

# *Affirming Immigrant Women's Health:*

## *Building Inclusive Health Policy*

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## Executive Summary

This project addressed an area of research that has been given limited attention by scholars. It explored immigrant women's experiences and perceptions of the factors that influence their health, their health behaviours and the health services they use.

The research methodology was qualitative, exploratory and descriptive and was designed to listen to, to hear and to include the voices of women not typically heard in health research. It was anticipated that the findings of this research would further the understanding of how to support immigrant women in their efforts to maintain their health and would lead to increased understanding of what they need from the health care system. It was also expected that the findings of this research would lead to a greater recognition of the women themselves as a resource for their own health.

Twenty-two women from 15 countries were interviewed. The sample was a non-probability, convenience sample selected from the accessible population of immigrant women in PEI. Criteria for inclusion in the study included being aged 20 to 80+ years and having lived in PEI for 20 years or less. Data saturation and accessibility were the main factors determining sample size. Respondents were identified mainly through the PEI Association for Newcomers to Canada (ANC).

The hypothesis that immigrant women have vastly diverse beliefs about health that significantly affects what they seek in terms of health care was not upheld. The findings of this study indicate that immigrant women have similar beliefs about health and how to maintain health as do Canadian-born women, however they have fewer resources and thus they are more vulnerable to health risks. The women in the study were found to have health needs related to five determinants of health: biopsychological endowment, social support, socioeconomic factors, personal health practices and health services (Munro et al., 2000). They were found to have well defined beliefs about health as a resource for daily living and to be very aware of the importance of health maintenance practices to protect their health, such as eating well, getting adequate rest, and engaging in exercise as well as hobbies and other stress reduction activities. However, they reported having little or no time for such activities, and while they valued a healthy diet, their traditional foods were frequently not available. They described having little or no social support and often felt unaccepted in their communities. They often lacked language skills and were frequently unable to find appropriate employment.

In terms of barriers to health care, the women identified language as a problem in accessing appropriate health care for themselves and their families. All of the women who were questioned on this topic identified the need for health care interpreters. Further, the women believe that Canadian physicians do not complete adequate examinations, do not spend enough time, and do not discuss or listen. This often caused the women to feel that their health problems had been unheard and unattended. At times the advice of the physician was found to conflict with the cultural and traditional beliefs of the woman.

The gender of the health care provider was a problem for more than half of the group; others just wanted a competent and caring physician who would listen to their concerns *before* prescribing treatment. Transportation, lack of information about available programs, and cultural insensitivity of health care providers were also found to be problems.

This group of women described feeling unfamiliar with the ways and customs in this country. Everything that offers the comfort of the familiar seems unavailable to them. Putting policies and programs in place to support immigrant women in their efforts to build a new life would be cost effective because, as they themselves affirmed, when they are healthy they are better able to take care of themselves and their families.

Based on the findings of this research, the following recommendations are made for policy development, as well as for strategies to support immigrant women in their health maintenance practices:

1. **Language programs:** Currently only language programs levels 1-3 are offered in PEI. In order for immigrant women to gain sufficient skills to compete in the job market, they need higher levels of English language classes.
2. **Employment programs:** A program is currently in place to assist those who have the language skills to obtain employment. This program must continue to receive stable and adequate funding.
3. **Health promotion programs:** Health promotion material in their native languages is needed. A food/nutrition/cooking class on how to adapt their traditional cooking styles to the foods available in Canada is also needed. The cooking class could provide an opportunity to share their rich knowledge about food and nutrition, and could serve the dual purpose of providing the opportunity to build a social support network.
4. **A community outreach program:** A community outreach program is needed to help the women to continue with their customary social and leisure activities, such as playing a musical instrument or singing in a choir. This program could help them to learn about their new location and to discover the kinds of social and leisure activities available to them.
5. **Affordable child minding services.** In the absence of social support networks, affordable child minding services are necessary to allow the women to continue with their social and leisure activities, to attend the suggested food/nutrition/cooking classes, to attend ESL classes, and to search for employment.
6. **Cultural language interpreters:** All of the women who were asked the question, identified the need for trained cultural/language interpreters. Such a service in turn requires a training program for the interpreters.
7. **Cultural sensitivity for health care providers and support people:** In order for health care providers in general to provide culturally sensitive health care, in-service and education programs promoting culturally competent and sensitive approaches need to be provided on a regular basis.
8. **Nurse education:** Nurse educators must continue to work to ensure that nursing students have the opportunity to develop culturally competent and sensitive interventions and that they have experience working with immigrant populations in clinical settings in both acute care and the community. This program should extend to continuing education programs and Licensed Practical Nurse (LPN) programs.
9. **Strategies to increase physician sensitivity:** The findings indicate the need to promote culturally sensitive approaches in doctors' clinics with both the doctors and their receptionists. Some ideas include:
  - Cultural groups in Charlottetown (e.g., PEI ANC, InterCultural Health Assembly (ICHA) of PEI, MultiCultural Council (MCC) of PEI) could work with the Medical Society on

how best to encourage local doctors to adjust their practice to meet the needs of immigrant women;

- Invite Dr Ralph Masi, a physician and leader in Canada in the area of multicultural health care, to work with doctors toward increasing cultural sensitivity;
- Encourage immigrant doctors to use their experience and work from within the medical community to encourage sensitivity;
- Cultural groups and/or the researchers (e.g., PEI ANC, ICHA, MCC) could inform doctors about immigrant women's experiences and encourage doctors to provide sessions on cultural sensitivity for their receptionists.

10. **Informing government:** Researchers and/or cultural groups should meet with the Minister of Health as well as with the Director of the Division of Public Health and with the Director of Evaluation Services to talk about the health care needs of immigrant and refugee women.

11. **Develop an information booklet on the health care system:** The women identified a need for information about the health care system and all feel that it is important to have the information upon arrival rather than 3-4 years later when they become Canadian citizens.

In conclusion, this study may increase awareness in the community of the health needs of immigrant women. It may influence practice to include a concern about hearing the voices of these women, and to recognize the role that gender and culture play in their health care. It is anticipated that this study will influence public policy and funding practices so as to place more emphasis on programs related to the social determinants of health identified as having an impact on the health of immigrant women. Specific areas that need to be addressed through education, funding and policy are identified and suggestions for implementation have been elaborated above and in Appendix I.





# **Affirming Immigrant Women's Health: Building Inclusive Health Policy**

## **1.0 Summary of the Research Project**

Societies throughout the world have become more culturally diverse as the number of immigrants and refugees increases worldwide. Canadian society is no exception. In Canada the largest number of immigrants and refugees can be found in Quebec, Ontario, Manitoba, Alberta and British Columbia (Statistics Canada, 1996). However, other provinces also receive a steady flow of people from different parts of the world and Prince Edward Island (PEI) is no exception.

Approximately 150 immigrants arrive in PEI every year and a total of 4,380 immigrants live on the island. Consistent with the national statistics on gender, slightly more than half of them (2,230) are women (Statistics Canada, 1998). While this is not a large number compared to those in some provinces in Canada, the immigrants who come to PEI face similar problems and they may also face somewhat different problems such as cultural isolation. Because they are fewer in number there are sometimes fewer cultural supports and services available to them.

### **1.1.1 The Current State of Knowledge about the Topic**

Many authors have commented on the effect of culture and ethnicity on the health and health beliefs held by immigrant women, as well as on family and professional relationships (Anderson, 1990; Majumbar & Carpio, 1988). Some authors have observed that immigrant women of all ages have encountered significant difficulty in adapting to the beliefs, values, and bureaucratic structures of a new culture (Barney, 1991; Die & Seelbach, 1988; Driedger & Chappell, 1987; Lipsom & Meleis, 1985).

Lack of language skills and uprootedness were found to be the two issues that caused the most emotional distress (Coombs, 1986). The women often feel torn from the familiar and placed in a setting for which they feel emotionally and culturally unprepared, and where established patterns no longer work (Stevens, Hall & Meleis, 1992). Lack of transportation has been rated highly as a cause of distress in that it often leads to physical isolation (Rathbone-McCuan & Hashimi, 1982). Violence in the home has also been noted in the literature as a problem affecting the health of immigrant women. The women were often found to be beleaguered with daily problems and difficulties that undermined their ability or desire to report the violence. In addition, mental health resources have been found to be limited and frequently culturally insensitive.

The health of immigrant women has been found to be at risk because of the many roles they carry, the work and energy required to try to make sense of two different cultures, the effort needed to make their values understood and accepted, the loss of their social life, the language difficulties they frequently encounter, and because of differences in symbolic meanings. Their life trajectory is dramatically altered from the expected, and in addition, the women often have to face the stress of feeling subordinate in the host society (Aroian, 1990; Lipsom, 1992; Meleis, 1991).

Social support has been reported by some researchers as a major variable providing protection from mental and physical illness, especially during stressful life events such as chosen or forced immigration. Loss of such support is believed to predispose the individual to feelings of vulnerability and to eventual illness (MacKinnon, 1993). During the transition period of

immigration there is often a loss of social support until new systems are established (Meleis, Lipsom, Muecke, & Smith, 1998). Hence, the health of immigrant women may be compromised (Meleis et al.,1998).

Grief represents another reason that the health of immigrant women is at risk. Anderson (1991) described a theme of persistent grief that influences everything in the life of immigrant women. Disman (1983) noted that, “an immigrant’s grief is for the loss of almost everything that once was familiar.” She further reported that accounts by immigrants of their feelings after arrival in the new country reflect a unified theme of a loss related transition.

Current knowledge about the effects of immigration adds support to Shareski’s (1992, p. 10) observation that in order to provide culturally sensitive care to immigrant women, “diet, language and communication processes, religion, art and history, family life processes, social group interactive patterns, value orientations, and healing beliefs and perceptions” must be understood. This author further notes that the most important step toward providing culturally sensitive and competent health care is an increased awareness of our own cultural beliefs and practices, especially an increased awareness that each of us *has* a culture and cultural traditions. In the end, culturally sensitive health care is “a matter of respect for the client’s viewpoint of health” (Shareski, 1992, p. 10).

