004, 2005, 2006; Meadows, Thurston & Melton, 2001; Nazroo, 2003; Thurston & Vissandjee, 2005; Raphael, 2004; Vissandjée et al., 2001; Vissandjée et al., 2005; Weber & Parra-Medina, 2003). These concepts represent important units of analysis within women's health research. Their integration within gender-based research is essential to the future of socially engaged women's health research and policy (Anand et al., 2004; Krieger, 2005; Marmot, 2005; Ostlin et al., 2001; Pearle, Foliaki, Sporle & Cunningham, 2004; Spitzer, 2005; Status of Women Canada 2005-6; Weber & Para-Medina, 2003; Wilkinson & Marmot, 2003; WHO, 2005). This is particularly important in the field of public health, where traditional, bio-medically driven research strives to identify and operationalize so-called risk factors (environmental, social, psychological and behavioural processes and traits) while

⁶ Health Canada has identified 12 such determinants: income and social status; employment; education; social environments; physical environments; healthy child development; personal health practices and coping skills; health services; social support networks; biology and genetic endowment; gender; and culture (*Health Canada's Women's Strategy Ottawa: Health Canada, 1999, p. 13*).

ignoring relevant socioeconomic status differences in access and power (Weber & Para-Medina, 2003).

The aim of this paper is to explore, via a scoping review, how the literature has incorporated these factors in the past. The ultimate goal is to promote the systematic integration of well-defined, socially grounded concepts in further research, as it is produced, disseminated and used to improve women's health.

Background

Canada welcomes approximately 250,000 immigrants annually (CIC, 2005). While most early immigrants hailed from European countries, more recent immigrants have come from a far more diverse variety of nations (CIC, 2005). Throughout the mid-1990s, for instance, 57% of all immigrants were born either in Asia or the Middle East (Statistics Canada, 2004). Our ability to understand the dynamics of migration and to consider the individual needs and potentials of men and women – and their communities – is fundamental to the nation-building process (Laczko & Wijkstrom, 2004). It also affects our ability to develop and implement relevant and effective health care policies, services and practice guidelines.

In this pursuit, much depends on which social determinants of health are chosen to be incorporated into health research frameworks; how this is done; and how public policies respond to research findings and recommendations. Emphasising the social dimensions of health reconstructs health beyond simply a medical or behavioural issue and re-frames it as *also* a socio-economic and political one (Krieger, 2001, 2005; Raphael, 2004; Spitzer, 2005; Vissandjée et al, 2006; Walters, 2003; Weber & Para-Medina, 2003; Wilkinson & Marmot, 2003; World Health Report, 2005). Yet even to recognize the relationship between complex social processes and health outcomes, one must learn to bridge the research gap between the social and biological determinants that shape health (Smith, 2001).

Given the fluidity of population demographics, developing effective health policies remains a work in progress. The health and wellness of the increasingly diverse Canadian population requires that the scope, applications and trajectories of health research keep apace with current developments.

Methods

The lens employed in this analysis focuses on the social dimensions of immigrant women's health, in which sex, gender, ethnicity and migration are viewed as overlapping and dynamic health determinants. These factors are acutely felt in women's lives. Methodological tools are required that focus on how, and to what extent, these interacting dimensions are integrated into women's health research due to the special nature of gender-related complexities above and beyond biology, and migration experiences above and beyond ethnicity.

In order to substantiate the diverse experiences attributable to sex, gender, ethnicity and migration, however, not only are clear and substantial conceptualizations needed, but methodological frameworks capable of systematic, intersectional study design and analysis need to be either uncovered or devised. One example of such a direction is the bio-social framework projected by Castro & Farmer (2005), which, significantly, acknowledges the underlying course of poverty, racism, and gender

inequality in poor countries in order to understand and measure social factors that heighten the risk of HIV/AIDS in those countries.

We begin our exploration with a conceptual overview of the concepts analyzed, followed by an explanation of the scope of our review and findings. The discussion of these findings will, we hope, stimulate ideas for the development of more robust and integrated methodological frameworks.

