Accessing Healthcare: Influences on Utilization Among Asian Immigrant Women

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Abstract

Previous research on immigrant integration has tended to focus on economic and social integration. As such, the factors shaping health integration are less understood. At the same time, health researchers suggest that immigrants in Canada may underutilize certain health services. For instance, studies have documented the low participation rates of cervical cancer screening among Asian immigrant women in Canada (Xiong, Murphy, Matthews, Gadag, & Wang, 2010; McDonald & Kennedy, 2007; Woltman & Newbold, 2007). This study sheds light on immigrant integration by exploring the experiences of Asian immigrant women with cervical cancer screening and Canadian healthcare services more broadly. Through in-depth interviews, Asian immigrant women share their experiences in the healthcare system. They report many difficulties including language, relationships with healthcare providers, cultural perspectives toward health, adjustment to a new healthcare system, and access to information. These findings help to shed light on health disparities and inform policies and practices that foster immigrant women’s health.

Keywords

Immigrant health, health inequalities, immigrant status, Asian immigrant women, cervical cancer screening, access to healthcare, healthcare service use, health behaviours, integration, culture
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Chapter 1

1 Introduction

Immigration has long been a driver of population growth and change in Canada. Over time, international migration has led to changes in the demographic makeup of the Canadian population. In 1961, 81.4% of Canada’s immigrants were of European or British origin (Statistics Canada, 2016). By 2011, only 30.8% of Canada’s immigrants were from the British Isles or Europe, with 69.2% of immigrants originating from other countries in Asia, Africa, and South America (Statistics Canada, 2016).

Changes in immigration policy and the introduction of the point system in 1967 allowed immigrants from all parts of the world to gain greater opportunities to settle in Canada (Green & Green, 1999). From 1960s onwards, Canada admitted an increasing diversity of immigrants from different ethnic backgrounds, languages, and religious affiliations. According to the 2011 National Household Survey, Asia (including the Middle East) is now the main continent of origin of the immigrant population, although Africa’s share has also increased (Statistics Canada, 2016).

Immigration is a major life event that has serious implications for the health and well-being of those who participate in this process. The healthy immigrant effect has been well-documented in Canadian literature on immigration (Ng, 2011; Gee, Kobayashi, & Prus, 2004; McDonald & Kennedy, 2004). New immigrants to Canada tend to have better health than native-born Canadians (Vang et al. 2015; Deri, 2004b; Newbold & Danforth, 2003). The foreign-born health advantage is seen to stem from selection effects associated with the immigration process: healthier people find it easier to migrate, while Canada’s strict immigration policies weed out the ill. However, the health advantage experienced by immigrants tends to decline over time (De Maio & Kemp, 2010; Ali, 2002). Recent research has also shown that the effect is not universal among immigrants. For example, children and immigrant mothers tend to fair less well than their male adult counterparts (Vang et al. 2015). Moreover, the effect varies by country of origin.
Women in particular experience distinct impacts on their health as a result of immigration. As migration is a gendered phenomenon, these different effects are not surprising. Gender is a core organizing principle that underlies migration and related processes, including transitions across state boundaries and adaptation to a new country (Boyd & Grieco, 2003). The experiences of immigrant women are important in Canada. In 2011, immigrants accounted for 20.6% of the total Canadian population. Similarly, immigrant women represented one-fifth of the country’s total female population, and 76% of immigrant women are members of a visible minority group (Statistics Canada, 2011). Gender, roles, and hierarchies produce differential outcomes for women, particularly in the post-migration stage where men and women often experience resettlement differently in a receiving country (Boyd & Grieco, 2003).

As a result of their membership in several marginalized groups, immigrant women face a combination of discriminatory practices and structural barriers: as members of a visible minority, they face ethnic and racial prejudice; as women, they are exposed to systematic gendered expectations; and as immigrants, they must navigate adjustments to a new language and society (Vissandjée, Weinfeld, Dupéré, & Abdool, 2001). The intersection of gender, ethnicity, and immigrant status creates unique stressors and barriers that contribute to disadvantages in health.

Variations in health outcomes across immigrant groups may have many sources, but access to preventative healthcare is an important piece of the puzzle. There is evidence that new immigrants have less access to preventative healthcare services (Degelman & Herman 2016; Lebrun & Dubay, 2010; Gee, Kobayashi, Prus. 2004; Vissandjée, Weinfeld, Dupéré, & Abdool, 2001). Even when opportunities to access are present, there may be additional barriers to healthcare utilization, including language, transportation, and lack of information (Sanmartin & Ross 2006). Access and utilization barriers may contribute to health problems among the immigrant population, and may hinder immigrants’ ability to integrate into and thrive within Canadian society.

This thesis explores immigrants’ access and use of healthcare services, through a case study of the experiences of Asian immigrant women living in a mid-size city in
Southwestern Ontario. Through in-depth interviews, I explore immigrant women’s use of preventative healthcare services – specifically cervical cancer screening – and seek to identify the factors that limit their use. These interviews not only shed light on immigrant women’s health, but their integration into Canadian society, and the barriers they experience in their day-to-day lives.

Three research questions will be addressed in this thesis: (1) What are the challenges that Asian immigrant women encounter when accessing resources in the Canadian healthcare system? (2) How do culture and other related challenges affect Asian immigrant women’s decision to participate in cervical cancer screening? (3) What are the strategies that Asian immigrant women use to navigate these challenges to maintain health in Canada? To answer these questions, I conducted interviews with 14 participants in one mid-sized city in Southwestern Ontario.

This thesis is organized as follows. Chapter 2 provides a review of the existing literature to provide context and background into the current issue at hand. This chapter establishes the gaps in the research, beginning with the examination of immigrant integration, social determinants of health, and the context of healthcare in Canada. A discussion regarding preventative health screening and the focus on cervical cancer screening will follow. Next, I investigate various influences that play a crucial role in shaping immigrant experiences in the healthcare system. This discussion involves an analysis of how access and utilization to health services can be influenced by culture, language, family roles, practitioner relationships with patients, language, and intersectionality. In Chapter 3, I discuss my methodology, outlining the research process and consider the strengths and limitations of the methods used in this study.

In Chapter 4, I present my research findings, highlighting key themes concerning the barriers and difficulties that inhibit access and use of healthcare services. This thesis focuses on barriers to the utilization of preventative healthcare services, as well as the regular utilization of services in the overall in the healthcare system. In this section, participants acknowledged the challenges that they, or others around them, as immigrant women faced in the healthcare system. Participants share their experiences and stories, as
well as the strategies they used to circumvent the obstacles that they faced when attempting to access and use health services.

Finally, the discussion in Chapter 5 connects the current literature, the results of this study, and the implications of my research for both scholarship and policy. I begin with a brief summary of my results discussed in Chapter 4, then link my findings to the existing immigrant health literature. I also discuss the implications of my research within the context of immigrant integration and propose policies and recommendations that could ease the challenges and barriers that Asian immigrant women face in the healthcare system. Lastly, I discuss the limitations of my study, and suggest directions for future research based on the findings of this study.
Chapter 2

2 Literature Review

The purpose of this chapter is to review the existing literature on Canadian immigrants’ healthcare challenges, and to establish the contribution of my study. This study explores immigrant access to and utilization of health services, since these are factors important to immigrant integration. I pay particular attention to the use of preventative health services, but also focus broadly on healthcare services as a whole. I begin this chapter with a brief overview of the relevant immigrant integration literature. Included in this discussion will be a brief review of sociological literature on immigrant health, as well as immigrants’ participation in health screening. Next, I will highlight the various factors identified in previous research as significant in shaping immigrant healthcare experiences. First, I explore the impact of culture and the use of alternative health practices among immigrants to meet their health needs. Second, I explore the influence of family roles on women’s ability to access health services. Third, I survey healthcare provider-patient relationships and discuss their importance in the provision of quality healthcare. Next, I examine how language impacts health attainment and utilization of health services. Last, I discuss the importance of intersectionality and its implications for research within the context of this study. I conclude the chapter with a brief summary of the gaps in the literature and I outline my research questions.