Further to the written academic knowledge, the co-investigators brought a substantial knowledge base of both cross cultural healthcare research and personal experience to this project. The Master’s thesis of the principal investigator concentrated on elderly Chinese (MacKinnon, 1993) and as the president of InterCultural Health Assembly of PEI, she has taken particular interest in intercultural health issues. The co-principal investigator worked with immigrants and refugees in PEI’s settlement agency since its inception in 1991. Furthermore, she worked closely with a co-worker who provided settlement services connecting immigrant and refugee women to the healthcare system in PEI for 11 years. This daily interaction with immigrant and refugee women provided valuable insights into certain aspects of their perceptions about health, factors they believe to influence their health, their health needs and their health care usage patterns.

A search of the academic literature and the local publications in PEI on immigrant women’s health demonstrates that most of the research has focussed on the problems that immigrant women face in the new country and in some cases looks at the effects of those problems on the women’s health. Few if any of the studies however, address what health means to these women, what, if anything, they did before they immigrated to maintain their health, and whether they are able to continue those practices in the new country. No studies were found that asked immigrant women what they believe influences their health or what their experiences are with the health care system of their new country. This research project attempts to address that gap in current research.

## **1.1.2 Research Questions, Goals and Objectives**

### **Research Questions**

1. How do immigrant women define health?
2. What factors do immigrant women perceive as influencing their health?
3. Is culture and gender sensitive health care available to immigrant women?

## **Goals**

1. Increase cultural awareness amongst health care providers about the health beliefs, health maintenance and health use patterns of immigrant and refugee women in PEI;
2. Improve the accessibility of health care services to immigrant women in PEI;
3. Influence health care policy towards inclusion of the cultural needs and patterns of immigrant women in PEI.

## **Objectives**

1. To determine what health means to immigrant women and to discover their perceptions of factors influencing their health;
2. To explore the health maintenance patterns of immigrant women;
3. To explore the experiences (positive and negative) of immigrant women in using professional health care services, focusing on the significance of gender, language and culture;
4. To provide guidelines to policy-makers with regard to the health, health care delivery and health service needs of immigrant and refugee women.

## **1.2 Methodology**

### **1.2.1 Design of the Study**

An exploratory descriptive design was used for this qualitative research study. This approach was consistent with the nature of the research questions under investigation.

Prior to development of a semi-structured interview guide, a focus group meeting (Appendix A) was held with 7 immigrant women to gather their ideas and suggestions regarding the topics to address and how best to frame the questions. Telephone interviews were then carried out with 5 individual health care professionals, educated in other cultures, to gain their input regarding questions for the interview guide. Once a draft of the guide was developed, further input was sought from the Research Advisory Committee (RAC), the members of which represented individual immigrant women, the University of PEI (UPEI), and relevant government and non-government agencies. The information gained was applied in developing the semi-structured interview guide used in this study (Appendix B).

Three interpreters were used for the study. They were not professionally trained, however one had worked with immigrants at ANC and another had been interviewed herself, hence two of them were familiar with the interview schedule. The third was given the opportunity to look at the interview schedule before the interview. Familiarity with the interview guide gave them the opportunity to identify any questions they may have had and to become comfortable with translation of the content. The research assistant was available to answer their questions.

### **1.2.2 The Population**

Twenty-two women from 15 countries: Bangladesh, Bosnia, Burma, Croatia, China, Cuba, Egypt, Germany, Guatemala, Macau, Morocco, Nigeria, Pakistan, the Philippines and Syria were interviewed. Criteria for inclusion in the study included being aged 20 to 80 years and older and

having lived in PEI for 20 years or less. Potential respondents were identified mainly through the PEI ANC and the InterCultural Health Assembly (ICHA) of PEI.

**The Sample.** The sample was a non-probability, convenience sample selected from the accessible population of both immigrant and refugee women in PEI. Data saturation and accessibility were the main factors determining sample size.

The women interviewed were between the ages of 21-70 years, and had arrived in PEI within the past 20 years. Two of the women were between the ages of 21 and 30, 10 were between the ages of 31 and 40, 4 were aged 41 to 50, 4 were between the ages of 51 and 60, and 2 were aged 61-70 years. Eighteen of the women were married, one was single with a child, 2 were widowed, and one was separated. The length of time they had lived in PEI varied from 14 months to 20 years, with the average length of time lived in PEI being 9 years, 2 months. Five women chose not to answer the question about income. The average family income for those who answered the question was \$29,000 per annum.

Two respondents were full-time students in career-oriented programs at the local college, and one was taking a short program at the college. Seven women were working full-time in paid positions outside the home, 6 were working part-time in paid positions outside the home, and one did not want paid work outside the home at this time. Five wanted paid work but were unemployed. Of those who worked outside the home in paid positions, almost half were not working in their area of educational preparation and experience. Most were working in positions that required less than their level of education, for example one woman was educated as an accountant and was working as a waitress. Another woman who was educated as a nurse in her country of origin and had achieved a managerial position there, was only able to attain a position as a staff nurse in PEI.

### **1.2.3 Data Collection**

Data were obtained by means of one to one audiotaped interviews in the homes of the women interviewed; the interviews were 1 ½ – 3 hours in length. The interview guide was intended to ensure that the same questions were asked in each interview. Open-ended questions were used to help focus the respondent's thoughts and to allow freedom of expression, while probes were used to encourage greater depth in the exploration of topics raised by the respondents. The interviews were conducted in English and translated, where necessary, by an interpreter. The audiotapes were transcribed word for word in their entirety by a typist. Data collection was completed over a period of approximately 4 months. A personal data questionnaire was used to collect demographic and other background data (Appendix C). The Principal investigator worked closely with the research assistant who conducted the interviews. From the date of receiving funding at the end of March 1998, to the writing of this final report (May 2000), the study spanned a period of approximately two years.

### **1.2.4 Data Analysis**

Content analysis and the constant comparative method (Glaser & Strauss, 1967) were used to analyse the data and the research assistant's notes. The two analytic procedures of making comparisons and asking questions were used to isolate emerging concepts into categories and themes (Strauss & Corbin, 1990). The data analysis was completed by the principal investigator

in consultation with the co-principal investigator and the research assistant who conducted the interviews.

No differentiation was made between immigrant and refugee women during data collection or analysis, and throughout this report the phrase “immigrant women” refers to both immigrant and refugee women.

### **1.2.5 Credibility**

Several measures were used to maintain the credibility and dependability (Polit & Hungler, 1996) of the study. The criteria of prolonged engagement (Polit & Hungler, 1996, p.305) was met through in depth exploration of the topics with each woman over a time period of 12 to 3 hours. Credibility was further strengthened through data source and investigator triangulation. In addition, the research assistant had considerable experience as a researcher; she had lived and worked in several different countries and cultures and had worked with immigrant groups in PEI.

The credibility criteria of persistent observation (Polit & Hungler, 1996, p.305) could have been better addressed in two areas. All questions were not addressed in each interview, and topics raised spontaneously by the respondents were not consistently followed through. These two omissions may have weakened the depth and scope of the data obtained in some areas. However, the criteria of persistent observation was strengthened through peer debriefing sessions with the research assistant who kept brief notes describing and interpreting her own experiences and behaviours and those of the respondents during the interviews. These notes were intended to provide a measure of her ability to be objective. The content of the notes were discussed in debriefing sessions with the principal and co-principal investigators.

The credibility of the data was further upheld when the data were returned to the target group and confirmed by them as representing the message they had hoped to convey. After reviewing the findings, the response of one member of the target group was: “I don’t see what I said, but everything put together is the feeling of most immigrant women”(Appendix D).

Discussions were held with the interpreters prior to the interview to confirm their understanding of the questions and to standardize approaches and translations to be used in each interview. In addition, every attempt was made to maintain privacy during the interviews.

### **1.2.6 Ethical Considerations**

The proposed study and semi-structured interview guide were reviewed and approved by the UPEI Senate Research Ethics Committee. The proposal was also reviewed for ethical considerations by the RAC.

At the beginning of each interview the focus of the study was explained to each respondent. Prior to the interviews verbal consent was obtained, using an interpreter if necessary. Permission to audiotape the interview was obtained. All respondents were verbally reassured that the information would be kept confidential and that they would not be identified in any way in the final written report or in other venues where the data may be presented.

In addition, each respondent was informed in simple terms that participation in the study was fully voluntary and that they had the right to terminate their participation at any time without jeopardizing present or future health care of themselves or their families. Respondents were further informed that they could refuse to answer any question with which they did not feel comfortable and they were encouraged to request clarification at any time on issues related to the study.

### **1.3 Findings and Discussion: Major Health Issues and Themes**

Meleis et al. (1998) identified four health care issues for immigrant women. Three of the issues identified are relevant to this study and will be used as a framework for discussion of the health concerns and health care needs disclosed in this study. The three relevant issues are: Immigrant women are unrecognized resources; Vulnerability to health risks; and Barriers to health care. Along with the 3 major health issues, several themes that correspond to some of the determinants of health emerged during data analysis. Several authors have described the determinants of health in slightly different ways. Those used to discuss the findings of this study are based on an adaptation of the determinants identified by the UPEI school of nursing (Munro et al., 2000), which are: social support networks, income and social status, education, employment and working conditions, physical environment, biopsychological endowment and genetics, personal health practices and coping, early childhood development, and health services. The 5 determinants that emerged as themes in this study are: 1) biopsychological endowment, 2) personal health practices, 3) social support networks, 4) socioeconomic factors, and 5) health services.

#### **1.3.1 Health Issue I: Immigrant Women are Unrecognized Resources**

Immigrant women have not been involved in studies about, and have not been recognized as resources for, their own health care (Meleis et al., 1998). This study begins to address that omission; immigrant women were involved in this study. They had input into the questions that would be addressed in the study, their voices were heard in the collection of data, and they had the opportunity to respond to the findings. The following two sections discuss immigrant women's beliefs about health and health maintenance practices. The two themes that emerged in this category relate to two determinants of health: biopsychological endowment and personal health practices. The women's beliefs about health are discussed first under the theme of biopsychological endowment.

##### ***Theme 1: Biopsychological Endowment***

Biopsychological endowment refers to the "interrelationship between biological, psychological, social and environmental factors affecting health, human behaviour and physical development" (Munro et al, 2000, p.10). The responses the women in this study gave in answer to the question about what health means to them seem to describe this interrelationship.