Concepts under study

Sex and Gender

Though these concepts are familiar, given the scope of this review and challenges with respect to 'gender', they merit additional attention.

'Sex' generally refers to biological, sexual and reproductive distinctions between males and females. 'Gender' generally refers to the social norms, perceptions and meanings associated with being a woman or a man. It has been argued, however, that gender also has other impacts, including the distribution of resources and opportunities, power relationships, perceptions of capacities and interests, and ways of knowing and being (Dyck & McClaren, 2002; Kinnon, 1999; Krieger, 2001, 2003; The 10/90 Report, 2003, 2004; Rummens, 2001, 2003; Spitzer, 2003, 2005, 2006; Status of Women, Canada, 2005-2006; Walters, 2003; WHO, 2005).

The complexity and fluidity of these categories is another factor to be considered. In a number of societies, for instance, gender variation extends beyond the dichotomous pairings of male and female, and it is only fairly recently that gender as a 'social epidemiological' variable has received more systematic attention (Herdt, 1996; Macintyre, 1996, 2001; Rummens, 2001, 2003; Spitzer, 2005). Judith Butler sees gender as a "fluid variable," which shifts in diverse contexts and at different times, according to one's performance (Butler, 1990). This premise of "performance" has been criticized as it presumes a deterministic view of individuals and of the socialization process, ascribing a greater share of power to culture and society than to the individual (Benhabib, 1995b in Fiona, 2006). Similarly, numerous social scientists have challenged the notion of sex as a stable category, since it has attributes such as socio-economic position, age, ability, and sexual orientation, which may shift over time (Krieger, 1998, 2001, 2003, 2005; Laqueur, 1990; Ostlin et al., 2001; Oudshoorn, 1994; Walters, 2003).

As it stands, women's specific experiences and outcomes in the context of migration still tend to be obscured in health research, planning and provision, just as the opportunities and resources for women may be at risk during the migration experience (Hyman, 2001; Hyman, 2002; Hyman & Guruge, 2002; Laczko & Wijkstrom, 2004; Macintyre, 1996, 2001; MacKinnon, 2001; Noh, Beiser, Kasper, Hoh & Rummens, 1999; Noh & Kasper, 2003; Spitzer, 2005; Thurston and Vissandjée, 2005; Vissandjée et al., 2004; Wu., Penning, Schimmele, 2005)

Ethnicity

In the interests of clarity, we must also define ethnicity. This is complicated by the use of different variables used in various studies. Such variables include race, birthplace, language, religious affiliation, duration of residence in a given society, and the racial/national/tribal identity (or identities) of one's parents. (Agnew, 1996; Cooper, 2002; Cagnet, 2001; Kinnon, 1999; Krieger, 1998, 2003, 2005; Miediema, Baukje, &

Tastsoglou, 2000; Nazroo, 1998, 2003; Ng, 1999; Ver Ploeg & Perrin, 2004; Williams, 2002).

Additional complexity is added when one considers family lineage, due to the increasing fluidity of frontiers, creating transnational families (Beiser, 2005; Raman, 2006; Barry, 1999). Transnational families often must deal with separation and reunification as part and parcel of their migration process. They may also subscribe to diverse practices in relation to marital life, including raising children, kinship and economic management (Charsley & Shaw, 2006; Gardner, 2002). In addition, transnational marriages often transform practices and notions of gender resulting from marrying a migrant or joining a spouse overseas (Mooney, 2006).

Much like the perceptions, practices and norms accompanying gender concepts, definitions of ethnicity shift with time and place. Complicating matters is the fact that the term 'ethnicity' is often replaced, overlapped with, or used interchangeably with other terms, most frequently culture and race (Agnew, 1996; Fausto-Sterling, 2004; Hooks, 1990; Ostlin, George & Sen, 2001; Weber & Parra-Medina, 2003). Current globalization trends, internal migrations within countries and transnational migrations have further disrupted the notion that ethnicity (or race, or culture) should be grounded in a specific place, space or time (Gupta & Ferguson, 1997; Rummens, 2003; 2001).

