

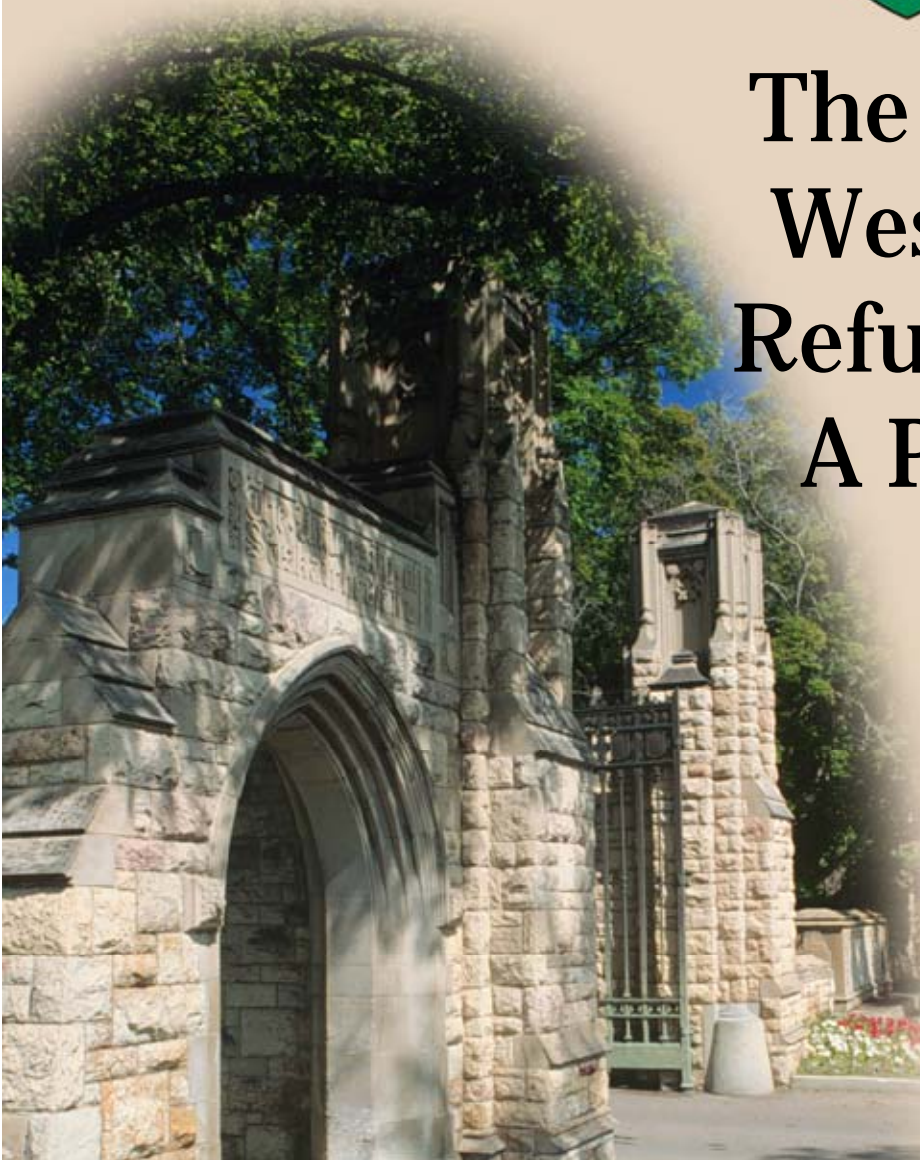


UNIVERSITY OF
SASKATCHEWAN

The Health Needs of Non- Western Immigrants and Refugees in Saskatchewan: A Postcolonial Feminist Ethnography

Louise Racine RN PhD
Assistant Professor
College of Nursing

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Objectives

- Explore perceptions of health and illness of non-Western immigrants and refugees in SK;
- Document patterns of utilization of health care services;
- Identify specific needs of health services among non-Western immigrants and refugees.

Background to the Study

- Very few studies on immigrants and refugees have been conducted in SK;
- One study conducted in 2002 on PTSF in SK;
- Readiness of the health care system to provide care to non-Western immigrants and refugees is to be explored.