One woman described the meaning of health as follows:

Able to do all things physically that you can and that you want to. Feel joyful.  
Can do many things, feel energetic, don't feel tired, feel happy, enjoy what I am doing. Can do all the things I have to do with my family, my father and my

children. Walk, think, work. When you are healthy, you can do anything you want.

When asked what she was able to do when she felt healthy, another woman emphasized the value of health when she answered,

I can work perfect, I can talk better, I can have [better] relationship with people, I can dance, I can do everything. Everything is positive in my mind when I am healthy.

Strong threads that emerged in the women's answers to the question about the meaning of health were the ability to: do what they want to do, fulfill their responsibilities at work and at home, be involved in their interests, and to look after their own health and that of their families. They reported that health means being able to do the things expected of them, "to work hard," "go to school," "go to work," "do housework, and take care of family."

Mental health was described by many of the women as feeling happy, being able to handle stress and to have good interpersonal relationships. A quotation from one of the women demonstrates this;

Mental health very important, translates outward to whatever you do and how you relate to people. Affects your thinking and everything.

Mental health was also described as being able to live on one's own, being able to work, to have hope, aspirations, and ambition, and to have a feeling of belonging to family and community. A comment that supports this is;

Think, the ability to handle stress, to face all of what affects you in your life ... I think mentally healthy people can treat things more objectively, so they can come over [overcome] the difficult times and they can still continue with their life. It means being able to adjust yourself to your environment. Be flexible to all changes. Like I was thinking, mentally healthy people can handle those things a little better than others.

Spiritual health was described as feeling comfortable, happy, confident, and safe. They further described spiritual health as feeling kind and helpful toward others, more patient, more composed, and able to enjoy simple things. Those who believe in a divinity said that part of spiritual health was feeling close to God. For one woman, being healthy in a spiritual way meant;

I am happy with myself, and if I am happy with myself, I feel fine. I feel comfortable, I will be able to transmit that to other people. If [I] feel spiritually healthy you can transmit that to your mind and then you can show physical[ly] that you are healthy.

Another woman described spiritual health as;

Contact with God, helping people, being honest, go [to] church. If spiritually aware of the good things and bad things, then we won't give each other trouble B kill them, beat them, rob them.

The women described a variety of ways they nurture their spiritual health: some read, others listened to music, still others found spiritual comfort in nature. One woman found that reviewing her day each evening, thinking about what made her happy or unhappy, helped to support her spiritual health.

All of the women interviewed believed that physical, mental, and spiritual health are closely related; that health in one area affects health in the other two areas. All stated that when they were physically healthy their psychological state was more positive; they were able to think about the future and make plans, they had hope, felt relaxed and did not feel homesick. They indicated that when they were physically healthy they felt satisfied and very capable and were inspired to engage in social and leisure activities, their self-esteem was improved, they felt full of energy and they were more motivated to take care of their own health.

When they were not healthy they reported feeling tired, depressed and had no energy. They declared that when they were not healthy they were not able to care for their family and were not motivated to care for their own health. They said they tended to isolate and to avoid social and leisure activities. Some said they felt depressed and cried. However, they did convey that they tried to force themselves to go to work or to school, and to continue to take care of their family even when they felt sick, "force myself to do things."

In summary, the immigrant women in this study appear to recognize the importance of health to their ability to take care of themselves and their families, to relate to other people in positive ways and to financially support themselves or go to school. This underscores the need for health care providers to create environments that support the physical, mental and spiritual well-being of immigrant women. It suggests the need to recognize the women as resources for their own health, and to empower them through appropriate policies and programs to achieve control over their own health (Meleis et al., 1998; Munro et al., 2000). "To empower is to value, to eliminate stereotyping, to decrease isolation and alienation, to develop partnerships, to enhance involvement, to support collectivity and to provide support, options and choices" (Shields, 1995, p. 27).

## ***Theme 2: Personal Health Practices and Coping***

The second theme in the category of immigrant women as unrecognized resources in their own health care is personal health practices. It refers to behaviours that individuals engage in for the purpose of maintaining or improving their health. These practices often include, physical activity, a healthy diet, social activities aimed at promoting relaxation and reducing stress, and building positive interpersonal relationships (Munro et al., 2000; Pender, 1996).

The immigrant women in this study reported that health is the "most important thing," and they were very conscious of the need to engage in activities to maintain their health. The activities included eating well, sleeping well, exercising, and keeping active and busy ("lots of hard work," "walking," "aerobics," and "swimming"). When asked what she does to maintain her health, one woman answered,



Have a good way of eating, it is easier in my country, we can eat all the vegetable[s], they are no expensive like here. Vegetables, fruits and many things are really, really nutritious. To stay healthy, eat right, walk, exercise.

Food was identified by all of the women as important, not only to maintaining physical health, but also to mental and spiritual health. One woman emphasized its importance when she said;

They don't realize how important it is to have the foods ... The public don't aware, don't aware, don't realize.

Another woman, voiced her concern about the importance of good food and seemed to miss former rituals around food preparation and family meals. She may also have been expressing some concern about acculturation when she declared;

My son used to Canadian food, fries, oh my god, the fries, the hamburger! But I use[d] to cook everyday to cook. We use[d] to cook everyday and everything fresh, not frozen. We don't cook anything here, everything frozen ...

Obtaining what they believe to be healthy food was reported to be a problem. One woman said, "Can hardly stay healthy. Too much dependence on cars. Need more physical activity, have gained 22 pounds and still gaining." Many women commented on the cost of fresh fruit and vegetables. They claimed such items were less available here and that most of the food in Canada and PEI is prepared (frozen) and therefore less healthy. They seemed to be influenced by what they see on TV, and tended to believe that all Canadians eat either frozen or fast food. All of the women who were asked the question about whether the food in PEI is different answered an adamant, "yes!"

Having social and leisure activities was also noted to be important. Some women reported that before coming to Canada, they belonged to a choir, played the flute or went dancing. Others described engaging in more physical activities such as going to the gym, playing basketball, and swimming. Several of the women mentioned walking, and the importance of getting out into the outdoors.

Use of herbal medicines was also described as part of their personal health practices. More than half of the women said they could not find the same herbs here, and therefore had family send them from their country of origin. For less serious illnesses they treated themselves with herbal medications. For more serious illnesses that did not respond to self-treatment, or when they did not know what was wrong with them, and when a child was ill, they went to a doctor. Usually, however, they used traditional or herbal remedies before going to a doctor. One woman said;

I don't take medicines unless I need a specific medicine. Umm, those kind of medicine not really good at the same time, so that's why I'm trying to ahh, I try to take those medicines just when I am really bad, you know.

Another woman shared a memory from her country of origin;

When I have a headache, my mom go out in garden and just pick some leaves and put on my head.

Some examples of herbal remedies included: a mixture of cloves and rosewater placed on the back of the neck for headache, taking a mixture of lemon and banana for sunstroke, and a hot honey and lemon drink for a cough and cold.

This group of women asserted that seeing a physician was not part of maintaining their health, but was important to return to health if sickness occurred. The majority of the women said they would *not* go to a doctor for an emotional condition such as depression; they indicated that they would treat themselves. Several of the women reported they would feel embarrassed or ashamed to go to a doctor for sadness or depression and said they dealt with such problems by talking to friends and/or family, through physical activity such as long walks, or through distraction, such as playing with the children or working hard. Some of the women openly stated they felt that a doctor would not be able to help with such a problem. Comments included, “It is my problem, I would solve it;” “Best to fight that by yourself or with the help of family, friends or with herbal medicines;” and another said she would not go to a doctor for sadness or loneliness, adding, “You think he is going to help me?” One woman, discussing how her culture deals with emotional problems said ,

... if we have problem, in our culture they say you only supposed to talk to family, like you shouldn't talk outside the family because you always want the family looks good. So, most ... people is pretty shy talk about their personal life, even [if] have problem.

Four women said they *would* go to a doctor for treatment of depression, and one had already done so.

All of the women included visiting with family and friends as activities that help to maintain their health. One woman described her family this way, “everybody reaching out and watching out for one another.” She included extended family in her description of family. Another woman expressed the importance of family this way;

... my own experience for my family, we have a very healthy food and also our relation for my family is really unite[d] - we really unite[d], relations [relatives] and family and we farm B lot of hard working, so that keep us full of energy and healthy too. We work the farm, and we work fishing ...

More than half of the women who were asked the question said they were not able to do the same things here to maintain their health as they did in their country. Those who had engaged in physical activity said it was more difficult to do so in PEI. Others who participated in social and leisure activities, such as music or dance, also felt unable to continue with those activities in PEI.

In summary, the findings presented in this section, seem to support the view that immigrant women should be recognized as a resource for their own health. They convey strong beliefs about health and how to maintain it. They treat themselves before going to a doctor and they treat emotional illness and distress through talking with friends or family, or by distracting themselves with certain activities. However, many report that they are not able to continue their health maintenance practices in PEI. Language limitations, absence of social support (for companionship and/or child minding), non-availability of traditional foods and herbal remedies,

as well as transportation problems and lack of familiarity with their new community all seem to interfere with their ability to continue with their former health maintenance patterns. The fact that they are unable to continue with their health maintenance patterns increases their vulnerability to health risks.

### **1.3.2 Health Issue II: Vulnerability to Health Risks**

Immigrant women are believed to be at greater risk for illness than their non-immigrant counterparts. Immigration itself is associated with increased morbidity. A number of other factors, singly or in combination, also increase their risk for illness. These factors include: language difficulties; multiple responsibilities; financial and employment stressors; lack of acceptance by their host communities; culture conflict; and a perceived lack of social support. As a result of these stressors, they may also be at risk of developing stress-related physical symptoms and mental health problems (Meleis et al., 1998). Immigrant women's health is also at risk because they do not have access to culturally appropriate health promotion material in their language. In addition, physicians are often unaware of illnesses that are more common to members of their cultural and ethnic background.

#### ***Theme 1: Social Support***

Social support refers to having ongoing access to a social network such as family and friends. Integration into a social support network contributes to the positive experiences of feeling loved and valued. It includes, emotional support, instrumental assistance, advice and information, and affirmation (Munro et al, 2000; Pender, 1996). Social support is believed to protect health by cushioning the impact of stressors.