The ongoing collection of scientific and health data using race as a category reify the notion that race is a fixed category accurately reflecting biological differences between groups of people – an assertion rejected by anthropologists and other social scientists ranging from France Boaz, in the early 20th century, to geneticists involved with the Human Genome Project (Anand, 1999; Fausto-Sterling, 2004; Graves, 2001; Harding, 1993; Krieger, 2001, 2005; Ostlin et al., 2001; Smedley, 2001). Racial categories, if deployed at all, must be articulated as social constructs situated within local social hierarchies. As Krieger argues, experiences of “discrimination, exclusion and exploitation are thought to have profound consequences for the economic and social well-being of women, particularly women belonging to marginalized racial or ethnic groups; specific consequences may ultimately be expressed as inequalities in health.” (cited in Cooper, 2002, p.694) Krieger cautions researchers against using “race,” on its own, as a category, since it may not encompass the complexities associated with cultural norms and values or ethnic affiliation. Race and/or ethnicity is also often used as a marker for socio-economic status, thereby eclipsing the intersections leading to social inequalities and further obscuring epidemiological mappings of factors which create health disparities (Anand, 1999; Krieger, 2001; Marmot, 2005; Nazroo, 1998, 2003; Spitzer, 2005).

Just as gender-sensitive women's health research takes the question of women's health beyond biology, likewise the complexity of using race, ethnicity or culture as determinants of health must go beyond purely biological or genetic analyses. By questioning and systematically deconstructing such complex variables, health researchers can and should contribute to conceptual clarity while reducing race/ethnicity/culture labelling and/or blaming.

Migration

Migration occurs within nation-states, across international borders, and between continents. Voluntary migration occurs primarily in pursuit of opportunities, such as education, employment or a higher standard of living. Involuntary migration tends to

occur in circumstances of socio-political conflict or natural disaster (Kazemipur & Halli, 2000; Kinnon, 1999; Newbold & Danforth, 2003; Noh et al., 1998; Noh & Kaspar, 2003; Renaud, 2003). Often, however, the difference is not so clear cut, making it difficult to determine where voluntary motivation ends and the involuntary one begins. Some women who migrate as family-class immigrants, for instance, may not have taken part to the decision to emigrate, while other such women may be motivated by a lack of employment opportunities in their country of origin. Political circumstances can also contribute to voluntary emigration before compelling women and men to flee their homeland as refugees. And, further to such events, family reunification may also trigger migration (Cooper, 2002; Dunn & Dyck, 2000; Hyman, 2001; Hyman & Guruge, 2002; Kawar, 2004; Kinnon, 1999; Laczko & Wijkstrom, 2004; Meadows et al., 2001; Ng, 1999; Noh et al., 1999; Noh & Kaspar, 2003; Oxman-Martinez & Hanly, 2005; Renaud, 2003, 2005; Spitzer, 2005; Thurston & Vissandjée, 2005; Vissandjée et al., 2001, 2004).

Migration represents a significant transition, with multiple long and short-term effects for all, including those left behind and those with whom immigrants come to live. These “effects” are typically described through terms such as acculturation, adaptation, assimilation and integration. Such terms often do not adequately address the pre-, per- and post migration experience, a process composed of multiple phases while including a number of decisions, challenges, ambitions and outcomes. These experiences are contained within porous and dynamic socio-cultural boundaries found in gender and inter-ethnic relations (Elliot & Gillie, 1998; Hyman, 2001; Hyman & Guruge, 2002; Jordan & Duvell, 2003; Kazemipur, 2002; Kessel, 1998; Kinnon, 1999; Nazroo, 2003; Noh et al., 1999; Noh & Kaspar, 2003; Renaud, 2003, 2005).

Scope of Review

Using selected health databases (Medline, Cinhal, Sociofile and PsychLit) and focusing on papers published between 1995 and 2004, combinations of keywords were used until evidence of recurrence was established (that is, until the same abstracts once again emerged). These keywords included: sex, gender, women, race, ethnicity, culture, migration, health, and access to health care.