2.1 Immigrant Integration

The processes through which immigrants become integrated into society continue to be a focus in the sociology of migration. Assimilation theories attempt to explain the pathways by which immigrant groups are incorporated into the larger culture, often focusing on the means by which the norms of the dominant culture are adopted. As stated by Alba and Nee (1997), “[As] assimilation is a social process that occurs … between majority and minority groups, assimilation remains a key concept for the study of intergroup relations” (p. 827).
In general, classic assimilation theories propose that immigrant and ethnic groups follow a linear convergence in norms, values, or behaviours, becoming more similar to those of the majority group over time. Milton Gordon (1964) provides a conceptual definition of assimilation. In Gordon’s account, the catalyst for more complete assimilation is structural assimilation, which he defined as “entrance of the minority group in to the social cliques, clubs, and institutions of the core society at the primary group level” (Alba & Nee, 1997, p. 830). His contribution encourages a multidimensional framework that allows for measures of immigrant groups along various empirical dimensions. Applying this theory to healthcare, one might conjecture that over time, immigrant groups would come to adopt the healthcare utilization patterns of the native born.

Different models proposed by various scholars concentrate on structural barriers that limit immigrants’ access to opportunities. In particular, segmented assimilation theory differentiates the assimilation process across different groups. Immigrants face discrimination or institutional barriers to opportunities, often resulting from racial or ethnic disadvantages. This process is dependent on influences of the larger social environment and individual level group adaptations and behaviours (Lee, 2009). Portes and Zhou (1993) propose that obstacles are often the most severe for the most disadvantaged members of immigrant groups, which often leads to downward mobility. This idea circumvents the notion of straight-line assimilation and suggests that immigrants are steered into divergent paths in the integration process depending on their resources and ethnicity. Applied to healthcare, this theory suggests that some immigrant groups might adopt the healthcare utilization patterns of native-born Canadians, but others will not depending on their resources and ethnic backgrounds.

Assimilation theories emphasize that immigrant integration is not always a smooth process. Existing research has documented that there are many barriers preventing immigrant groups from adapting or assimilating in society. For example, the social integration of immigrants remains a challenge in Canada. Immigrants face social and structural barriers that prevent them from fully participating in their communities. A substantial portion of immigrants struggle to build social relationships in their communities and a significant number report that their greatest challenges since arriving
in Canada include discrimination or racism, access to housing or education, and access to professional services or childcare (Lai & Hynie, 2010). Research suggests social exclusion may be experienced as a result of language differences, time constraints, and discrimination (Goodkind & Foster-Fishman, 2002). Immigrants also experience processes of ‘othering’ which prevent their full inclusion in Canadian society. Visible minority immigrants report a lower sense of belonging than others due to their immigrant status and the inability to identify with dominant groups in Canada (Veronis, 2015).

Widely and extensively documented, the economic integration of immigrants in Canada also remains a challenge. Since the 1990s, an increasing number of immigrants have been admitted into the economic class and the number of immigrants with a university degree has considerably increased (Schellenberg & Hou, 2005). Yet, despite this increase, immigrants continue to have difficulties integrating into the labour market. Furthermore, immigrants with qualifications and work experience in high demand “knowledge occupations” such as information and communications technology, engineering, and natural sciences occupations still experience difficulty in securing employment (Picot 2004). Some reasons for this gap include the devaluation of foreign credentials (Buzdugan & Halli, 2009), and potential difficulties related to language, culture, networks, and discrimination (Bachi, 2001, Bloom, Grenier & Gunderson, 1995, Chiswick & Miller, 1995). The challenges of integrating into the labour market have also been well documented among second-generation immigrants. Despite consistently higher levels of education (Abada & Lin, 2011), second-generation immigrants experience poor labour market outcomes, such as unemployment and lower rates of pay (Palameta, 2007).

Most studies on immigrant integration tend to focus on socioeconomic pathways that facilitate integration. Although such domains are extremely important in facilitating immigrant integration, other social spheres are largely ignored. Moreover, the experiences of some groups are obscured through such a focus. Some immigrant women, for example Asian female immigrants, do not participate in the labour market or seek education in their new country of residence. Research shows that after four years of residence in Canada, immigrant women were engaged in employment at lower rates than Canadian-born females, and at lower rates than male immigrants (Xue, 2008). The lower
participation rates for Asian immigrant women have been attributed to cultural expectations that they remain at home, as well as to their own perceptions that it was difficult to access well-paid jobs (Tossutti, Hagar, Kelly, LeBlanc, & Pitre, 2011). Looking at other dimensions of immigrant integration may shed light on their experiences.

Although acknowledged to be a key domain in immigrant integration alongside established domains such as education and the labour market, healthcare access has often been overlooked in research (Craig, 2015). Access to healthcare can be a critical element for supporting the general wellbeing of immigrants and can influence their ability to participate in other important domains that facilitate integration (Craig, 2015). Existing literature documents many barriers that immigrants face in the healthcare system (Kalich, Heinemann, Ghahari, 2016; Edge & Newbold, 2013; Lebrun & Dubay, 2010).

In Canada, access to healthcare is a major right for individuals. Nevertheless, recent immigrants are especially vulnerable to health disparities. Immigrants who have fewer years of residency in Canada have lower use of health services than native-born individuals, often as a result of challenges and barriers that they face in the healthcare system (Degelman & Herman, 2016; Lebrun, 2012; Asanin & Wilson, 2008; Lai & Chau, 2007; Newbold, 2005; McDonald & Kennedy, 2004). Compared to Canadian-born individuals, immigrants are almost two and a half times more likely to experience difficulties accessing immediate care and are ten times more likely to identify barriers related to personal circumstances, such as transportation, language, or lack of information about where to go for care (Sanmartin & Ross, 2006).

Women face distinct challenges in the health system even though women typically use health services more frequently than men (Nabalamba & Millar, 2007; Dunlop, Coyte, & McIsaac, 2000). Studies document gender disparities in the delivery of health services as well as the treatment of health conditions. For example, women are less frequently offered certain health procedures, such as in cardiovascular disease or critical care (Kent, Patel, & Varela, 2012). Women also receive fewer referrals for services (Peeva et al., 2012) and obtain treatment for certain procedures later than men (Kausz et al., 2000).
Gender disparities in the health system in Canada have been less well-documented. To account for possible gender-based challenges, it is important to study women in their specific contexts and explore how they employ unique strategies to obtain and access healthcare.

### 2.2 Immigrant Healthcare

Canada has a national health insurance program, which is comprised of thirteen intertwined provincial and territorial health insurance plans, all of which share common features and basic standards of coverage under the Canada Health Act (Health Canada, 2011). Under this act, residence in a province or territory is the basic requirement for health insurance coverage, and the national health insurance program is designed to ensure that all residents of Canada have access to health services without financial or other barriers.

In Ontario, the Ontario Health Insurance Plan (OHIP) covers the cost of many health services that individuals may need in the healthcare system. OHIP extends their coverage to not only Canadian citizens, but to any individual who is a permanent resident (also known as a landed immigrant), any individual who has made an application for permanent residency, as well as any individual living in Ontario with a valid work permit (Government of Ontario, 2017). Services covered by OHIP include doctor visits, hospital visits and stays, as well as certain optometry and podiatry services. Core screening programs for cervical cancer, breast cancer, and colorectal cancer are also covered by OHIP and individuals are funded by OHIP to take these tests for free (Government of Ontario, 2016). This being the case, all immigrants in Canada have access to healthcare and screening through the OHIP program.