All of the women in this study identified social support (the ability to visit family, have a good family environment and support from family, and the ability to visit friends), as an important factor influencing their health. In terms of how social support helps to maintain health, and reduce health risks, a couple of comments were:

Family. Miss them a lot and when I think too much about them, I get depressed. [That] affects my health (pause) miss my country. I can live without my country, but without my family is more difficult

Well, in my country I was always healthy, yeah. Not having family and being home too much, depressed here, you know, feel you are alone. We don't have any relatives ... always have a headache and tired, being with family makes you always happy. So since I move here, I always have headache, tired, all the time, bored.

A single mother in the study emphasized the importance of social support from family and friends when she said,

I worry because I want family and friends. [I feel] safer or something like that, like, I am just my son and I, (pause). Sometimes I thought I don't have anybody else. Feel all alone.

Two other women accentuated the importance of friends to maintaining health when they said, “Friends very important B to be able to talk,” and another remarked, “to stay healthy its really difficult because when you are get over still think about your friends and you got [get] depressed and still its empty.”

These findings are important demonstrations of the significance of social support from family and friends to the health of immigrant women. Social support is believed to reduce the influence of stressors by providing a sense of stability, predictability and acceptance (Stewart, 2000). Social support was found by Meleis et al.(1998) to provide protection from mental and physical illness especially during stressful life events such as chosen or forced immigration. Loss of such support is believed to increase health risk and predispose the individual to illness (MacKinnon, 1993; Pender, 1996). Social support is thought to influence health by “promoting healthy behaviours, by providing information, or by providing tangible resources” such as childcare (Pender, 1996, p.266).

## ***Theme 2: Socioeconomic Factors***

The socioeconomic factors discussed in this section include language ability, employment and social status (acceptance by the community). These topics were raised by the women in this study as important elements affecting their health.

The majority of the women interviewed identified language as a major factor influencing their health. Some comments from the women may best demonstrate this point:

Language stresses out. Not being able to communicate.

[Language] big problem, because you can't say anything you want to say. When you know the language is easy to do anything fast.

You want to talk to somebody, just to talk. Without language you can't, you feel frustrated.

Referring to the inability to completely express herself, one woman said “language alone does not describe this fully.” Immigrant women are frequently frustrated in their attempts to fully communicate feelings and symbolic meanings. They need time to express themselves and to tell their story. They are not accustomed to the North American “communication style based on short answers to short questions” (Meleis et al., 1998, p. 26).

Analysis of the demographic data raised the issue of under-employment and low status jobs. Almost half of the women who were employed were not employed in their area of educational preparation and expertise and most were in low paying, low status jobs. Boyd (1984) also found that immigrant women tend to have low status jobs such as domestic work or fast food clerk. In addition they were found to have family responsibilities and consequently to do double, if not triple shifts.

In addition, immigrant women frequently have to deal with the feeling that they are not fully accepted and tend to be viewed as subordinate to the dominant culture. One woman, indicating a need for greater acceptance, described the feeling of not fitting in, in this way:

... We are living in the community but its just like water and oil, you shake the bottle, they mix together, you cannot tell the difference and I say >Hello, hi Joe, how are you?’ and then the bottle settles down, oil and water separates. We don’t feel we are really mixed with the neighbours, with the community ...

Hottar-Pollar and Meleis (1995) asserted that “Immigrant women often have to deal with unfriendly neighbourhoods and outright hostility in the communities where they live. Many are frustrated and saddened by the frequent reminders that they do not belong and this makes their integration into the mainstream even more difficult”(p.15). Their accents or appearance often set them apart and they may be treated with disrespect or outright prejudice (Lalonde, Taylor & Moghaddam, 1992).

### **1.3.3 Health Issue III: Barriers to Health Care**

Immigrant women may have fewer problems accessing health care in Canada than they might have elsewhere. In Canada, they are able to access basic health services free of charge, however, few have extra health insurance coverage. In spite of the advantage of “free” health care, they still have to face the complexity of learning how to access health care services, and they must endure the problem of language.

In spite of some difficulties, such as those identified above, 18/22 of the women indicated they liked Canada’s health care system in general. There were several very positive comments, one woman said;

I don’t know anyone have a problem for Medicare or support from the government. I don’t know, but all the immigrants I know, I have never heard a complaint.

An additional comments was:

I like it because you get sick, you don’t need to worry tonight, you can go to the hospital right away. You don’t have to wait until you have money.

### ***Theme 1: Health Services***

Language was identified as a major barrier by almost all (20/22) of the women in this study. In addition all of the women (13/13) who were asked the question, conveyed the need for trained professional interpreters. One woman expressed this need when she said:

You don’t feel comfortable when some other people is [interpreting] especially the special exams that women have to have.

Another comment was:

You want to talk to somebody, just to talk and without language you can’t. You feel frustrated!

Researchers have noted that inadequate English may interfere with identifying appropriate sources for care, making appointments, describing their problems, and understanding verbal and written instructions (Lipsom & Omidian, 1997). Often the women are expected to find their own interpreter and this in itself is daunting. Finding a friend or family member who has the time and the language skills to interpret is difficult, and in addition, there is the privacy issue (Lipsom & Omidian, 1997). As articulated by the women in this study, they are likely to go for medical or hospital care only when they or their children are very ill or in the case of an emergency.

More than half of the women said their visits to a doctor in Canada were similar to a visit to a doctor in their country of origin and that the questions asked were similar. Some comments about Canadian doctors however, indicate that they may have encountered barriers to obtaining the kind of health care they value. The following comments demonstrate their concerns:

Doctors [here] don't really listen. If I go to the doctor, I want help, I do not want to be told I will get over it. I want to be taken seriously. I feel angry and frustrated. Take tylenol, I get that a lot (pause) ...

They just do in [sic] a physical check-up from head to toe. They don't use, I find, like a holistic view to assess your, like, physical and mental problems. I guess they don't have time, and like, they never have time to ask me how I feel;

Doctors here full of theory. They are really knowledgeable persons, but I never get the help I was expecting. In my country, they don't know so much, but they help me;

[Doctors] don't give you enough time. They want that you say them [tell them] so fast, what do you want or what do you feel and when you go with children, it is really difficult.

The finding that immigrant women don't feel they receive adequate care from physicians in Canada is supported by the findings of Meleis et al.(1998), who claim that immigrant women need to talk and need time to tell their story in their own way. If this does not happen the women often feel that their concerns have not been heard, that they have not been given good care, and quite possibly that they have been misunderstood. They are not accustomed to the brief 10-minute appointments as is the custom in Canada.

Another barrier, for more than half of the group (13/22) was the preference for a female doctor, especially for gynecological examinations and any situation where they had to remove their clothing. One woman said, "If there is no female doctor, I would not get a gynecological exam." The remainder of the women stated that it did not matter whether the doctor was male or female, "what matters is how they do their work." Because of the shortage of doctors in PEI, the women who preferred to go to a female doctor had difficulty in doing so.

Cultural sensitivity was perceived as a barrier for almost half (10/22) of the group. Three comments on cultural sensitivity in health care were:

I think it is a good one. They are quite helpful, [but] not sensitive to your culture.

Its really, really good. But strange to me.

Doctor doesn't know about tropical medicine or health problems from other countries and isn't open to learning about them.

Notably, the women identified cultural insensitivity (rudeness) among doctor's receptionists as a barrier to health care. Two quotes demonstrate this:

No, they don't try and sometimes they are really, really easy words, that they are really easy to understand, but they look that B and in that way you, you feel sometimes worse because you are trying hard to do the best that you can, but in that time that they say that or they look at you in that way, you in that moment, you like come back [withdraw] and you don't want to talk ... or you don't want to ask more ...

... The receptionists are so, so rude, especially when they see you are not from here. You try hard, but they really can't understand you; they don't try.

Approximately half of the women (10/22) found the long waits for appointments with doctors and the long waits in doctors offices to be frustrating. One woman said:

[It is] not convenient to see a doctor. You have to wait two weeks to get an appointment, then wait 2–3 hours in a clinic. I rather stay home if I have a problem.

She acknowledged that this is an issue for everyone and does not indicate discrimination against immigrant women.

Referral to a specialist was also perceived to be an issue by almost all (19/22) of the women. They asserted that they were accustomed to going directly to a specialist and were frustrated with the delays in being referred. They stated that it is "hard to get past the family doctor." All felt that they should be able to go directly to a specialist without being referred by the family doctor. One comment was:

Have to wait three months for specialist. In pain the whole time, no family doctor, don't know the system, don't know who to ask.

All of the women who were asked (10/10), identified the need for information about the health care system. All felt that it was very necessary to have the information upon arrival rather than 3-4 years later when they became Canadian citizens. They also said they need to know about Canadian laws and women's rights and other relevant issues. Unfortunately, because of inconsistencies in following the interview guide, 12 women were not asked this question.

In summary, factors described as barriers to getting the health care they need included language and the need for interpreters; long waits for doctors' appointments and availability of doctors; inappropriate and or culturally insensitive care; the feeling that doctors don't listen, don't discuss and don't give enough time; and reluctance on behalf of family doctors to refer to a specialist. A small number of women identified transportation as a problem, and an additional few identified

no health plan, lack of coverage of medication and dental services and of alternative health care services such as masseuses and chiropractors as interfering with getting the health care they need.

### **1.3.4 Conclusion**

Immigrant and refugee women have health needs similar to Canadian-born women. However, these needs are intensified because of their lack of resources. They are unfamiliar with the ways and customs in this country, they often lack language skills, they have few or no social support systems, they feel unable to engage in their usual health maintenance activities, and they frequently cannot find appropriate employment. Everything that offers the comfort of the familiar seems unavailable to them. The first step toward affirming immigrant women's health and toward inclusive health policy is for politicians, health care providers, and communities to begin to value these women, to develop partnerships to enhance involvement, and to provide support, options and choices where relevant. Putting policies and programs in place to support immigrant women in their efforts to build a new life would be cost effective because, as they themselves report, when they are healthy they are better able to take care of their families and themselves.