In all, 779 abstracts were gleaned from the preliminary selection. Of these, 185 studies with the most combinations of keywords (limiting to sex, gender, ethnicity and migration) matching the query were retained, to ensure credibility. Additional keywords were then applied, such as acculturation, adaptation, integration, cultural values, and traditions, resulting in a final sample of 59. This sample included only papers which clearly outlined their research phases as well as whether they belonged to the qualitative or quantitative paradigm. Review papers were also retained. Studies focusing exclusively on pre, per and postnatal as well as child health were excluded. It should be noted that although both French and English language studies were included in the search, the final sample consisted only of English language papers.

The team members (n=5), representing the disciplines of sociology, women’s studies, nursing, medicine, and public health, conducted a two step, in-depth examination of the concepts at hand: first, the definition of each concept was searched for (ideally earlier in the paper than later); second, attempts by the author to discuss the complex nature of the determinants under study, as well as how they proposed to take such complexity into account, were identified. Finally, using a two or three-point scale (depending on the question), each reader independently ranked the adequacy in which each study defined

and integrated the concepts. Some of the criteria used to assess the adequacy of study concepts are presented in Table 1. For example, a paper was considered to have adequately defined gender if it was defined above and beyond sex, or at least one definition in that sense was provided within the paper. A paper was considered to have adequately integrated sex and ethnicity if both concepts were clearly defined and discussed in relation to each other.

Table 1

- How many concepts were addressed in the study?
 - Was a definition provided for each concept prior to reaching the goal and research questions/hypotheses underlying the study?
 - Were arguments put forth regarding the ‘intersectionality’ of the concepts at hand?
 - Was/were the concept(s) acknowledged in the results section?
 - Was/were the concept(s) acknowledged/discussed in the discussion in regards to the ‘intersectionality’?
 - Was/were the concept(s) addressed in the recommendations?
-

A few words of caution

The studies included in this analysis were limited to research papers available in selected databases, such as Medline, Cinhal and PsychLit. The grey literature as well as studies unavailable through these databases were not included. The papers which were part of the database at one point or another were dependent on the keywords that the authors proposed in their titles, abstracts and texts; this may have also limited cross-referencing capacity.

Results

A description of the 59 studies selected, including authors, country of publication and/or where the study was carried out, databases and/or study populations, research designs and research themes is presented in Table 2.

As can be seen, the studies were either published and/or carried out in North America, Europe, Australia and New Zealand. Databases included national surveys and more targeted population/community-specific studies. National surveys, which were typically population-based, included males and females, immigrants and, in some cases, a reference population of non-immigrants. Selected studies focused more specifically on refugee populations. Quantitative, qualitative and mixed designs were found, as well as review papers on women’s health.

Table 3 provides a breakdown of the number and frequency of studies in which following the author’s intent to address one or more of the concepts under study, the study adequately defined and/or integrated those concepts.

Table 3

Number of studies (n) which included a definition of the concepts under study (n= 59)

Concepts	n	%
Sex	59	100
Sex and Gender	34	57,6
Sex and Ethnicity	26	44
Sex and Migration	22	37,2
Sex and Gender and Ethnicity	17	28,8
Sex and Gender and Migration	15	25,4
Sex and Gender and Ethnicity and Migration	9	15,2

Because “women” was one of the main keywords, all of the studies included women either by themselves (n=20 out of 59), or along with men (n=39 out of 59). In 34 (57.6%) of the papers reviewed, gender was defined above and beyond ‘sex’ (i.e., some discussion was provided regarding the social context of the study population prior to reaching the goal of the study). Ethnicity was merely mentioned without being expanded upon and at times being substituted with race in 26 (44%) of the papers reviewed. Migration was defined in 22 (37.2%) of the papers, and was predominantly *operationalized* by length of stay in the country. To sum up, most studies neglected to capture gender specificities beyond sex as a biological variable, or to define migration experiences beyond ethnic identity.

Reviewers also determined whether authors had provided some discussion of the integration of two or more concepts relevant to women’s health. A three-tiered analysis was conducted in this regard. First, papers were reviewed for an attempt to integrate two concepts, such as sex and gender, sex and ethnicity, or gender and migration. For example, Sundquist et al., (1998) in a population-based study, integrated the concepts of sex and ethnicity, as well as gender and migration, in order to investigate the quality of life and health in young to middle aged Bosnian female war refugees. Ostrove et al., (2000) used a similar integration approach to look at the association of socioeconomic status and self-rated health among an ethnically diverse sample of pregnant women.