Background to the Study (2)

- Non-Western refugees, men and women are more at risk of presenting health issues; (Hyman & Guruge, 2002)
- Women differ from men in their experiences of settlement and migration (Dyck & Tigar-McLaren 2004; Thurston & Vissandjée, 2005)

Literature Review

- Structural effects of the Canadian Health Act and the Immigration and Refugee Protection Act on women with precarious immigration status reported (Oxman-Martinez et al., 2005);
- Issues of 'inequity' in accessing health care services documented in previous studies;
- Systemic barriers in the delivery of health care to non-Western immigrants and refugees also reported.

Research Questions

- What are non-Western immigrants' and refugees' perceptions of health?
- What structural barriers may impinge on non-Western immigrants' and refugees' access to culturally sensitive health care services?

Theoretical Approaches

- **Postcolonial Feminism**
 - Ontological and Epistemological Underpinnings
- Black Feminism (Anderson, 2002)
- Postcolonial Theories (Quayson, 2000)
- Postcolonial Feminist Theories (Anderson & Reimer Kirkham, 2002; Racine, 2003; 2009a; 2009b)

Methodology

- Recruitment Strategies;
- Sampling & Sample;
- Critical Ethnography;
- Data Collection;
- Data Analysis;
- Findings.

Recruitment

- Regina Open Door Society
- Saskatoon Open Door Society
- Global Gathering
- International Women of Saskatchewan (Saskatoon and Regina)
- Community Leaders
- Sample of Convenience (Volunteers)
- Snowball Sampling

Sampling Strategies

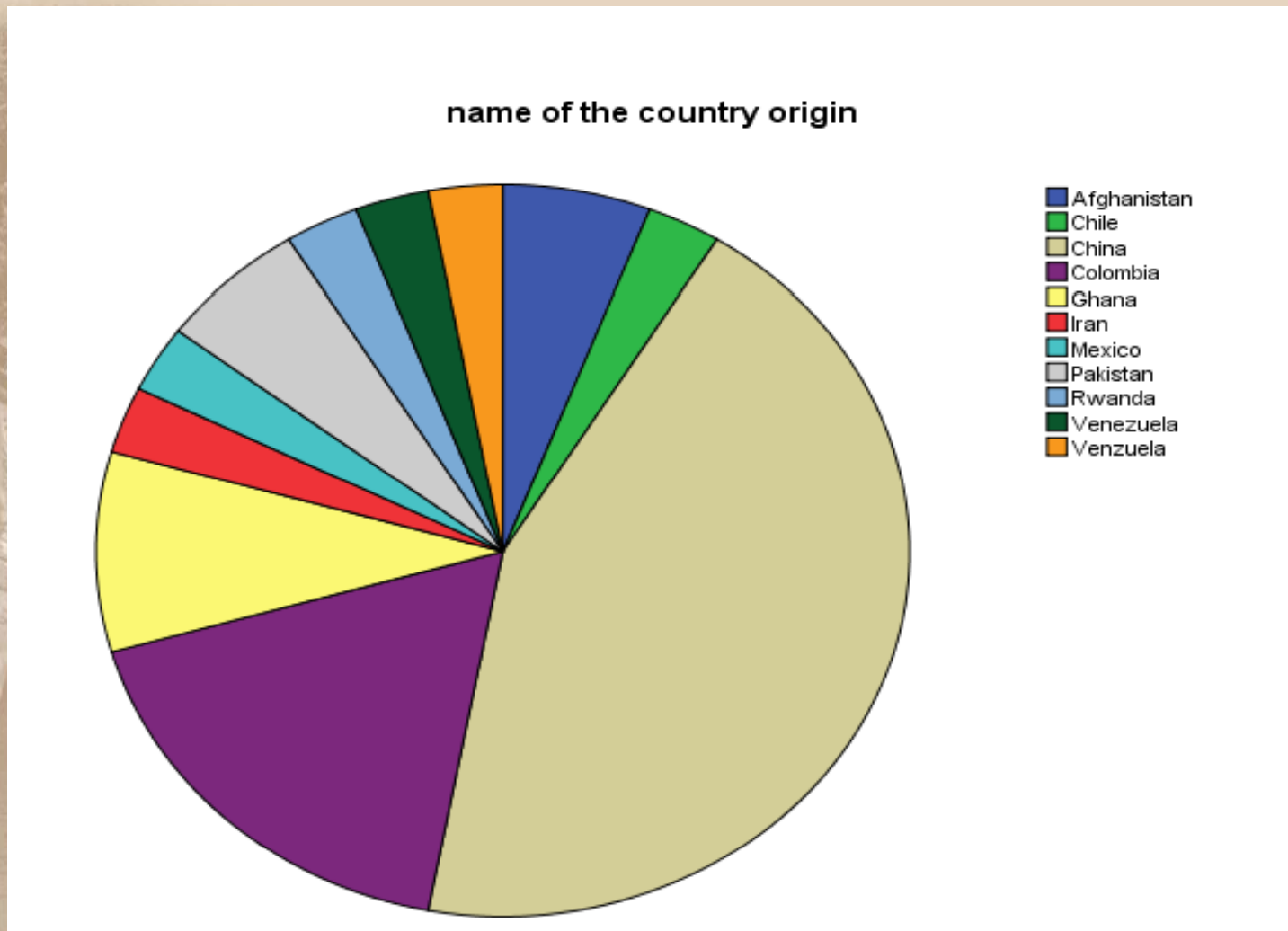
- Agreeing to participate in the study;
- Being interviewed in English or the language they felt more at ease to speak;
- Be aged of 18 years old or more;
- Living in SK since 6 months or more;
- Born and raised outside Canada;
- Being or having been in contact with a health care provider (preferably a physician or a nurse) within the last year;
- Being a government-assisted refugee or a legal immigrant