However, although immigrants have equal access to healthcare through the OHIP program, an essential component of accessing the benefits of this healthcare is acquiring a family doctor. Since many immigrants do not have a family doctor, this reduces their access to healthcare. Studies have documented that immigrants struggle to find a family doctor upon arrival, and the process of finding a family doctor can take a long time (Asanin & Wilson, 2008). Research has also found that both recent and established
immigrants use physician services less compared to native-born Canadians, and in particular, recent immigrants are more likely to visit an emergency room than visit a family or general practitioner for care (Tiagi, 2016). The inability to acquire a family doctor reduces access to health services and opportunities for screening. This type of structural barrier, among others, has implications for health outcomes and behaviours.

2.3 Social Determinants of Health

Sociological research has highlighted the role of social conditions in shaping health outcomes and health behaviours. Health inequalities are often an outcome of social inequalities and can result from societal structures which reinforce these inequalities (Mikkonen & Raphael, 2010). Social conditions can include relationships to others in society, as well positions that individuals occupy within the social and economic structures of society, including the influence of factors like race, socioeconomic status, and gender (Link & Phelan, 1995). The movement to gain a greater understanding of sociocultural influences challenges the individualism of many health paradigms which often underestimate the impacts that social structures can have on health experiences (Currie & Wiesenberg 2003).

Socioeconomic status (SES), regardless of whether it is measured by income, education, or occupational status, remains one of the strongest determinants of variations in health outcomes (Phelan, Link, & Tehranifar, 2010; Marmot, Friel, Bell, Houweling, & Taylor, 2008). Social scientists and public health researchers have long known that socioeconomic inequalities have detrimental effects on health that are strong and persistent over the lifetime (Corna, 2013; Link & Phelan, 1995). Central to the persistence of inequalities is access to resources that can be used to avoid risk or minimize the consequences of disease or illness once it occurs. As Link & Phelan (1995)’s theory of fundamental causes argues, SES influences access to resources such as money, knowledge, power, prestige, as well beneficial social connections that protect health. Despite advances in medical knowledge or technology, individuals from low SES backgrounds lack the resources to protect and improve their health outcomes. Furthermore, other factors such as race/ethnicity and gender that are closely tied to
resources like money, power, prestige, and social connectedness are also considered a potential risk factor for poor health as well (Link & Phelan, 1995).

Since race/ethnicity and socioeconomic status are so closely linked to each other, the combination of these characteristics also has the ability to shape health. However, it has been documented that race can matter more for health even when socioeconomic status is taken into account. This is largely because visible minorities have an increased risk of exposure to a range of stressors, including institutional discrimination and structural disadvantages (Williams, Priest, & Anderson, 2016). Research indicates that racial-ethnic minorities experience poorer health than whites on numerous health outcomes and these differences in health have been persistent over time (Williams & Sternthal, 2010). Disparities in health outcomes range from earlier onset of illness, more severe disease, and poorer quality of care for ethnic minorities compared with their majority peers (Williams, Priest, & Anderson, 2016).

Intrinsically related to race/ethnicity, immigrant status emerges as an important predictor of health as well. Sociological research has characterized how risk factors and resources in immigrant populations can affect the health of immigrants (Williams & Sternthal, 2010). Specifically, strains associated with migration and adaptation, as well as factors related to larger social structures and context, such as racism and discrimination, can affect health outcomes among immigrants (Angel & Angel, 2006). Research has found that minority ethnic groups are more vulnerable to changes during post-migration settlement and adaption to a new country, contributing to poor health (Kim, Carrasco, Muntaner, McKenzie, & Noh, 2013). The stress involved in moving to a new country can be taxing on health, and utilization of health services may mitigate the effects of poor health. However, studies have found that immigrants are less likely to access primary care and have significantly lower odds of consulting practitioners for specialized care (Tiagi, 2016; Deri, 2004a).

Although structural barriers affect the health of immigrants, acculturation and changes to regular patterns of behaviour can have implications for health outcomes in a new country as well. As immigrants are exposed to different lifestyle practices that are detrimental to
health, such as unhealthy diets, smoking, or alcohol consumption, the adoption of these new behaviours can have harmful effects on health (Morales, Lara, Kington, Valdez, & Escarce, 2001). However, some researchers have noted that these acculturation behaviours can be the product of constraints specific to the host society and not necessarily inherently agentic behaviours (Étémé, Girard, Massé, & Sercia, 2016.)

These types of choices can also affect health behaviours as well. For example, all things being equal, immigrants who have a family doctor have equal access to healthcare, but still may not utilize health services. This may be due to cultural reasons or personal decision-making. Sociological research about health decision-making shows that such decision-making is a dynamic and interactive process that is fundamentally intertwined with the structure of social life (Pescosolido, 1992). Social processes, which include social interactions between individuals and social institutions, are a crucial part of the decision-making process concerning health. Studies of health services usage indicate complex relationships between cultural beliefs and observed behaviours, suggesting that single scale measures may not adequately tap dimensions of cultural beliefs that influence outcomes (Salant & Lauderdale, 2003). In this manner, applying a sociological lens to understand health behaviours is valuable, helping to shed light on the factors that contribute to immigrant disparities in healthcare utilization.

2.4 A Focus on Asian Immigrant Women and Cervical Cancer Screening

Preventative health screening not only has public long-term cost benefits of decreasing the use of subsequent treatment due to ill health conditions, but also individual benefits such as providing individuals with security and knowledge about their health (Sabates & Feinstein, 2006). Preventative health screening as a key strategy of preventative medicine has received significant attention in medical and health disciplines. However, the topic of preventative health screening also raises fundamental issues for sociological inquiry. Not only are screening programs used as a medical strategy for the prevention of illness and the maintenance of health, screening programs are also social interventions which are inherently tied to social processes and social implications (Armstrong & Eborall, 2012). Sociological analyses of preventative health screening can shed light on challenging
social dilemmas, and can also inform policy, and the development and implementation of screening programs.

Most of the existing research that is focused on preventative health screening consists of quantitative studies that investigate various demographic groups and the likelihood of these groups to access preventative health screenings (Cesario et al., 2015; Khan, Carpenter, Watson, & Rose, 2010; Reindl Benjamins & Brown, 2004). Immigrants are identified as a group who disproportionately under-utilizes preventative health screening services (Kim, Chandrasekar, & Lam, 2015; Lofters, Moineddin, Hwang, & Glazier, 2010; Kandula, Wen, Jacobs, & Lauderdale, 2006; Wong, Gildengorin, Nguyen, Mock, 2005, Goel et al., 2003). Ethnicity has also been found to be an important predictor of participation in screenings. Visible minority immigrants are recognized to access preventative health screenings at much lower rates than native-born individuals (Ahmed, Pelletier, Winter, & Albatineh, 2013; Ndukwe, Williams, & Sheppard, 2013; Lebrun & Dubay, 2010; Moser, Patnick, & Beral, 2009; Beydoun & Beydoun, 2008). Asian immigrants in particular are highlighted to be a distinct group that is much more hesitant to access and utilize healthcare services (Ye, Mack, Fry-Johnson, & Parker, 2012; Kim & Keefe, 2010; Sun et al., 2010; McDonald & Kennedy, 2007). Exactly why this is the case in Canada remains unclear as a majority of studies focus on the American context; however, culture appears to be a significant factor.