## **1.4 The Development of Partnerships**

In 1994 there was little or no cultural content in the UPEI School of Nursing (SON) program and it was recognized at that time, by the SON faculty, that there was a need to address that deficiency. The InterCultural Health Assembly (ICHA) was created in 1995, and members of the PEI ANC, the UPEI School of Nursing, and the Multicultural Council (MCC) of PEI became members of ICHA's board. An alliance was then formed between UPEI, PEI ANC and the ICHA of PEI. The initial purpose of this partnership was to provide fourth year nursing students with a clinical placement in the community that would give them the opportunity to work with people from other cultures and to learn about those cultures. This experience partially fulfilled a community component of the Bachelor of Nursing Degree at UPEI. All partners recognized the need for improved accessibility and culturally appropriate healthcare services in PEI.

This MCEWH research project provided the opportunity to work together on a proposal of mutual interest: immigrant women's perceptions of health, their health maintenance patterns, and their experiences with the health care system. The PEI ANC, the ICHA of PEI and the UPEI School of Nursing have worked closely on this research initiative from its inception to the writing of this report.

### **1.4.1 The Partnership in Action: Roles and Functions**

The research partners worked closely to develop the research proposal. The principal investigator was responsible for gaining the approval of the UPEI Senate Research Ethics Committee to proceed with the research. Both partners contacted individuals who might be interested in becoming members of the RAC and both were involved in meeting with the RAC to brief them on the nature of the research project and later, to gain their feedback on the questionnaire. Both partners were also involved in the first focus group (Appendix A) with immigrant women. The responsibility for contacting the immigrant women and arranging the room and food for that initial focus group was largely managed by the co-principal researcher at the PEI ANC.



Contacting the immigrant women to set up the research interviews, conducting the interviews, and transcribing the data was contracted out to a paid research assistant. Analysing the data, writing the report and disseminating the results has largely been the responsibility of the principle investigator at UPEI. Sharing the data with the respondents following data analysis, and communicating with the RAC regarding the findings was coordinated by the co-principal investigator.

Members of the RAC (Appendix E) were also partners in this project. Members of the committee represent partnerships with: The Office of Employment Equity and Official Languages; Veterans Affairs Canada; PEI Association of Newcomers to Canada; Transition House Association; Race Relations Association; PEI Department of Education; PEI Department of Health and Social Services; Cooper Institute; Community Legal Information Association; Federal Department of Citizenship and Immigration; UPEI Women's Studies, and the UPEI; School of Nursing. Included on the committee were individual immigrant women who were nurses, and an alternative medicine practitioner from the Philippines.

The members of this group (Appendix E) provided guidance in developing the questionnaire, feedback after it was developed and feedback once the data were analysed (Appendix F). They will also provide influential contacts for the important task of disseminating the data.

## **2.0 Evaluation**

### **2.1 Review of Initial Evaluation Plan**

Three types of evaluation were planned in the original submission.

- 1) "The process of developing the questionnaire will be evaluated by a focus group and by the Research Advisory Committee."

This step in the evaluation plan was partially carried out. The focus group of immigrant and refugee women had input into the development of the questionnaire; however time did not permit evaluation of the final version by this group. In retrospect, had we taken the questionnaire back to the immigrant women's focus group for feedback, we might have avoided some of the problems that were later recognized, such as length of the questionnaire and openness of the questions.

- 2) "The ethical aspects of the research plan will be reviewed by the UPEI Senate Research Ethics Committee before the research is implemented and by the Research Advisory Committee on an ongoing basis."

This step was completed and a letter of acceptance was received from the UPEI Senate Research Ethics Committee before the research was implemented. A meeting was held with the RAC giving them the opportunity to review the questionnaire and make suggestions for change. The researchers met with them again for their input once the data had been analysed and a draft report written.

- 3) “The target population will take part in the analysis of the data as well as in reviewing the findings.”

Time restraints did not permit the opportunity for the target group to take part in the analysis of the findings. However, once the analysis was complete, the data were shared with them for their feedback (Appendix D).

## **2.2 Review of the Research Objectives**

Fulfilment of the objectives is one indicator of the success of the project. We interviewed immigrant women about what health means to them and the factors influencing their health. We talked with them about their health maintenance patterns and whether they were able to engage in the same activities in Canada. We explored their experiences as immigrant women using the Canadian health care system, as well as their concerns regarding the significance of gender, language and culture in seeking and receiving health care. We believe we obtained in-depth and useful information on those topics that can be used to implement programs and policies to support immigrant women in maintaining their health.

The final objective, to provide guidelines to policy makers regarding the health, health maintenance, health care delivery and health service requirements of immigrant women, is being fulfilled through meetings with the RAC who are charged with the duty of sharing the findings with the organizations and government departments they represent. In addition, an executive summary, including recommendations, will be distributed to relevant government departments, the Deans of Schools of Nursing in the Atlantic region, pertinent departments at UPEI, and other appropriate non-government organizations and associations in PEI.

## **2.3 Review of the Research Plan**

The original plan was to interview 30 immigrant and refugee women 20 years and older who had been in Canada for up to 7 years. In fact, we interviewed 22 women because we did not have access to a larger number. The number interviewed was probably sufficient because by the last few interviews, the data were becoming repetitive. Regarding, the criterion of “up to 7 years,” we had to increase the number of years lived in PEI to 20 years or less in order to have an adequate number of women in the 50 plus age group. Again, there may have been a positive aspect to this change. For example, the data obtained would be based on women’s experiences in their new country over a greater span of time.

Sixteen women were in the age group 21 to 50 years and 6 were in the 51 plus age group. Hence, the goal of having approximately 2/3 of the respondents in the 21 - 50 age group was realized. However, we fell short of our goal to have approximately 1/3 in the 51 plus age category. In fact only 1/5 of the women interviewed were in the older age group.

The sample was small, however it was diverse, and the data obtained were broad in scope. The diversity of the sample may support transferability of the findings to other groups of immigrant women in PEI. However, because PEI is a small, largely rural culture, transferability to groups of immigrant women outside of PEI, especially those living in large urban areas, may not be dependable.

The women were drawn from both immigrant and refugee groups that were different than those originally planned and this could not be avoided due to accessibility and the changing face of immigrant and refugee groups in PEI. The sample, however was not statistically representative of immigrant groups in PEI. No differentiation was made between immigrant and refugee women during data collection.

## **2.4 Challenges**

There were many challenges. Language was a major challenge. While some of the women spoke English quite well and did not seem to need an interpreter, they occasionally found it difficult to understand certain English phrases and concepts used in the interviews. They also seemed to find it difficult to fully express what they wished to say.

Interpreters added another challenge. Because of the diversity of the sample, in terms of culture and language, three interpreters were required. Thus consistency was somewhat challenged. In addition, two of the interpreters were known to the respondents. Even though the researchers realized this was not the most favourable setup (Kaufert & Putsch, 1997), professional culture and language interpreters were not available.

The principal investigator conducted one of the interviews and gained personal experience with use of a family member as an interpreter. In the initial part of the interview with an elderly respondent, her daughter acted as an interpreter. During this time the respondent spoke very little and gave very brief, at times, one-word answers. The daughter then left the room and the interview continued with just the principal investigator and the respondent. The respondent became obviously more vocal and expressive in her responses. When this was mentioned to her she said she was ashamed of her English and did not want her daughter to hear her speak.

## **2.5 Lessons Learned**

In terms of lessons learned, the questionnaire was too long and the women were often tired by the end of the interviews. Aside from the length of the interview guide their fatigue may have been a result of trying to make themselves understood. The relationship between respondent, interpreter and researcher is complex and almost certainly tiring.

Although we set out to have a semi-structured interview guide with probes to encourage focus and depth, in the opinion of the writer, the questions were too specific. This may have led the women to “answer questions” rather than talk to us about the areas that were of primary concern to them. The first draft of the questionnaire was much shorter and more open ended. However, when it was taken to the RAC for feedback, some members insisted that certain specific questions be included. This was done, with the result that the questionnaire became too long and the questions too specific to allow the women to lead the interview in the direction that allowed full expression of their health concerns.

The principal and co-principal investigators were aware of the need to ask the same questions in each of the interviews. This did not happen in all cases and consequently the strength of the data in some areas may have been affected. Furthermore, the questions were not always asked in an open-ended way, again possibly affecting the quality and depth of the data obtained. It may have been a case of “too many cooks spoil the broth.”

Completing the project took longer than anticipated. Perhaps consideration should be given to the fact that one year may not be long enough to carry out significant research in a meticulous manner. Time is particularly necessary for qualitative data where the interviews are long and data analysis can be time-consuming and onerous. The researchers involved in this project had very demanding positions aside from the research, and time was needed to pay thoughtful attention to each step of the research process to assure its credibility, dependability and confirmability (Polit & Hungler, 1996). Time is also required to adequately report the findings.

Although there are some limitations, this study does address a void in research related to immigrant women's health, health maintenance patterns and experiences using the health care system. The main findings of the study identify important health needs of immigrant women that may have implications for program and policy development, as well as for future research on the influence of certain determinants of health on immigrant women's health.

### **3.0 Dissemination Plan and Knowledge Sharing**

An executive summary of this project will be presented in person, by RAC members, or otherwise to the following individuals, government departments and agencies: The PEI Minister of Health; PEI Provincial Department of Health and Social Services; Federal and Provincial Department of Citizenship and Immigration; Department of Veterans Affairs; the PEI Provincial Department of Education; Holland College, Transition House Association, Race Relations Education Association; the Multicultural Council of PEI; the PEI InterCultural Health Assembly; the Queen Elizabeth Hospital; Four Neighbourhoods Community Health Centre; the Cancer Society; and the following departments at the University of Prince Edward Island (UPEI): the School of Nursing; the Women's Centre; the Women's Studies program; the Canadian Studies program; and the Institute of Island Studies. Regionally, the knowledge will be shared through the Atlantic Region of the Canadian Association of University Schools of Nursing. The principal investigator is the PEI representative to this association and the findings will be presented at the Fall, 2000 meeting of this group. The findings will be communicated to the ICHA Board members in the fall of 2000 and they will hopefully share the information with their communities and organizations. It is hoped that this broad dissemination of the findings will result in the development of programs and policies that will benefit the health of immigrant women in PEI.

The target group was informed of the findings at a social gathering at the PEI ANC in April, 2000, and indirectly through a local press release to the Canadian Broadcasting Corporation (CBC).