Description of the Sample

(n = 34)

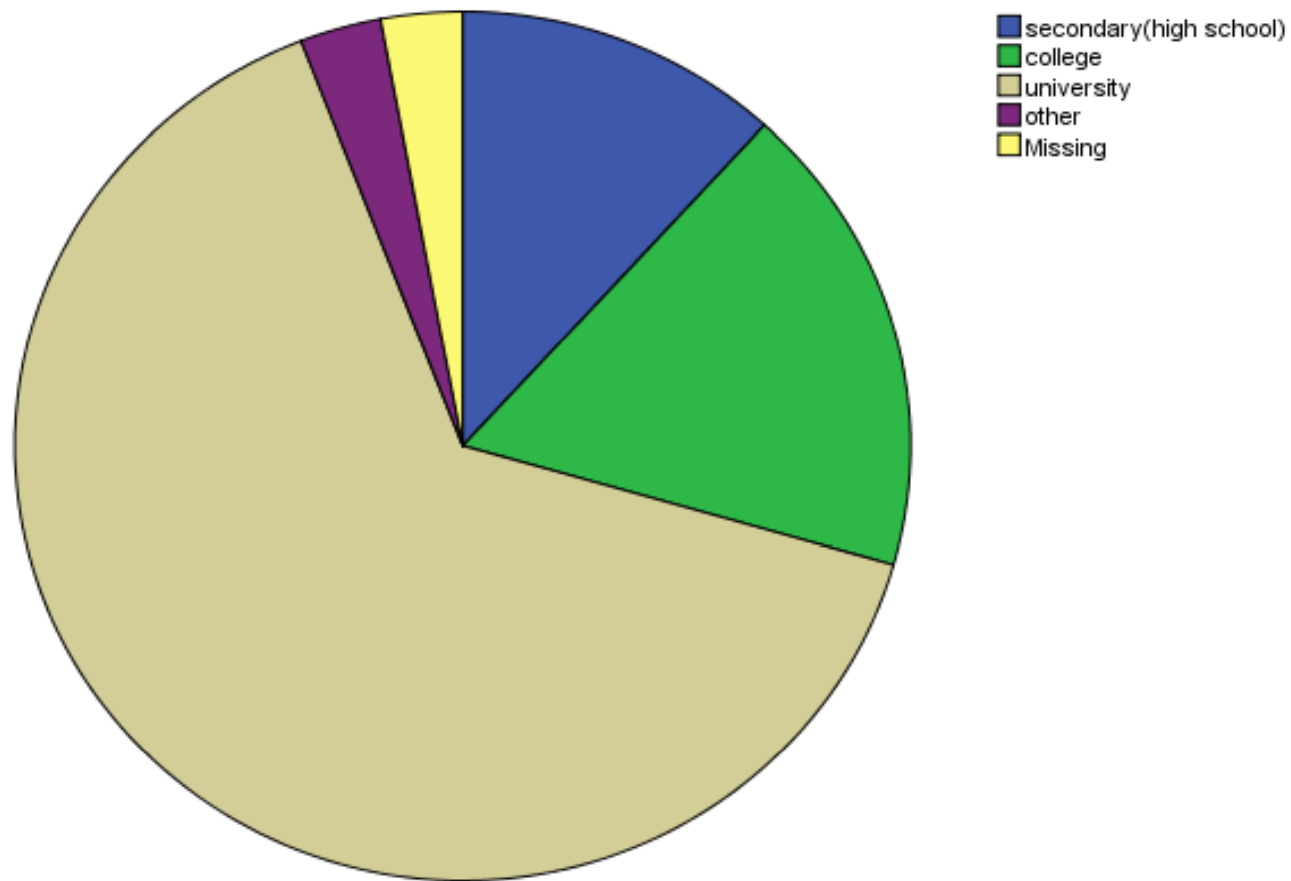
- Gender: 26 women (76%) and 8 men (24%);
- Age: Me: 42 years old, Md: 40 years old
- Years of residence (Can): Me: 7.9, Md: 3.7
- Years of residence (SK): Me: 6.8, Md: 3.0
- Countries of origins: China (15), Colombia (6), Ghana (3), Afghanistan (2), Pakistan (2), Rwanda (1), and other Latin American and African countries.
- Marital status: 27 M, 5 D, and 2 W;