Cervical cancer screening becomes of interest because it is a widely available form of cancer screening, and one of the more preventable forms of cancer. Morbidity and mortality rates from cervical cancer have considerably decreased since the introduction of cervical cancer screening programs (Pottie et al., 2011). However, due to the significantly lower rates of screening among immigrants, mortality rates for immigrants are much higher than Canadian-born individuals. Mortality rates from cervical cancer are 1.4 times higher among foreign-born women, and women who have never had cervical cancer screening or cervical cancer screening in the previous five years account for 60%-90% of invasive cervical cancers overall (Pottie et al., 2011). Individuals who are diagnosed in the early stages of cervical cancer have drastically increased survival rates ranging from 80%-93%, compared to individuals who are
diagnosed at a later stage, whose survival rates can range from only 15%-16% (Canadian Cancer Society, 2016). Since immigrant women in Canada are not utilizing the screening services that can detect cervical cancer in its early stages, they are more susceptible to deaths from cervical cancer. Early diagnosis and treatment are highly effective in lowering rates of cervical cancer deaths, but this can only occur if women are participating and making use of these services. Within this context, Asian immigrant women are at an increased risk. Asian immigrant women have been identified as a group that has significantly low rates of participation in cervical cancer screening in Canada (Xiong, Murphy, Matthews, Gadag, & Wang, 2010; McDonald & Kennedy, 2007; Woltman & Newbold, 2007).

2.5 The Impact of Culture

Barriers faced by immigrants when using health services can be largely influenced by factors that are related to cultural differences (Khan, Kobayashi, Lee, & Vang, 2015). Culture is inherently tied to specific beliefs and values that shape individual behaviours and actions. Kagawa-Singer, Valdez-Dadia, Yu, and Surbone (2010) affirm that “culture also frames attitudes towards gender roles, concepts of health and suffering, meaning of body parts, and decisions about life [and] illness…” (p. 18). These worldviews that are fostered by cultural upbringing inform the everyday actions, practices, and beliefs of immigrant women, which become an important part of the immigrant narrative in how it can affect health experiences.

Culture can permeate experiences in the healthcare system in a variety of ways, including utilization of health services, quality of healthcare received, as well as types of services used. As immigrants come from many different backgrounds, they bring distinctive cultural beliefs and practices with them to their new host country. Cultural values, beliefs, and practices can often alienate immigrants from the healthcare system (Montoya, 2005). Although the experience of health and illness is linked to conceptualizations of health, illness, and disease, the role of culture is often not taken into consideration in the provision and delivery of healthcare services (Baldeo, 2012). This can be problematic as cultural differences can propagate underutilization of health resources among immigrants, resulting in delays in identifying health problems and hindering early prevention and
treatment of issues. The complexity in understanding how culture interrelates with health requires in-depth investigations with broader sociological considerations. The question is not whether culture and health interact, but rather in what ways and along what measurable domains (Salant & Lauderdale, 2003).

Often, immigrant women’s views on health are not merely focused on the physical, much like the predominant biomedical framework of Western societies, but rather centered on more holistic approaches to health, which incorporate physical, mental, social, and even spiritual aspects (Pollock, Newbold, Lafrenière, & Edge, 2012; O’Mahony & Donnelly, 2007; Meadows, Thurston, & Melton, 2001). Some immigrant women articulate that their own ethnocultural views of health often feel incompatible with the Canadian health system that is deeply embedded in biomedical norms (Weerasinghe & Mitchell, 2007).

Dissension or misunderstanding between conflicting cultural perspectives can create friction when devising health plans or seeking health advice. For example, immigrant women who lack understanding or trust in the approach of Western style healthcare prefer to use alternative medicine or their own traditional medications to address their health issues (O’Mahony & Donnelly, 2007). Chinese immigrant women often prefer using Eastern medicine to treat or prevent illness because they believe that it is “milder” than Western medicine (Lee-Lin, Menon, Nail, & Lutz, 2012). Somali women have explained that their perceptions of health are strongly dependent on their culture, which values alternative medicines and prayer for health problems (Francis, Griffith, & Leser, 2014).

Cultural differences also have the ability to influence how immigrants perceive and evaluate their experiences within the health system. For example, Korean immigrants find that the American health system is much more focused on procedures and processes than in Korea (Son, 2013). Korean immigrants see this emphasis on procedures as a hindrance to a more efficient use of time and effort. The administrative procedures that are required to use U.S healthcare services deters their healthcare utilization to a greater extent than other population groups (Son, 2013). Differences in health service expectations can be a cause for conflict as well. The healthcare system in Canada is
poorly designed to cater to specific immigrant needs. For example, Muslim immigrant women who are used to being guaranteed a female provider might expect this cultural norm to be respected, but the structure of Ontario’s healthcare system makes this extremely difficult (Newbold & Ng, 2011).

Immigrants have pre-established cultural routines that deviate from norms in their new country of residence and these different cultural practices limit the regular and habitual use of health services. Immigrant women, particularly older immigrant women, from Africa, the Middle East, and Asia do not seek medical attention unless there are very serious illnesses that need to be attended to, such as cases of cancer or incidents of stroke (Kushniryk, Titus-Roberts, Wertz, 2014). Lai and Kalyniak’s (2005) study revealed that the lower rates of healthcare utilization among Chinese immigrants were due to the fact that many were unfamiliar with the idea of consulting a physician when there were no particular serious health problems that needed to be examined. These previous customs and practices can affect use of health services in a new country.

2.5.1 Cultural Competencies

Not only can culture affect how, or even if, health services are utilized, culture can also influence patient trust in professionals and institutions, which can greatly impact the health outcomes of immigrants (Kagawa-Singer et al., 2010). The nature of the doctor–patient relationship is important for many immigrant women. Factors shaping this relationship include the physician’s degree of cultural awareness, the gender of the physician, and the communication of guidelines by the doctor to the patient (McDonald, 2012).

McGibbon, Etowa, and McPherson (2008) argue that cultural considerations, including the cultural competence of healthcare providers, are important in the delivery of healthcare services, particularly at the point of care. However, healthcare workers have expressed that the biggest challenges in working with immigrant women concern differences in cultural backgrounds, and practitioners’ own lack of experience in dealing with these particular populations (Teng, Robertson Blackmore, & Stewart, 2007). When providers are not knowledgeable about cultural norms or preferences, there are
opportunities for misunderstandings, which can be detrimental for health (Sheppard, Williams, Wang, Shavers, & Mandelblatt, 2014).

Cultural competence can affect the process of establishing rapport and the quality of assessment and care (Montoya, 2005). Physicians receive little or no formal training in intercultural relations and miscommunication often occurs due to a lack of knowledge of the effects of culture on doctor-patient relationships (Rosenberg, Richard, Lussier, Abdool, 2005). Furthermore, even with the best diagnosis, failure to recognize that sociocultural factors can affect patient compliance can result in inadequate treatment or lost opportunities for follow-up (Montoya, 2005). In the case of treating and diagnosing immigrant women with postpartum depression, healthcare workers noted that the lack of understanding and insufficient knowledge about the particular life circumstances of immigrant groups leads to inappropriate assessments, posing significant barriers to treatment (Teng, Robertson Blackmore, & Stewart, 2007).

Culture informs social interactions and for many immigrants, status plays an important role in the dynamic between a healthcare provider and a patient. Donnelly (2008) reports that Vietnamese immigrant women in Canada have difficulty asking their doctors for information as they feel intimidated by their doctors’ social status. Vietnamese women understand that the role of the patient is to accept whatever information is provided, and asking additional questions is seen as undermining the doctor’s authority.