Dissemination of the research findings will continue to occur at academic and professional development conferences as well as by other identified means as opportunities arise over the next 2–3 years. Two publications based on this research have already appeared in *Health and Cultures*, a publication of the Canadian Council on Multicultural Health. A paper on this research has been accepted for publication in the refereed journal, *the Canadian Nurse*. As well, the findings have been presented at the MCEWH conference in Halifax, October 3-6, 1999; at the Society for the Psychological Study of Social Issues (SPSSI) Conference in Toronto, August 12-15, 1999, and at *Removing Barriers II: Keeping Canadian Values in Health Care - Inclusion, Diversity, and Social Justice in Health*, May 25-27, 2000 in Vancouver, BC.

## **4.0 Summary of the Outcomes and Implications for MCEWH Mandates and Programs of Research**

### **4.1 Implications for MCEWH Mandates**

This research illuminated the perspectives of immigrant women on their health, their health maintenance practices and their needs and experiences in relation to the health care system in PEI. The findings indicate that some of the determinants of health play a significant role in the health of immigrant women. This finding has implications for further research in the area of immigrant women's health and the determinants of health. The results of this research also indicate a need for language programs, employment programs, health promotion programs in several languages, a community outreach program, and the need for professional cultural/language interpreters in health care, along with training programs for them. The findings indicate the need to promote culturally sensitive care in hospitals, clinics, and in the community. The study reveals a need for cultural content to be included in nurse and physician education programs and for an information booklet on Canada's health care system.

Strategies to address immigrant women's needs have been developed and are presented in Section Five, Implications for Policy Development (pp.44-46). These strategies will be shared with appropriate government departments and community organizations to inform both public and social policy on immigrant women's health needs.

Communication of the findings has been addressed in Section Three, Dissemination Plan and Sharing Knowledge. A wide net has been cast to disseminate the knowledge intersectorally.

This project has provided the opportunity to build and strengthen networks in the community and province wide. The project itself brought together three groups, PEI ANC, UPEI, and ICHA. The RAC committee brought together many more groups and organizations from government departments, to non-governmental organizations and individuals. As well, contacts have been made across Canada through information sharing on the Internet. Requests for information from across Canada have been sent out and received. The liaisons formed during the process of developing the research plan, conducting the research, sharing the findings will hopefully continue to provide opportunities to improve relationships and increase cultural awareness within government and in the community as a whole.

### **4.2 Implications for MCEWH Programs of Research**

Recommendations for future research (Appendix H) include the need to:

- repeat the study in PEI after shortening the interview guide and making the questions more open ended, also using more probes on topics raised by the respondents;
- repeat the study in other provinces in Canada where immigrant populations are larger and more condensed;
- investigate existing interpreter programs to determine best practices for PEI and the Atlantic region in Canada;
- initiate specific research on the influence of language ability on the health of immigrant women, on their health maintenance practices and on their health seeking behaviours;
- develop and test strategies for culturally competent care;

- initiate research on the influence of the specific major determinants of health identified in this study.

In addition, many of the women in this study talked about their impression that all food in Canada is prepared and therefore unhealthy. An investigation into immigrant women's impressions of what Canadians eat and how media images influence the dietary choices they make for themselves and their families would provide useful information for health promotion programs.

Domestic violence was a topic that could have received further exploration in this study and suggests another area for future research. The importance of conducting this research is confirmed in a statement made by a member of the target group when the findings were shared with them. She said: "What about violence ... I didn't see anything on abuse, it's probably an aspect of health – because I don't remember anything concerning abuse in the questions."

## 5.0 Impact on Policy-Making/Implications for Policy-Making

The findings of this study do not support the hypothesis that immigrant and refugee women have different health care needs than their Canadian-born counterparts. Their needs were found to be similar; the difference was in the presence or absence of certain determinants of health. Their resources in terms of the biopsychosocial determinants of health were, for the most part, present. However, they met with problems in the areas of social support, socioeconomic factors (language and employment and belongingness to the community) and health services. The findings of this study support the need for more culturally sensitive health care, the need for trained cultural/language interpreters, and the need to recognize the significance of the gender of the health care provider. The findings also support the need to recognize and empower immigrant women as resources in maintaining their own health. Public policy and health care programs in hospital and in the community must support immigrant women particularly in relation to the determinants of health identified in this study. In consideration of the influence of the certain determinants of health on the health of immigrant women, public and social policy and program development should be directed to the following areas:

1. **Language programs:** Currently only language programs levels 1-3 are offered in PEI. In order for immigrant women to gain sufficient skills to compete in the job market, they need higher levels of English language classes.
2. **Employment programs:** A program is currently in place to assist those who have the language skills to obtain employment. This program must continue to receive stable and adequate funding.
3. **Health promotion programs:** Health promotion material in their native languages is needed. A food/nutrition/cooking class on how to adapt their traditional cooking styles to the foods available in Canada is also needed. The cooking class could provide an opportunity to share their rich knowledge about food and nutrition, and could serve the dual purpose of providing the opportunity to build a social support network.
4. **A community outreach program:** A community outreach program is needed to help the women to continue with their customary social and leisure activities, such as playing a musical instrument or singing in a choir. This program could help them to learn about their new location and to discover the kinds of social and leisure activities available to them.

5. **Affordable child minding services:** In the absence of social support networks, affordable child minding services are necessary to allow these women, to continue with their social and leisure activities, to attend the suggested food/nutrition/cooking class, to attend ESL classes and to search for employment.
6. **Cultural language interpreters:** All of the women who were asked the question, identified the need for trained cultural/language interpreters. Such a service in turn requires a training program for the interpreters.
7. **Cultural sensitivity for health care providers and support people:** In order for health care providers in general to provide culturally competent and sensitive health care, in-service and education programs promoting culturally sensitive approaches need to be provided on a regular basis.
8. **Nurse education:** Nurse educators need to continue to work to ensure that nursing students have the opportunity to develop culturally competent and sensitive interventions and that they have experience working with immigrant populations in clinical settings in both acute care and the community. This program should extend to continuing education programs and Licensed Practical Nurse (LPN) programs.
9. **Strategies to increase physician sensitivity:** The findings indicate the need to promote culturally sensitive approaches in doctors' clinics with both the doctors and their receptionists. Some ideas include:
  - Cultural groups in Charlottetown (e.g., PEI ANC, ICHA, MCC) could work with the Medical Society on how best to encourage local doctors to adjust their practice to meet the needs of immigrant women;
  - Invite Dr Ralph Masi, a physician and leader in Canada in the area of multicultural health care, to work with doctors toward increasing cultural sensitivity;
  - Encourage immigrant doctors to use their experience and work from within the medical community to encourage cultural sensitivity;
  - Cultural groups and/or the researchers (e.g., PEI ANC, ICHA, MCC) could inform doctors of immigrant women's experiences and encourage doctors to provide sessions on cultural sensitivity for their receptionists.
10. **Informing government:** Researchers and/or cultural groups should meet with the Minister of Health, the Director of the Division of Public Health and with the Director of Evaluation Services to talk about the health care needs of immigrant and refugee women.
11. **Develop an information booklet on the health care system:** The women identified a need for information about the health care system and all feel that it is important to have the information upon arrival rather than 3 B 4 years later when they become Canadian citizens.

In conclusion, this study may increase awareness in the community of the health needs of immigrant women. It may influence practice to include a concern about hearing the voices of these women, and to recognize the role that gender and culture play in their health care. It is anticipated that this study will influence public policy and funding practices so as to place more emphasis on programs related to the social determinants of health identified as having an impact on the health of immigrant women. Specific areas that need to be addressed through education, funding and policy are identified and suggestions for implementation have been elaborated above and in Appendix I.

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## **Appendix A: A focus group with immigrant women on the topic of health: A preliminary report on a research project funded in Prince Edward Island by the Maritime Centre for Excellence in Women's Health**

The Prince Edward Island Association for Newcomers to Canada, the InterCultural Health Assembly of Prince Edward Island (PEI) and the University of PEI collaboratively engaged in a research project involving immigrant women. The project, titled *Affirming Immigrant Women's Health: Building Inclusive Health Policy*, was funded by the Maritime Centre of Excellence for Women's Health. This research will explore immigrant and refugee women's experiences, perceptions and perspectives of the factors that influence their health, the things they do to protect their health, and their experiences using Canada's health care system.

The method to be used for this research is qualitative and is designed to listen, hear and include the voices of women not typically heard in health research. The hope is that through hearing the voices of these women this research will further understanding of their health and health care needs. The target groups will be immigrant women aged of 20 - 80+ and representative of immigrant and refugee groups in PEI. The plan to collect data includes the use of two focus groups to guide the researchers in developing an interview guide for talking with immigrant and refugee women about health. The first focus group will be with immigrant women and the second with health care providers from diverse cultures. This paper describes the focus group with the immigrant women.

Seven women attended the focus group meeting. Six were between the ages of 26 and 49 and one woman was over the age of 50 years. More women were invited but for a variety of reasons were not able to attend. Four of the women in attendance were from the former Yugoslavia, one was from El Salvador, one from Pakistan and one from Iran. There were three people involved in leading the group, a facilitator, an observer and a recorder. The recorder noted the ideas and comments on a flip chart.

As the women arrived they were welcomed and everyone was introduced. The furniture in the room was comfortable and was arranged as near as possible in a circle to facilitate openness. Everything possible was done to make the women feel comfortable and to feel that it was a safe environment in which to share opinions and views (Then, 1996). The research project and the reason for the gathering was briefly explained and the women were given the opportunity to clarify anything they did not understand. They were also encouraged to ask questions and to share opinions at any time during the focus group session. They were asked if they would mind if the process was tape recorded. They gave their verbal permission to do so and an unobtrusive recording system was set up. The use of written consent forms was avoided because of the fear many immigrant and refugee women have about signing papers. It was felt that if they had to sign a paper it would change the atmosphere and many either would no longer want to participate or would participate less freely. The issue of confidentiality was explained, and everyone in the room agreed that what took place in the group would stay within the group. The women indicated they were very comfortable with the researchers and with the situation.