COUNTRIES OF IMMIGRATION



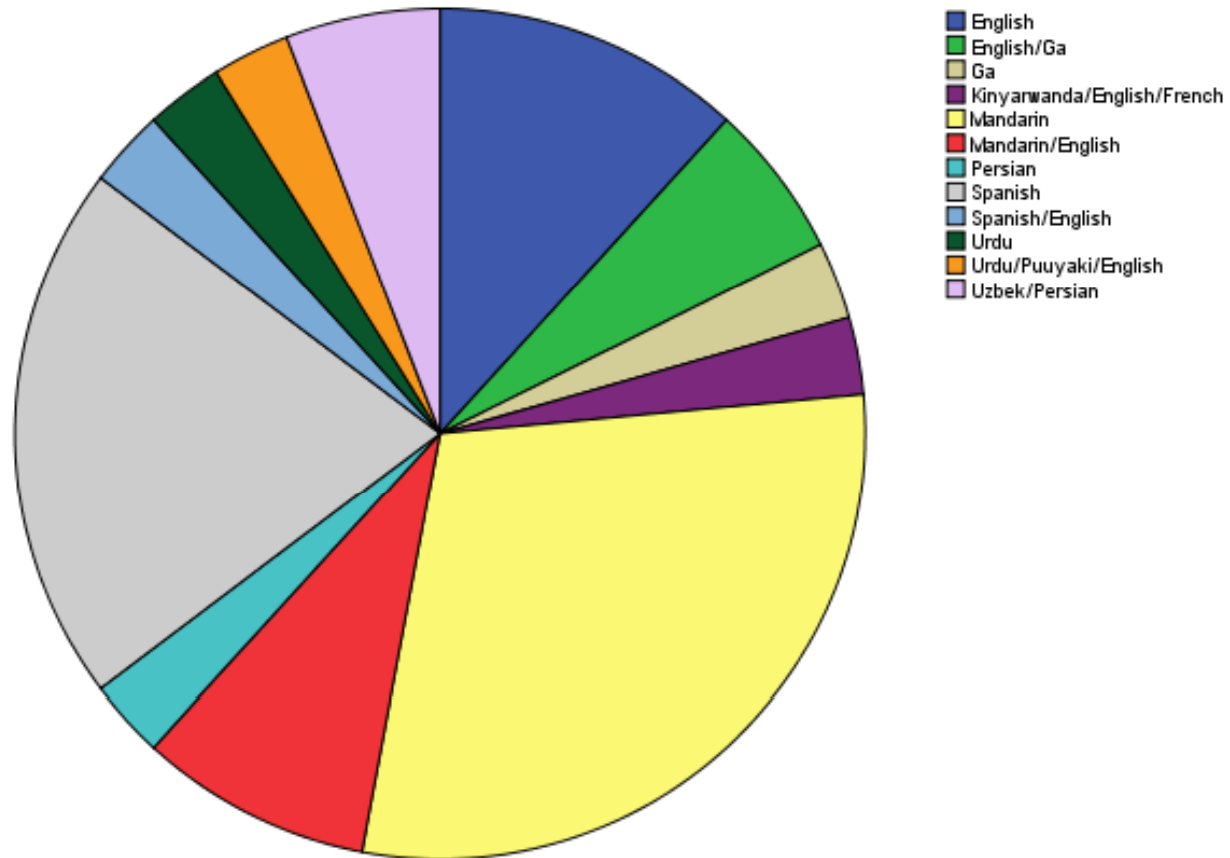
LEVEL OF EDUCATION

level of highest education



Languages Spoken in the Household

language spoken in the household



Data Collection

- Open-ended Interviews (Immigrants/Refugees/ Community Leaders)—let the informant tells her/his story;
- Participant Observation (ESL courses);
- Participant Observation (Cultural Activities);
- Other artifacts like Laws on immigration, Citizenship Canada;
- Fieldnotes.

Data Analysis

Thematic Content Analysis (TCA)

- Based on Carspecken's (1996) and Emerson, Fretz & Shaw's (2004) coding techniques.