Communication styles in Asian and South-Asian cultures can be very indirect and non-confrontational, affecting the quality of healthcare received, as well as patient satisfaction (O’Mahony & Donnelly, 2007). Misunderstandings are likely to occur when culturally unaware healthcare providers overlook indicators that imply lack of understanding about health issues or concerns. Healthcare providers may also offer fewer opportunities for immigrants to participate in health decisions. Ethnic minorities have found that their relationships with physicians are less equitable, where patients do not have as much of an active role in decisions concerning treatment and management of health conditions (Alexander, Hearld, & Mittler, 2014).
Communication difficulties stemming from cultural differences contribute to barriers to quality healthcare. Many immigrants report that Western physicians do not pay attention to their experiences and explanations. Asian immigrants often report that doctors did not listen; neither did they spend as much time with them, or involve them in decisions as much as they wanted (Ngo-Metzger, Legedza, & Phillips, 2004). Chinese immigrants without perceivable language barriers still reported frustration about not being given the opportunity to communicate with physicians adequately or to express their health concerns (Kwong & Mak, 2009). Differences between patient expectations and the behavior of healthcare providers can present formidable barriers to developing strong relationships that encourage health-seeking behaviours (Montoya, 2005).

2.5.2 Cultural Options

The right to cultural autonomy and the growing presence of multicultural approaches to healthcare reflect the growing ethnic diversity fueled by immigration in Canada (Chiu, 2006). Despite the fact that most immigrants report having a family physician with whom they can consult, every two out of three older Chinese immigrants report using Traditional Chinese Medicine (TCM) in combination with Western health services (Lai & Chappell, 2007). The increased use of complementary and alternative medicine (CAM) in Canada may be linked to the cultural and structural barriers that affect immigrant use of mainstream treatment through the Canadian healthcare system (Roth & Kobayashi, 2008). Immigrants may turn to these alternative practices as a way to alleviate cultural and structural barriers.

Immigrants may also choose alternative health resources for cultural familiarity. Immigrants and refugees in Ontario have mentioned that they actively seek alternative healthcare services from homeopathic, naturopathic, or Chinese medical practitioners because they find the preventative and holistic approach less alienating and more compatible with their cultural values than Western-style medicine that focuses mostly on physical symptoms (Pollock, Newbold, Lafrenière, & Edge, 2012). Furthermore, immigrants feel that Western physicians depend too much on diagnostic tools to the point where it is counterintuitive and ineffective (Wang, Rosenberg, & Lo, 2008). Many are discouraged by close family and friends who describe frustrating experiences using
Western health services. One participant in Wang, Rosenberg, & Lo’s (2008) study decided not have a family doctor in Canada because he did not want to repeat his friends’ experiences of “repeating blood tests and other lab tests without getting timely and proper treatment” (p.1418).

Contrary to mainstream ideas that immigrants who decide to use either CAM or TCM practices rely solely on these services as sources of healthcare, immigrants tend to use an amalgamation of both alternative health resources and Western health services to meet their healthcare needs (Roth & Kobayashi, 2008; Lai & Chappell, 2007; Tjam & Hirdes, 2002; Lee, Rodin, Devins, & Weiss, 2001). Many immigrants consider TCM not as an alternative form of treatment compared to Western health services, but rather an integrative complement to Western health services (Chung, Ma, Lau, Wong, Yeoh, Griffiths, 2014). More research is needed on how immigrant women use alternative health services in conjunction with Western health services, and the impact of this combination on their healthcare experiences in Canada.

2.5.3 Traditional Chinese Medicine

Many Asian immigrants have a preference for Traditional Chinese Medicine (TCM); Western health services are not always able to satisfy health needs or cultural expectations. Asian immigrants appreciate the qualities of TCM that Western medicine cannot offer. Where Western doctors tend to only treat certain symptoms, TCM practitioners target root causes with a holistic approach. Chinese women have expressed concerns about the way Western practitioners are disposed to use treatments that are aggressive to the human body, which could result in concerning side effects and dramatic changes in the human body (Lu & Racine, 2015). Many proponents of TCM note that Western medicine’s focus on particular anatomic areas fails to recognize the importance of a holistic understanding of the natural processes in the human body and health (Merighi & Wong-Kim, 2007).

Some patients who consult with Western doctors find that their suggestions often do little to remedy or cure the problem (Chiu, 2006). TCM focuses on patterns of illnesses rather than identification of diseases, and is able to always provide diagnosis and treatment
(Chiu, 2006). Although Chinese immigrants believe that Western medicine is stronger and acts faster than Chinese medicine, Chinese immigrants believe that TCM treats the cause of the disease, leading to permanent cures or long-term remissions, making it extremely effective in the management of many chronic diseases (Zhang & Verhoef, 2002).

Aside from various medical benefits, most immigrant patients find more ease and comfort in accessing TCM. Asian immigrant patients almost always want to call and visit Chinese doctors because of the mutual sympathy, common language, and flexible appointment schedules (Chung, Ma, Lau, Wong, Yeoh, Griffiths, 2014). Zhang and Verhoef (2002) found that in response to an illness, immigrants often chose to consult Western family physicians first, but after receiving Western treatment, Chinese healers are often consulted in response due to the ineffectiveness of Western medicine and the indifferent manner of physicians. Similarly, immigrants recounted experiences where Western physicians’ diagnosis would only be based on the lab result the day of the visit, whereas Chinese doctors would trace back the patient’s medical history for several months (Chung, Ma, Lau, Wong, Yeoh, Griffiths, 2014).

Not only do Asian immigrants use TCM services, other immigrants from diverse regions use TCM in Canada due to the perceived effectiveness of Chinese medicine and acupuncture, as well as the ease of communicating with a Chinese herbalist doctor (Wang & Kwak, 2015). The fuller and more comprehensive care provided by TCM is more desirable for immigrant patients who seek more attentive relationships with their provider. In particular instances, not only is TCM a resource for illness management, TCM as a health practice also allows Chinese immigrants to reaffirm cultural identity, fulfill social roles, and pass down health knowledge and cultural heritage (Kong & Hsieh, 2012). Within this context, patronage of alternative health practitioners may impact health screening utilization. Alternative healthcare providers may not emphasize medical health screenings to the same extent as Western medical doctors. The significance of alternative healthcare utilization, in combination with Western medical services, is deserving of more attention in the literature.
The desire for more culturally familiar services may drive immigrants to even seek healthcare outside Canada. Different strategies used by immigrants seeking healthcare include traveling to their home countries for medical examinations and treatment, importing medications, or even consulting health resources from their home country by phone or email (Wang & Kwak, 2015). Korean immigrant women favour travelling to Korea to get care because of the cultural comfort of being in a familiar environment, in addition to receiving more effective and timely treatment (Son, 2013). Immigrants often demonstrate high personal responsibility for their health by engaging in transnational healthcare in response to barriers and complexities encountered regionally in their country of residence (Calvasina, Muntaner, Quiñonez, 2015; de Freitas, 2005; Messias, 2002).

### 2.6 Family roles

Family roles are the reoccurring patterns of behavior by which individuals fulfill family function and needs (Epstein, Bishop, & Levin, 1978). Socially defined meanings of gender roles in the family and how they are expected to be performed may place specific obligation and duties on immigrant women that may restrict how they seek and participate in health services. Currie and Wiesenberg (2003) state that “gender is central to the meanings that people give to the everyday activities through which they are socially reconstituted as members of society” (p. 893). They argue that since such roles are associated with socially defined attributes and expectations, as well as behaviours that are determined by what is expected of that position, women have more limited opportunities for health service use. Through this understanding, it is necessary to examine women’s individual health behaviours as socially influenced.

Individuals in families occupy roles that have certain social and family expectations for how those roles should be fulfilled. In particular, it seems that immigrant women may hold strong ideals about obligations associated with their roles in the family. For example, the value of personal health for immigrant South Asian women is the ability to do their family work and not be a burden to others (Meleis, Birch, & Wachter, 2011).
These women equate health with the ability to perform expected caregiving roles for their children and husbands. In Korean culture, the family is considered more important than the individual, and the woman’s role and priority is to look after the children (Pak, 2006). Caregiving is central to many immigrant women (Spitzer, 2005). These expectations of caring for the family can place obligations on immigrant women that persuade them to ignore their own health and focus on family members’ health as their main priority.