Second, papers were examined that attempted to integrate three study concepts, such as sex, gender and ethnicity or sex, gender and migration Cornelli et.al., (2002),

for example, in a study examining the factors hindering women of colour from obtaining preventive health care integrated sex, gender and ethnicity, among other variables (race, location and region of residence, insurance status, income level, education level, perceived health status and perceived discrimination). In Research conducted by Rianon & Shelton (2003) to explore perceptions of spousal abuse expressed by married Bangladeshi immigrant women in USA has also enhanced the integration of these concepts. Liamputtong and Naksook (2002) integrated the concepts and investigated the perceptions and experiences of motherhood, health and the husband's role among Thai women in Australia. In this study, the positive and negative aspects of motherhood, including health, traditional practices, dietary precautions, post natal beliefs and practices, and the 'presence of the husband' were focused on as contributing towards an understanding of the socio-cultural environment in which immigrant women try to be mothers.

Third, papers were identified which attempted to integrate all of four determinants of health in this review (). The intersectionality of sex, gender, ethnicity and migration are all adequately considered in a study by Steel, Silove, Phan & Bauman (2002), in which a variety of demographic and post-migration factors are looked at for their influence on the mental health of refugees in Australia that . A study by Iglesias et. al., (2003) is another instance that seeks to bridge the gap in the literature by reporting how international migration during two periods with different economic conditions (1980-85 and 1992-97) influenced the self-reported health status and psychosomatic complaints of women of childbearing age. The integration of sex, gender, ethnicity and migration as determinants of health was reflected in such variables as age, country of birth, marital status, number of children, educational status, employment status, economic resources, poor social network and acculturation). Mehta (1998) also considers the interconnectedness of these four determinants in exploring the relationship between acculturation and mental health for Asian Indian immigrants in the United States. Acculturation, perception of acceptance, cultural orientation, language usage and mental health, psychological distress, acculturative stress, and satisfaction were the controlling factors in this study used to assess the relationship between acculturation and mental health in immigrant men and women.

As expected, the percentage of papers decreased as the level of integration increased. Only 17 (28.8%) of the total sample defined and integrated ethnicity and gender, defining gender beyond sex. Slightly fewer papers (15, or 25.4%) presented an integrated definition of gender and migration. Only 9 (15.2%) papers out of the total sample of 59 defined and integrated all four concepts.

Concluding remarks

The incorporation of women's health into health research, policy and practice over the course of the twentieth century has been noteworthy for its progress beyond biological, sexual and reproductive well-being. A growing body of knowledge is developing around women's health, a body of knowledge which, like others, must keep pace with new social developments in a constantly evolving world. More specifically, it must address how structural conditions and the socio-political climate shape women's health (Jolly et al., 2003; Kawar, 2004; Meadows et al., 2001; Ostlin et al., 2001;

Rosenberg & Wilson, 2000; Spitzer, 2005; Status of Women Canada, 2006; Williams, 2002; Boyd, 2003; Walters, 2003; Weber & Parra-Medina, 2003).

The integration of diversity and gender sensitivity into health care planning, provision and clinical research has been shown to reduce disparities in women and men's health outcomes (Beiser & Stewart, 2005; Health Canada, 1999; Krieger, 2001; Ostlin et al., 2001; Reitz and Banerjee, 2007; Tudiver, 2002). However, there is still no systematic integration of the diversity of social determinants in health research, and the lack of adequate health care planning for women experiencing migration is a case in point (Bauer et al., 2000; Blackford & Street, 2002; Hyman, 2006). The goal of this review was to assess the extent to which the integration of the concepts were socially reflective to what extent, for example, were gaps due to methodological shortcomings? If the limited number of studies integrating sex, gender, ethnicity and migration is a reflection of methodological challenges, what types of suggestions would best enable health researchers to move forward towards 'affordable' qualitative and quantitative study designs which would integrate the most variables possible? In other words, if the production of socially grounded women's health research depends upon accurate, fully integrated and applied conceptualizations of relevant dimensions, how can this be facilitated by policy-makers, health research funding bodies, the researchers themselves and ultimately by health care practitioners?