CA is based on the research questions;

CA is theory-driven;

CA is a “research technique for making replicable and valid inferences from texts or other meaningful matter to the contexts of their use” (Krippendorff, 2004).

Findings

- Access to Health Care Services;
- Self-Reported Health Issues;
- Self-Reported Problems within the Health Care System
- Reported Structural Barriers

Access to Health Care Services

Health Care System Point of Entry:

Medical Clinics (14)

Walk-in Clinics (3)

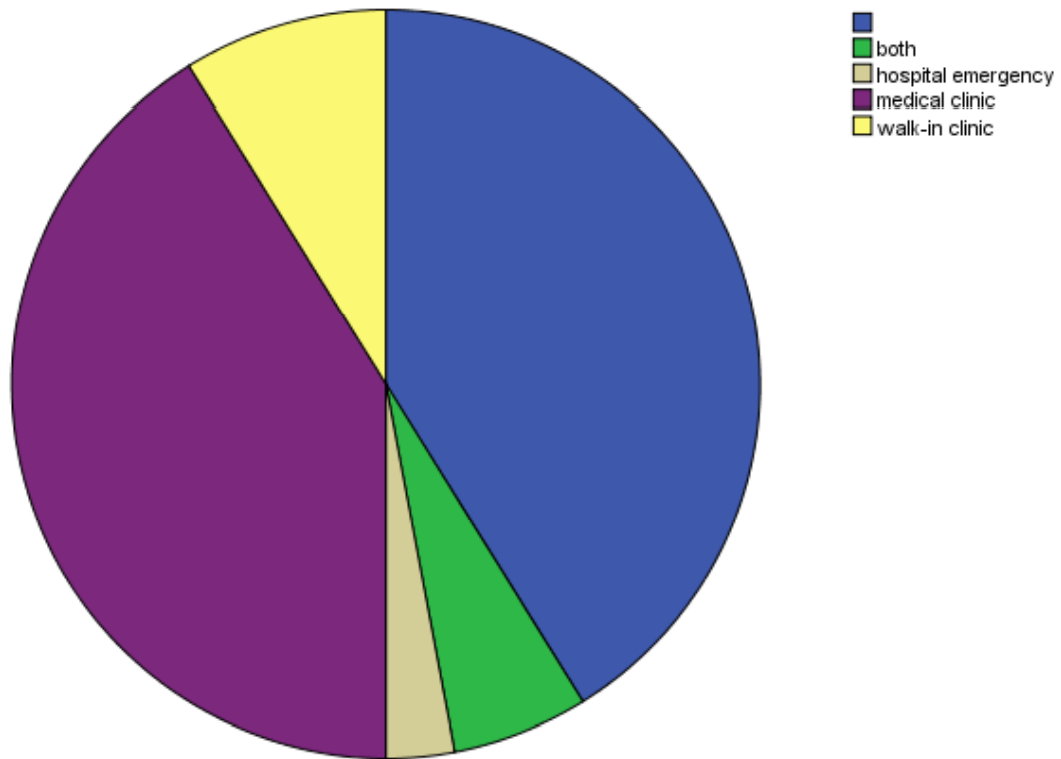
Emergency Rooms (1)