Women tend to associate health service use with family planning or caring for their children (Vlassof & Bonilla, 1994). Taking the time for self-care can be difficult for many women, particularly for mothers who are engaged in family responsibilities. Women may believe that taking the time to visit a healthcare provider may represent time lost to other more important activities, such as childcare, food production, or paid employment (Currie & Wiesenber, 2003). Even for women who engage in unpaid labour, the time engaged in personal health seeking behaviours may be great and costly for families.

Despite the fact that women are the main caregivers in most households, they are less likely to consult health services, are more reluctant to spend resources on their own needs, and often cope with health issues by self-treatment, by consulting traditional healers, or by simply living with the condition and resulting discomfort (Kitts & Roberts, 1996).

Women, more than men, more often strongly encourage other family members to seek treatment (Nirualla, 1994). While roles of caregiving may actually ensure that women will have more contact with healthcare practitioners than men, and consequently have more opportunity to access healthcare for themselves, their caregiving role contributes to negative health outcomes, and may limit their personal health-seeking behaviors (Currie & Wiesenber, 2003). These additional obligations and responsibilities not only create an environment that contributes to adverse health outcomes, but also reduces women’s ability to seek health services for their personal use.
2.7 Healthcare Providers and Gender

Gender also shapes women’s relationships with their healthcare providers. While the literature has documented challenges experienced by all immigrants in forging strong healthcare provider-patient relationships, the literature highlights several concerns specific to women. Physician gender seems particularly important. Some immigrant women indicate that being able to access a female clinician is of higher priority than language compatibility with providers (Redwood-Campbell, Fowler, Laryea, Howard, & Kaczorowski, 2011). Modesty about the female body can be a significant barrier for immigrant women who endorse more conservative values. Male physicians reveal experiences where, unaccustomed by culture, immigrant women would refuse to talk about their menstruation history to a man who is not her husband. The portions of information provided about their gynaecological history were usually insufficient to fully understand their gynaecological and obstetrical problems (Degni et al., 2012). Muslim women recounted experiences where they felt increased stress when they were refused a female physician. Modesty for Muslim women is an innate aspect of their religious beliefs and the gender of their physician is very important, especially for reproductive care (George, Lennox Terrion, & Ahmed, 2014). One participant even mentioned that she left the healthcare facility rather than get treatment from a male health provider.

Physician gender is also pertinent for healthcare screening. Immigrant women have indicated that having a female perform a Pap test significantly increases comfort levels (Hulme et al., 2016; Black, Frisina, Hack, & Carpio, 2006; Ahmad, Gupta, Rawlins, & Stewart, 2002). Furthermore, women who had at least one female health service provider were more likely to be screened for cervical cancer (Lofters, Moineddin, Hwang, & Glazier, 2011).

In interviews conducted with Canadian healthcare providers about interactions with immigrant women in their clinical practices, physicians revealed that although many women were supportive of breast and cervical cancer screening, many were also uncomfortable with the procedure as the female body is considered to be a private and intimate matter (Donnelly, 2008). Immigrant women indicated that they avoided seeking care due to discomfort with seeing a male doctor (Asanin and Wilson, 2007). Similarly, a
lack of female specialists, such as gynecologists, resulted in an avoidance of healthcare services (Asanin and Wilson, 2007). Results from a study conducted by Wu, West, Chen, and Hergert (2006) indicated that some of the most common barriers to breast cancer screening experienced by Filipino, Chinese, and Asian-Indian women were being examined by a male practitioner and having the breast touched by a stranger. Immigrant women often have unique needs that need to be addressed in their interactions with healthcare providers. The inability of the healthcare system to accommodate their needs influences the quality of healthcare they receive, as well as their likelihood to use health resources, including preventative health screening.

2.8 Language

Language proficiency can be a concern for immigrants as it is common that many arrive without adequate proficiency in the host country’s predominant language. Although language proficiency is required in the selection of skilled immigrant workers, immigrants who apply under the refugee or family class are not required to know one of Canada’s official languages (Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008). As immigrant women are more likely to be admitted under these categories (Statistics Canada, 2011), they may be more susceptible to experience language challenges. Research supports this claim: fluency in language has been found to be advantageous for health among immigrant women while no such effect is seen among men (Singh Setia, Lynch, Abrahamowicz, Tousignant, & Quesnel-Vallee, 2011). Knowledge of language may increase independence and ability to more freely seek services, rather than needing to rely on a spouse or family member in order to use health services.

Language-proficient immigrants tend to have better healthcare experiences than immigrants with limited-proficiency (Lebrun, 2012). Hidden discrimination in the healthcare system can occur through language and visible minority status, where individuals have reported that they felt they were being treated unfairly by nurses who “were nicer to native-speaking white patients” (Wang & Kwak, 2015, p. 345). Immigrants who lack language proficiency have been found to have lower use of health services and preventative services, as well as have lower frequency of general checkups and visits for non-urgent medical problems (Pottie et al., 2008; Pearson et al., 2008;
Language limitations also lead to delays in seeking and receiving care, as well as restricted use of a range of healthcare providers (Guruge et al., 2009). Not only is lack of language proficiency related to lower rates of health service usage, it is also associated with poorer self-reported health (Pottie et al., 2008). The effects of language can increasingly and adversely impact the health of immigrants over time. Most notably, Ng, Pottie, and Spitzer (2011) found that “during immigrants’ first four years in Canada, the prevalence of poor self-reported health rose dramatically among those with persistently limited language proficiency: from 5% to 12% for men, and from 8% to 21% for women” (p. 5). It becomes evident within this context that language plays an essential role in the maintenance of health and well-being.

Despite limited resources to aid immigrants when communicating with healthcare providers, healthcare professionals are not taught to be aware of how differences in language proficiencies may require them to make adjustments in their methods of communication (Zanchetta & Poureslami, 2006). Communication barriers that result from speaking in an unfamiliar language impede the delivery of important health information that is crucial for proper diagnosis and treatment. Not only can poor communication result in an inaccurate diagnosis on the health provider’s part, patients may also have difficulty understanding their health provider’s explanations or instructions (Bowen, 2015). According to Asanin and Wilson (2008), South Asian patients feel anxious about their ability to voice their health concerns to their physician and they feared that this inability will compromise the physician’s ability to understand their health concerns adequately. In another study, Korean immigrants reported having difficulty understanding what a healthcare provider was telling them, and that language barriers sometimes led them to avoid seeking health services (Son, 2013). Chinese immigrants also experience difficulties in understanding medical terminologies in English (Chung, Ma, Lau, Wong, Yeoh, Griffiths 2014), and healthcare providers who do not recognize immigrants’ needs for extra clarification or guidance may reduce immigrants’ ability to properly follow health advice.
Language challenges are present at every stage of interaction within the healthcare system. Many new immigrants do not understand how to find services that they need to care for themselves, and this disorientation is further exacerbated by the inability to adequately communicate these needs in English (Sanchez-Birkhead, Kennedy, Callister, & Miyamoto, 2011). The simple task of making an appointment or locating which health services are available is difficult for those who are not fluent in an official language (Bowen, 2015).

Information that is typically available to the public is not easily accessible to immigrants with language difficulties. Information about health resources that are available online or in written formats does little for those with language limitations (Zanchetta & Poureslami, 2006). Resources accessible by telephone, print, or internet are often only available in English, and language barriers prevent acquisition of ambient health information (how the majority of the public typically becomes informed), which is information that can be “picked up” through everyday activities like reading the newspaper, viewing a bus advertisement, or listening to the radio (Bowen, 2015). As language is the main medium by which health information is disseminated, immigrants who lack language skills may have difficulty finding appropriate health services for their needs.