The number of studies that *defined* and *integrated* gender, sex, ethnicity and migration in this selected review were very few. This finding raises a number of important questions and concerns.

What is the value in conducting intersectional research where concepts are brought together in a more substantial and systematic way? The emphasis within women's health scholarship for conceptual clarity and accuracy stems from the consensus that multiple and interactive social and biological determinants of health, as well as structural conditions, affect women's health. A shift in health research to a social dimensions perspective, some believe, would allow for an increased understanding of the impact of structural inequities (Aroian, 2001; Cooper, 2002; Reutter, Harrison, & Neufeld, 2002). In turn, the way that key dimensions, such as gender, ethnicity and migration (among others) are conceptualized shapes how research findings are understood and integrated into the public policy recommendations put forth.

In order to capture gender-related complexities above and beyond biology, and migration experiences above and beyond ethnicity, methodological tools are required that focus on how, and to what extent, interacting dimensions are integrated into women's health research. For example, in order to demonstrate that migration is neither a gender-neutral process nor blind to race/ethnicity, socio-economic status, or other dimensions of social stratification, tools are needed to allow researchers to "plug in" multi-dimensional concepts to a clear theoretical framework. Health researchers are in a unique position to best support this process by devising methodologies which not only enable a more systematic integration of complex social identifiers (e.g., sex, gender, ethnicity, and migration), but also describe how such findings can be concretely integrated into existing health policies. Clear and socially grounded conceptualizations must be utilised throughout (WHO, 2006; Baum & Harris, 2006). This is the critical first step toward the substantial integration of complex dimensions in women's health.

Much has been written about the many relevant dimensions of women's health in the context of migration. However, while efforts have been made to integrate gender into international migration theory, and new social dimensions, such as migration, are being incorporated into women's health research (Grieco and Boyd, 1998, Hyman, 2001; Hyman 2002; Kinnon, 1999), research gaps remain. Migration is more than the experience of crossing physical borders. Systems of socio-economic infrastructure, cultural and political boundaries, and even individual ways of being, knowing and experiencing the world must often be traversed as well. Women's access to relevant, high quality and timely health care and information is likely influenced and often challenged in these new contexts (Krieger, 2003, 2005; Ray, 2002; Schulz et al., 2000; Still et al., 2002; 2005; Vissandjée, et al., 2005). If women are going to benefit from public policy in this area, it is imperative that more intersectional research be done, where concepts are substantially and systematically integrated. Accurate conceptualizations of women's health in the context of migration must be developed so that policies implemented in response to the needs, interests and successful integration of recent immigrant women and their families might actually reach their goals.

A best practices review for researchers, highlighting articles using well-conceptualized and multiple, integrated dimensions of women's health, would be instructive to develop. A best approaches manual, modeling the presentation of research findings in a way that is easily adopted by policy makers and health care providers, could benefit not only women's health researchers, but also health practitioners. Framing the social dimensions of women's health within a justice and social equity approach, for example, is accurate and appropriate, and very often the case. However, women's health researchers may also need to better frame their perspective within more "technical and institutional" approaches to ensure that recommendations are more easily understood and implemented by policy makers— and health care practitioners — as socioeconomic and political concerns continue to heavily influence priorities in the health care arena (Linking Research, . Research on Equity and Community Health, August 2005).

Further research, using intersectional modes of inquiry into the social determinants of health, must be encouraged. The result will be a new level of sophistication and social analysis, creating a more socially accurate and engaged literature able to more effectively inform health policy makers. This initiative is required to counter the impact of past research, which obscures the impact of social determinants in women's health. From praxis to methodology, from conclusions to recommendations, consistent applications of socially grounded, intersectional conceptualizations in emerging research will better facilitate population health policies and strategies towards the alleviation and prevention of persistent disparities in women's health.

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