Both ER and Medical Clinics: (2)

**Time of Consultation (Tri-Modal); 1 month,
6 months, less than a year after arrival in
SK**

POINT OF ENTRY HEALTH CARE SYSTEM

medical clinic or hospital emergency?



Self-Reported Health Issues

- High blood pressure (HBP);
- Thyroid problems (Hypo-hyperthyroidism);
- Pregnancies (pre and postnatal care);
- Children's health issues (Immunizations, fever);
- Stress, anxiety, insomnia/sleeplessness;
- Heartburns, skin problems (rash);
- Gynecologic and sexual health problems;
- Diabetes;
- Addictions (e.g. computer games addictions);
- Domestic violence (mostly under-reported, 'taboo', 'shame');
- Mental issues (e.g. depression, suicidal ideas) (mostly under-reported).

Self-Reported Problems within the Health Care System

- Accessibility of health services for chronic illnesses;
- Long waiting time to see a specialist;
- Bureaucracy and lack of efficiency (e.g. too many tests (e.g. blood work));
- Delays in establishing early diagnosis compounded by extended waiting time to meet with a specialist;
- Medical visits are too short;
- Mixed evaluations (either lack of satisfaction or satisfied)

Reported Structural Barriers

- Dominance of the biomedicine;
- Gender issues; Male vs. Female physicians;
- IE physicians vs. immigrants/refugees;
- Marginalization of traditional medicines or folk remedies (Chinese vs. Western medicines);
- Dominance of the 'expert' model:
Marginalization of clients' frames of interpretations of their illnesses;
- Listen to symptoms as expressed by clients;
Hearing is not listening.
- Need for active listening, empathy, genuine understanding, and TIME have been identified.

Discussion

- In some US studies, somatisation among Afghan women was found to be related to cultural resistance and resettlement experiences;
- Somatisation illustrates a symptom of depression related to cultural shock (Askaryar, 2006; Omeri, Lennings & Raymond, 2006);
- Recommendations for health care practitioners

Recommendations for Health Care Practitioners (1)

- Accessibility: Take the time to listen to the client's history; Take the time to answer clients' questions. "Hearing is not listening" (Cicourel, 1993).
- Interest to know the family background (migration and resettlement experience, life in the country of origin, or any traumatic experience);
- Let clients express their 'story' despite language barriers;
- Patience as a sign of openness to immigrants and refugees;
- Explain tests, treatment and medications (side effects);

Recommendations for Health Care Practitioners (2)

- Enhance education: Tropical diseases, cultural sensitivity (e.g., birthing practices);
- Need for “Raising consciousness of health professionals” (woman participant);
- Enhance health promotion: Exercise, leisure time, social isolation (e.g. women at home with young children), social support;
- Be aware of issues may be silenced while affecting holistic health: 1) mental health, 2) domestic or intimate violence, 3) gambling & addictions, 4) women’s sexual health, 4) depression expressed as physical symptoms, and 5) torture and war-related crimes.

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