2.9 Intersectionality

Health researchers, policy makers, and practitioners have increasingly acknowledged the importance of intersectionality as a valuable approach for furthering the understanding of the complexity involved in health inequalities (Hankivsky, 2012). However, the complexities manifested at the individual level present several challenges. Researchers continue to grapple with how best to conceptualize these distinct components of identity, and how to respond to the issue of differences how these variances shape lives and health (Sen & Östlin, 2007).

In the traditional and prominent literature on social inequality and health, different dimensions of inequality tend to be viewed as separate processes (Sen, Iyer, & Mukherjee, 2009). However, multiple sources of disadvantage, such as class, gender,
race/ethnicity, immigrant status, and so forth, work together to influence health in unique and interactive ways. Studies that have examined such intersections have found that individuals with distinct role configurations experience significant differences due to complex mediating variables which all contribute to effects on health (Waldron, Weiss, & Hughes, 1998). These interactive processes have important effects that are not uniform, and often depend on contexts and settings (Sen, Iyer, & Mukherjee, 2009).

Intersectionality “moves beyond single or typically favoured categories of analysis to consider simultaneous interactions between different aspects of social identity, as well as impacts of systems and processes of oppression and domination” (Hankivsky, Cormier, & De Merich, 2009, p. 3). This concept intends to trace categories to their intersections, circumventing the dominant assumptions that categories such as race and gender are fundamentally separate or exclusive (Crenshaw, 1991). McCall (2005) adds that “the concern is with the nature of the relationships among social groups and, importantly, how they are changing, rather than with the definition or representation of such groups” (p. 1785). This approach allows for fluidity and richness in the conceptualization and analysis of research.

Intersectionality promotes the idea that human lives cannot be reduced to single characteristics and that social categories such as race/ethnicity, gender, class, and sexuality are socially constructed, fluid, flexible, and mutually constructed and reconstructed (Hankivsky, 2012). People also experience social divisions in different ways, and these experiences can range subjectively in terms of inclusion and exclusion, discrimination and disadvantage, specific aspirations, and specific identities (Yuval-Davis, 2006). Choo and Ferree (2010) argue that part of the utility of an intersectional analysis is, therefore, to give voice to the particularity of the perspectives and needs of individuals.

Because theoretical foundations influence and direct the way health inequalities are conceptualized, studied, and responded to (Krieger et al., 2010), focusing on the complexities of individuals and their daily experiences is important to truly understand and address the issues that exist in their lived realities. When studies include the
perspectives of multiply-marginalized people, studies become much richer in their empirical findings, due to the treatment of inequalities as multiply-determined and intertwined rather than assuming one central institutional framework (Choo & Ferree, 2010). Studying inequality through an intersectional lens and considering how ethnicity, gender, and immigrant status intertwine to shape health experiences will produce greater knowledge that will serve as a basis for better approaches to address the challenges that Asian immigrant women face in the healthcare system.

2.10 Summary

Research on health service utilization amongst immigrants, and especially immigrant women, has identified many barriers limiting their use of health services. These barriers include language, culture, and poor physician awareness. In combination, these factors appear to shape immigrant women’s health-seeking behaviours in a manner that could negatively affect their health. Research also suggests that these barriers contribute to lower levels of preventative health screening amongst immigrant women. Nonetheless, the literature in this area is scarce. Studies have identified some difficulties, faced by some women, in some circumstances. Few studies explore a combination of factors influencing women’s health decisions, and the interplay between them. Moreover, little is known about the particular circumstances under which these influences are actualized and whether or not all immigrants encounter these challenges in the same way. There is some evidence that Asian immigrant women may be particularly affected by these barriers, but the dearth of research has resulted in a limited understanding of their experiences.

Further explorations are needed to identify the factors that contribute to health service use disparities, especially amongst Asian immigrant women. This thesis contributes to the literature on health disparities by examining the particular experiences of Asian immigrant women and the conditions under which they encounter challenges in the healthcare system, within the context of immigrant integration in Canada. This thesis seeks answers to the following questions: (1) What are the challenges that Asian immigrant women encounter when accessing resources in the Canadian healthcare system? (2) How does culture and other related challenges affect Asian immigrant’s
women decision to participate in cervical cancer screening? (3) What are the strategies by which Asian immigrant women use to navigate these challenges to maintain health in Canada?

While research has identified the patterns of immigrant use of health services, less is known about the particular factors limiting use. This qualitative study will contribute by addressing this gap, while examining the intersections of immigrant status, race, and gender that shape Asian immigrant women’s experiences in the healthcare system, including their use of preventative health services in Ontario, Canada.
Chapter 3

3 Methodology

The purpose of this study is to explore the challenges that Asian immigrant women encounter in the healthcare system, as well as the factors that influence Asian immigrant women’s use of preventative health services in Canada. To examine this issue, qualitative in-depth interviews were conducted with 14 Asian immigrant women in one Southwestern Ontario city.

In this chapter, I provide a detailed account of the methods used in the study, including the rationale behind these decisions. I will begin with a discussion on the eligibility criteria, followed by an explanation of the recruitment procedure used in the study. I will then provide an outline of the interview guide structure, including a profile of the participants. I will conclude the chapter with a discussion of the data analysis process that led to my findings, as well as an acknowledgement of the role of reflexivity in the research process.

3.1 Eligibility Criteria

Eligibility criteria were established in order to locate appropriate participants to participate in the study. As Snape and Spencer (2003) state, “the aims of qualitative research are directed at providing an in-depth and interpreted understanding of the social world, by learning about people’s social and material circumstances, their experiences, perspectives and histories” (p. 22). Establishing eligibility criteria ensures that participants included in the study will have the necessary characteristics or have undergone relevant experiences, processes, or events to inform understanding of the subject matter under study (Ritchie, Lewis, & Elam, 2003).

Participants were chosen based on several key requirements. Respondents had to be female, between the ages of 30-50, and either be married or have children. These criteria aimed to ensure that participants had similar shared life experiences, in order to generate insights about the challenges or barriers to healthcare experienced by immigrant women during particular life stages. All respondents had to be of East Asian or South Asian
descent and have immigrated to Canada. Since this study was focused on understanding Asian immigrant women’s healthcare experiences, it was necessary that participants fit these two criteria. This requirement was crucial to ensure that respondents were familiar with their culture and could speak to the immigrant experience. Eligible participants would also be required to reside in a city in Southwestern Ontario. Since health experiences can be subject to regional differences, it was important to ensure that all participants resided in the same local area.

3.2 Recruitment and Sampling

All procedures were conducted in compliance with the University of Western Ontario Research Ethics Board. The ethics application for this study was approved on July 15, 2016 and participant recruitment for this study began in late July 2016. Recruitment posters were posted in various public locations such as libraries, grocery stores, and malls. Recruitment emails were also sent to local immigrant organizations, community centres, and associations to help spread awareness about this study in order to locate potential participants. Recruitment posters were also posted on social media websites to promote further outreach. Recruitment was a challenge in the beginning where almost two month passed with no sufficient interest in the study. Eventually in late September, several participants expressed interest through email.

Passive snowball sampling was the main method by which subsequent participants were recruited. Referrals were spread out where participants typically referred one individual. This approach involved asking individuals who had already been interviewed to pass on information about the study to other people they know who fit the selection criteria as well (Ritchie, Lewis, & Elam, 2003). This type of non-purposive sampling is particularly useful where the targeted population is hidden or difficult to reach directly (Hesse-Biber & Leavy, 2011). Since the eligibility criteria in this study was quite specific, snowball sampling also provided a way to identify eligible participants who would have otherwise been difficult to locate.