One of the first questions discussed was "What does health mean to you?" Many of the answers to this question related to mental health. The first answer to the question was "[health means] health in body and mind, sometimes mind is more important." Other responses included; "if the mind is not well, the body is not well;" "a good mind is an important thing, you can have surgery

to fix everything but the mind;” “when you travel to other places, you can undergo a big shock spiritually. You can get sick because spiritual needs are not being fulfilled, you are disconnected with things;” and “As our body needs food, our mind also needs spiritual food.” Some of the women felt that employment and money affected health and others did not. Two women, one from Iran and the other from El Salvador felt that employment and money do indeed affect health because if a person is not employed or there is not enough money, then stress will be increased and physical and/or mental illness can occur.

The group felt that family and friends had a very important impact on health. One respondent said, “It is very hard, homesick, hard to be far from family, need the love, support and understanding from family and friends.” Another respondent said that depression is epidemic and there is a high rate of sickness because of depression. Anderson (1985) found that for many immigrant women, loneliness and depression were of greater concern than their physical symptoms. If physical pain was involved however, the loneliness and depression increased.

In answer to the question, “what means you are sick?” the answers included: “pain somewhere;” “sick means fever,” “changes in your body,” “something different happening;” “You are sick if you are fatigued, weak, don’t feel like working, don’t want company, stay at home all of the time, no appetite, tired;”

When asked, “how do you stay healthy?” many of the women from former Yugoslavia and Iran related similar things to what people living in Canada do to stay healthy. They said “good food, exercise, feeling young, thinking positively.” The respondent from El Salvador indicated that the social problems in that country are so great that they hinder people from doing things to stay healthy. She said “they don’t consciously exercise, [their] mind is on other things, [there] is not emphasis on health.” Another moving comment was “[Immigrant] women have to be braver here, they need more energy because they have sole responsibility for family - they don’t have the support of extended family and friends as they did in their own country.”

The women agreed that a question on traditional remedies for illness should be included. During that discussion some interesting interventions were shared. For example, the herb thyme is used to cure headaches, rosemary tea is used for thyroid problems, sage is used to cure sore throats, and boiled lemon peel is used for those who have difficulty sleeping. On the subject of hemorrhoids, yeast was used to shrink them and reduce itching. The women related that they use these remedies at times, but that physicians don’t acknowledge them as useful.

An important point made was that food in Canada, “has no taste and little or no odour.” The women described how very much they miss favourite foods from their country and how they try to obtain them whenever possible. For instance, when they travel to their country of origin, or when they go to a larger centre such as Toronto, they purchase the ingredients for their favourite foods and bring them back to PEI. They then keep these foods for special occasions. They talked about how they mentally savour the thought of preparing these dishes for special family occasions and they remarked that familiar foods replenish not only the body but also the soul and the spirit.

The next topic of discussion was their experiences with the health care system in PEI. More than half of the women in this group, although from another culture, were not visible minorities. However, even though they did not look different, they felt that because of their accent, they

were treated differently in the health care system. Of those who were visibly different, all indicated that the difference in their physical appearance caused them to be seen as less credible and as not knowing very much. They felt that the doctors made assumptions about them and didn't listen to what they were trying to say and didn't allow them to participate in decisions regarding their own health care. Instead, they were told what to do and what was needed.

When asked if it mattered whether the physician was a male or a female, most said no. This is consistent with the literature. Flaskerud (1990) in a review of the research literature on the topic of matching client and therapist ethnicity, language, and gender found that gender was less significant than language match or match in attitudes and lifestyles. However, one indicated that it was very important for women of east Indian origin to have a doctor of the same gender. She said that they "do not feel good inside themselves to be touched by a man" and that they would not share their feelings. She went on to say that if they are forced to have a physician of the opposite gender, "they will not get well, they will become more sick." It appears that the gender of the health care provider is very meaningful for women from east Asian cultures.

The information provided here is a summary of the first focus group with 7 immigrant women. They were asked to come together to relate to the researchers what health means to them, what their usual health maintenance patterns are and to determine whether they are able to engage in those same health maintenance patterns after coming to Canada. The information gathered from this focus group will be used to develop the interview guide for individual interviews for this research project with immigrant women on PEI.

The group lasted for 1 2 hours. Refreshments were provided for the group, and that gesture did seem to contribute to a warm and friendly atmosphere for interacting. The food was enjoyed by both the respondents and the researchers. The women attending this session seemed to enjoy the session and some lingered on chatting and asking further questions following closure of the official focus group activities. One woman said "It was a lovely group. Thank you for doing that."

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## Appendix B: Semi-Structured Interview Guide

ID Code #: \_\_\_\_\_  
Date: \_\_\_\_\_  
Location of Interview: \_\_\_\_\_  
Time to Complete: \_\_\_\_\_  
Audiotaped: \_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ #: \_\_\_\_\_

### Guidelines

1. Questions are asked in an open-ended manner that requires more than a “Yes” or “No” answer and in a way that allows the respondent to determine the direction of the answer.
2. Questions are very broad and open-ended to begin with and then move to being more specific, using probes or the respondent’s answers (reflection) to obtain more specific information, if needed.
3. A probe might be: “Could you talk a little more about that ... about how employment affects your health?”
4. Use of reflection would be paraphrasing what the respondent has said and then waiting for them to elaborate. For example, “... health is ... (pause) good mental and physical health ... (pause)”?
5. Both probes and reflection can be used for each question to obtain depth of meaning (both the broad and the specific) about the topic in question.

### Semi-Structured Interview Guide

1. What does health mean to you? If someone tells you they are healthy, what do you think they mean?  
*Probes:* Is mental well being a part of it? Does a spiritual life or spirituality play a part?
2. Talk a little about the relationship between physical health, mental health, and spiritual health?
3. What are some of the ways you feel when you are healthy?  
*Probe:* What kinds of feelings, and thoughts are part of being healthy?
4. Talk a little about some of the things you are able to do when you are healthy?  
*Probe:* What kinds of activities are a part of being healthy?
5. Tell me about some of the things you are *not* able to do when you are *not healthy* or when you are ill?  
*Probe:* Family obligations, work?
6. Compare what you do here to stay healthy with what you did in your country?  
*Probe:* Traditional medicines, herbal treatments  
Dietary practices  
Do you have hot and cold conditions? What are some of the treatments you use for them?  
Exercise

7. Can you think of some general kinds of things in your life that affect your health?  
*Probes:* Would money or having a job be some of the things that affect your health? Employment? Family and friends? Language or the availability of language classes? Interpreters?
8. How do they affect the things you do to stay healthy?
9. What are some of the things you like about our health care [system]? What are some of the things you don't like about it?
10. Describe (for me) some of your experiences going to the clinic, the hospital or a doctor?
11. When you first came what would have helped you to meet your health care needs?
12. How important is a doctor to maintaining your health?
13. How important are other professionals besides your doctor to maintaining your health?  
*Probes:* Social worker? Employment counselor? Interpreters? Pharmacist? Religious leader? Dentist?
14. Can you describe for me some of the reasons you would go to your doctor?  
Here? In your own country? Are the reasons for the visit the same?  
*Probes:* Would you go to a doctor if you felt sad? Lonely? Why or why not?  
If you were having family problems, such as not getting along with your husband or having difficulties with a teenage child? Why or why not?
15. Describe your visits to your doctor in your own country ... and your visits to your doctor here ... what were they like ... (pause)?  
*Probe:* What kinds of questions did your doctor ask? What kinds of questions did you ask? What kinds of topics did you raise?
16. Does it matter to you whether the doctor is male or a female?  
*Probes:* Tell me how it matters? What are some things that make it matter?  
How comfortable are you talking to a male doctor about female health concerns?  
How comfortable are you being examined by a male doctor?
17. What, if anything, would stop you from going for health care when you need it? (Interfere or prevent)  
*Probe:* Are you able to make your own decision about going for health care? Does your husband play a role?
18. What else or what other things are needed in Canada's Health Care system in order to meet your health needs?  
*Probes:* Qualified interpreters?
19. Is there *anything else you would like to say or talk about?*  
*Probe:* Anything you would like to tell me about ... ?

## Appendix C: Personal Data Questionnaire

### Personal Data

Country of birth?

What is your ethnic group?

What is your occupation?

Citizenship: a) Canadian b) Other \_\_\_\_\_

When did you come to Canada? (example: April, 1990)

What is your age?

a) 21 - 30 \_\_\_\_\_

b) 31 - 40 \_\_\_\_\_

c) 41 - 50 \_\_\_\_\_

d) 51 - 60 \_\_\_\_\_

e) 61 - 70 \_\_\_\_\_

f) 71 - 80 \_\_\_\_\_

g) 81 + \_\_\_\_\_

Marital Status:

a) Married \_\_\_\_\_

b) Widowed \_\_\_\_\_

c) Separated \_\_\_\_\_

d) Divorced \_\_\_\_\_

e) Single \_\_\_\_\_

What languages do you normally speak at home? \_\_\_\_\_

Outside the home? \_\_\_\_\_

What languages do you speak when you are with your children?

Friends?

What languages do you read?

How many children do you have?

a) None \_\_\_\_\_

b) 1 - 2 \_\_\_\_\_

c) 3 - 4 \_\_\_\_\_

d) > 4 \_\_\_\_\_

What ages are your children?

a) 0 - 5 \_\_\_\_\_

b) 6 - 10 \_\_\_\_\_

c) 11- 15 \_\_\_\_\_

d) 16 -20 \_\_\_\_\_

e) 21 + \_\_\_\_\_

Are you presently employed?

a) If yes, what do you do?

b) If no, would you like to work?

c) If yes, are you employed in your field?

What is your annual household income?

a) less than \$10,000 \_\_\_\_\_

b) \$11,000 - \$20,000 \_\_\_\_\_

c) \$21,000 - \$30,000 \_\_\_\_\_

d) \$31,000 - \$40,000 \_\_\_\_\_

- e) \$41,000 - \$50,000 \_\_\_\_\_
- f) \$51,000 - \$60,000 \_\_\_\_\_
- g) \$60,000 - \$80,000 \_\_\_\_\_
- h) \$80,000 + \_\_\_\_\_

What are your main sources of income?

Do you have additional expenses?

*Probes:* Does your family have a health care plan that covers extra services, e.g., dental coverage?

Do you send money back to family in your home country?

Do you support other family members here?

Are there other expenses, for example medications or other treatments that are expensive, that make it difficult to get by?



## Appendix D: Feedback from Target Group, April 10, 2000

- all 22 women were called
- three could not be reached (disconnected lines)
- one had moved
- one was traveling
- four received the full report by e-mail
- one received the full report hand delivered
- one responded in detail by phone
- three attended slide presentation of findings

### Comments from Presentation

- you did lots of work
- very nice
- every aspect the same for women and for men, this is not specific to women, good info for both
- what about violence/ I don't know about our community but there is a lot...I didn't see anything on abuse, its probably an aspect of health...because I don't remember anything concerning abuse in the questions
- concerning the question "What interferes with getting health care?", you go to see the doctor and get the information, doctors don't give you time, any explanation. I don't understand them. They say anything is okay B but something is wrong B sometimes they get mad "why do you ask for that? You don't suppose to know that"..but..I want to know my problems. I want to know everything. If they are not allowed to give information because they are not sure, or need to clarify with someone else, then, okay. (Asked if this concern was noted in the presentation:) Yes, I heard it in the research.
- I have a recommendation, there is community support for elementary school thru to university to do cultural diversity, but not for the general community. The majority of public are not aware of cultural diversity. I give you an example. The new Superstore has a big section on oriental food B but they don't have any idea what oriental people eat, i.e., chow mein, sauces in a can ... this is Chinese food for Canadian people. I sent a list of Chinese food to the manager of superstore B he said wait til new store, so I called back B asked them ..., follow-up, and they said, "no we can not do it," so I went to Sobey's B same thing B nothing. They don't realize how important it is to have the foods. We eat only 1 B 2 items on the oriental shelf B out of 50 items B so they eat westernized Chinese food! The public don't aware, don't aware, don't realize."
- Concerning research finding #3: "that's funny for me, in my case, I don't have any complaint male or female. I just need a good doctors, that's it.
- concerning research finding #3: I agree with the research findings.
- sometimes I put myself in the passive position. Why don't I go to the community and make an effort.
- we use to get together B now everybody has jobs B almost the whole community is working B no parties anymore. (Name) planned them. Now she's busy. We are taking the Canadian way.
- Where does the money come from to do the programs?

## Comments from Phone Call Feedback

- Research questions: Put how the questions were asked, not the global view.
- Current knowledge about the topic: What part of the first sentence is from the author? Is it a quote or a sense of Meleis. Do people carry roles or play roles? Inconsistent referencing in first paragraph. Second paragraph is clear reporting, not referencing.
- Methodology: The target population was immigrant and refugee women aged 20B70 years (delete 80 years and older)
- Objective #2: quote “My son....everything frozen...” quotation didn’t advance the context. The page didn’t flow smoothly. Perhaps another quote or paraphrase.
- Objective #4: second last paragraph , respondent suggested a column tabulation instead of the numbers in the text.
- Section 4 a): could indicate what Program 1 and Project1 is.
- Research fact sheet: inconsistency between major finding and research finding. What is a “female examination”?
- respondents overall comment: I didn’t see what I said, but everything put together is the feeling of most immigrant women.
- a few missing words

**Note:** The Target Group Meeting for feedback on the findings was organized and conducted by the co-principal investigator. The feedback is on the first draft of the final report and their concerns were addressed in this final draft of the report.

## **Appendix E: Research Advisory Committee (RAC) Members**

Members of the RAC included:

- Juana Polanco, Acting Policy and Research Officer, Employment Equity & Official Language Office, Veterans Affairs
- Nedeljka Samu, Professional Nurse from the former Yugoslavia
- Adaluz Cierra, Professional Nurse from El Salvador
- Marilyn Yu, Medical Doctor from the Philippines and alternative medical practitioner in PEI
- Joy Ikede, writer, teacher and Board member for ANC and MCEWH Steering Committee
- Joanne Ings, Executive Director, Transition House Association
- Wanda Whitlock, Race Relation Consultant, PEI Department of Education
- Loraine Poole, PEI Department of Health and Social Services
- Maureen Larkin, member, Cooper Institute
- Ann Sherman, Executive Director, Community Legal Information Association
- Asifa Rahman, Federal Department of Citizenship and Immigration
- Patricia Whitney, Director, Women's Studies, UPEI
- Sheila Dresen, Dean, School of Nursing, UPEI

## **Appendix F: Feedback from Research Advisory Committee, April 12, 2000**

- All nine advisors were e-mailed the report, recommendations, and implications and notified of meeting
- One could not be reached
- Four regrets
- Two no response
- Two attended: Maureen Larkin, Cooper Institute; Colleen MacQuarrie, PEI Dept. of Health

### **Comments from Presentation**

- average family income is usually not a range (is this the mode?). Does this represent the most frequently occurring response for this range, and the majority of the sample
- an average is usually one number
- pg.4 of report “not working” means not paid work outside the home?
- work with the Medical Society to strategize how best to deal with the doctors
- bring in Dr. Ralph Masi (A leader in culturally sensitive health care)
- have immigrant doctors who can use their experience to advocate from within the medical community i.e., the new doctor in O’Leary
- culturally sensitive health care curriculum at School of Nursing, LNA programs, medical schools, continuing education
- meet with Director of Division of Public Health and Evaluation, Teresa Hennebery and director of Evaluation Services, Rosemary White
- strategize with Joanne Irwin where impact can be made
- the information booklet is tangible ... can be looked at within the province

**Note:** The feedback session was organized by Laura Lee Howard and is based on the first draft of the final report. The concerns raised by the Research Advisory Group have been addressed in this final version of the report.

## Appendix G: Policy Fact Sheet

<p><b>Names of Investigators:</b> Marian MacKinnon, and Laura Lee Howard</p> <p><b>Contact Name:</b> Marian MacKinnon, School of Nursing, University of PEI, 550 University Ave., Charlottetown, PE. C1A 3R2 Phone: (902) 566-0769 E-mail: mamackinnon@upei.ca</p> <p><b>Contact Name:</b> Laura Lee Howard, Executive Director, PEI Association for Newcomers to Canada, 179 Queen Street, Charlottetown, PE. C1A 4B4. Phone: (902) 628-6009. E-mail: exdir@isn.net</p>	
<p><b>Major Finding # 1:</b> 20 out of the 22 women in the study identified language and the ability to express them selves as a major factor affecting their health.</p>	<p><b>Policy/Program Implications with Major Finding #1:</b></p> <ul style="list-style-type: none"> <li>• Language programs should be adequately funded and immigrant and refugee women supported in attending classes.</li> <li>• All levels of language classes need to be made available on PEI.</li> </ul>
<p><b>Major Finding #2:</b> Immigrant women indicated the need for professional interpreters trained in health care interpreting.</p>	<p><b>Policy/Program Implications with Major Finding #2:</b></p> <p>Programs to train interpreters in health care interpreting need to be set-up and funded.</p>
<p><b>Major Finding # 3:</b> Immigrant and refugee women identified social support, personal health practices (nutrition, exercise) and socioeconomic factors (employment, education) as the major factors affecting their health, as well as important factors in maintaining their health.</p>	<p><b>Policy/Program Implications with Major Finding # 3:</b></p> <ul style="list-style-type: none"> <li>• Programs to help women build social support networks should be put in place and adequately funded. An example of this would be the International Teahouse in Charlottetown, which currently only operates from January to early April.</li> <li>• An Outreach worker Program needs to be initiated and funded to introduce immigrant women to available fitness programs and social activities on PEI. These women need to be supported to maintain their personal health and fitness programs in the early months of arrival while they are learning the language and beginning to look for jobs.</li> <li>• Programs to speed up the assessment and acceptance of qualifications needs to be put in place so that immigrant and refugee women are able to find employment in their area of educational preparation.</li> </ul>
<p><b>Major Finding # 4:</b> Immigrant women (13/22) prefer to have a female physician, especially for female examinations or when they have “female problems”. If they must go to a male doctor they prefer to keep their clothes on during an examination.</p>	<p><b>Policy/Program Implications with Major Finding #4:</b></p> <ul style="list-style-type: none"> <li>• Develop programs to attract female doctors to the Island, especially female gynecologists.</li> <li>• Programs to educate doctors to be sensitive to the needs of immigrant women and to allow them to remain in their clothing as much as possible during an examination.</li> </ul>

## Appendices H: Research Fact Sheet and Recommendations for Future Research

<p><b>Names of Investigators:</b> Marian MacKinnon, and Laura Lee Howard</p> <p><b>Contact Name:</b> Marian MacKinnon, School of Nursing, University of PEI, 550 University Ave., Charlottetown, PE. C1A 3R2 Phone: (902) 566-0769 E-mail: mamackinnon@upei.ca</p> <p><b>Contact Name:</b> Laura Lee Howard, Executive Director, PEI Association for Newcomers to Canada, 179 Queen Street, Charlottetown, PE. C1A 4B4. Phone: (902) 628-6009. E-mail - exdir@isn.net</p>
<p><b>Major Finding # 1:</b></p> <p>The majority (20/22) of immigrant women in the study identified language and the ability to express themselves as a major factor affecting their health.</p>
<p><b>Research Finding # 2:</b></p> <p>Immigrant and refugee women indicated the need for professional interpreters trained in health care interpreting.</p>
<p><b>Research Finding # 3</b></p> <p>Immigrant and refugee women identified social support, personal health practices and employment as major factors affecting and maintaining their health.</p>
<p><b>Research Finding #4</b></p> <p>Immigrant women (13/22) prefer to have a female physician, especially when they must have female examinations or when they have Afemale problems.@ If they must go to a male doctor they prefer to keep their clothes on during an examination.</p>
<p><b>Recommendations for Future Research:</b></p> <ol style="list-style-type: none"><li>1. Repeat the study with immigrant and refugee women in other parts of Canada;</li><li>2. Investigate the role of language ability and health;</li><li>3. Research existing interpreter programs to determine best practices for PEI and the Atlantic region;</li><li>4. Investigate immigrant and refugee women’s impressions of what Canadian’s eat and how this influences dietary choices they make for themselves and their families.</li><li>5. Specific research on the role of the social determinants of health and immigrant women’s health.</li></ol>