At the end of each interview, respondents were given contact cards and flyers promoting the study to pass on to other eligible participants at their discretion. As a gesture of
gratitude for participants taking the time, they were offered the option to be entered into a draw to win 1 of 5 $10 Tim Hortons gift cards. Contact information was collected separately to maintain confidentiality.

The intentions of qualitative research are not to make explicit claims about the generalizability of its findings (Maxwell, 2013). Rather, the value of a qualitative study may in fact depend on its lack of generalizability, in the sense that it provides an in-depth exploration and descriptive account of a particular setting, issue, or population (Maxwell, 2013). In line with the goals of qualitative research, the deliberate selection of characteristics among participants through non-probability sampling was necessary to ensure that findings would be pertinent to the study and participants would have relevant experiences to draw from to share and provide insights regarding the issue at hand. Furthermore, it served as necessary in order to locate eligible participants who would have otherwise not been accessible through public recruitment postings. In this approach, participants were chosen purposively for the ability to provide detailed understanding.

3.3 The Interview Process

In-depth interviews offer researchers the opportunity to learn about people extensively and on their own terms, within the context of their situations (Schutt, 2015). It was important in this study that participants were offered the opportunity to tell their own stories. All participants, as members of the target population this study sought to investigate, had valid experiences, informed perspectives, and unique insights that only they could offer to address my research questions. Individual interviews provide an undiluted focus on the individual, making them useful for detailed investigation of people’s personal perspectives, including the opportunity for clarification and detailed explanation of subject matters (Ritchie, 2003). The personal narratives told during these individual in-depth interviews would be useful and enlightening, exposing the challenges that Asian immigrant women encounter in the healthcare system.

Interviews typically lasted 30 to 60 minutes and were conducted face-to-face at a location of the participant’s choosing. Locations included malls, coffee shops, libraries, and participants’ own homes. Informed consent was requested before the beginning of each
interview, and participants were provided with a letter of information explaining the
details of the study. This document was provided in both English and Chinese.
Participants were informed that their participation was entirely voluntary and that they
had the option to withdraw at any time without penalty. Interviews were audiotaped and
subsequently transcribed for analysis. Participants were notified that they had the right to
refuse audio recording and the right to answer off the record, or to stop the recording at
any time.

Participants were also given the option to have the interview conducted in English or
Cantonese, two languages which I was able to speak fluently. One out of the fourteen
interviews was conducted in Cantonese. Participants were also given the option to bring
an individual to help interpret the proceedings in the case where participants felt more
comfortable speaking in another language. The interpreter would be required to sign a
form agreeing to the conditions of confidentiality. One participant requested this option
and brought a friend who could speak both English and Mandarin to interpret the
proceedings.

Interviews began with simple descriptive questions to ease participants gently into the
interview. The relatively straightforward nature of the opening questions was important
to get participants talking, and to help them understand the tone and discursive nature of
the conversation (Arthur & Nazroo, 2003). Interviews were semi-structured and an
interview guide was used to ensure that the conversation remained relevant to the purpose
of the study. Interview guides serve as an important tool to enhance the consistency of
data collection, ensuring that all relevant issues are covered systematically and with some
uniformity, while still allowing flexibility for each individual participant (Arthur &
Nazroo, 2003). The interview guide was composed of questions that focused broadly on
topics including general attitudes about health, preventative healthcare experiences,
cultural perspectives, and personal opinions about the healthcare system in Canada. The
guiding questions were also followed by various prompts to elucidate unclear responses
and to gain more fulsome answers. Using prompts also allowed participants to further
reflect and think on issues, sharing details that helped unpack meanings and ideas
The flexible nature of the semi-structured interview encouraged an environment in which participants felt at ease to express their opinions without being constricted to a rigid question and answer format. The semi-structured interview also fostered opportunities for new knowledge to be gained. Due to the flexible nature of the interview, questions could be modified depending on responses given by participants. This adaptability allowed conversation to flow and sometimes led to discussions on unanticipated themes. The unexpected direction of conversations helped identify new insights that had not been considered previously and these ideas were able to be investigated further with prompts.

3.4 Profile of Participants

The sample consisted of 14 participants whose ages ranged from 35-49. Nine participants were from China, 4 participants were from Taiwan, and 1 participant was from Vietnam. All but 2 participants were married, and all but 1 participant had children. All participants had relatively high levels of education attainment, ranging from a high school diploma to a PhD degree. Employment levels among participants were mixed where 8 participants were employed and 6 were unemployed. The preferred language of participants was typically their native language, which was commonly Mandarin. Among participants, there existed a wide range of years of residency in Canada where individuals ranged from having resided in Canada for 2 years to 24 years. The mix of both recent immigrants and long-term immigrants was sought to reflect the diverse experiences of immigrants throughout their duration in Canada. The information discussed in this section is summarized in Table 1 (below).
### Table 1: Participant Profiles

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Country of origin</th>
<th>Age</th>
<th>Highest level of education attained</th>
<th>Married</th>
<th>Number of children</th>
<th>Years resided in Canada</th>
<th>Employed</th>
<th>Preferred Language</th>
</tr>
</thead>
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<tr>
<td>REN</td>
<td>Taiwan</td>
<td>38</td>
<td>Bachelor</td>
<td>Yes</td>
<td>2</td>
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3.5 Data Analysis

Each interview was transcribed without the use of any data management software. All participants were assigned pseudonyms to maintain anonymity and confidentiality. The transcripts were then examined and coded line by line in order to identify broad trends and themes regarding the challenges that participants faced, as well as the strategies that were used to navigate the healthcare system. This meticulous process proved to be particularly useful as I was able to familiarize myself with the data and classify dominant themes that appeared across interviews. Common themes emerged, highlighting key facets of Asian immigrant women’s healthcare experiences in Canada. Themes that addressed my research questions include the following: (1) difficulties communicating in the English language (2) degree of comfortableness in their relationships with doctors (3) different cultural perspectives towards health (4) adjustment to a new healthcare system (5) locating and accessing health information. Entrenched within this process of data analysis was the organic and iterative nature of qualitative research work, moving back and forth between data exploration and interpretation to adequately and extensively discover important insights embedded within the data.

3.6 Reflexivity

Rubin and Rubin (2004) state that “the depth interview […] focuses on facilitating a co-construction of the interviewer’s and an informant’s experience and understanding of the topic of interest” (p. 188). It is important that qualitative researchers recognize that their perspective on social phenomena will reflect in part their own background and current situation (Schutt, 2015). In this respect, it is important to acknowledge the role of the researcher in data interpretation process. Through the use of in-depth interviews, the researcher inevitably influences the discourse, impacting the research process.

As an Asian immigrant myself, I quickly recognized the implications of my insider status while conducting interviews. Throughout this process, I realized that this insider status allowed me to be privy to more honest and candid accounts of participant experiences. Participants in this study felt more comfortable discussing topics of culture and their opinions regarding the challenges they faced in the healthcare system to an individual
who had a similar background. Participants used phrases such as “You know, how we are, we’re Asian”, or “As Chinese, you know”. The ability to identify with the researcher allowed participants to feel at ease to discuss issues that they felt other individuals from different backgrounds might not understand. However, the assumption that we had shared experiences and understandings required me to use more prompts and probing questions to ensure that full details were shared and properly understood. In particular, participants were more willing to discuss in-depth their experiences of alternative health resources, especially regarding Traditional Chinese Medicine (TCM). From their discussions, they felt that since we come from the same background, my exposure to such a subject matter would allow me to be understanding about this topic, without judgement of their choice of medical practices.

My immigrant and racialized status had the potential to affect my interpretation of the data. In an effort to limit my own biases, I consistently reflected on my position and acknowledged this reality throughout the research process. I also made sure to contextualize all findings and results with other research in the existing literature. Ultimately, my insider status and identification with participants afforded me a unique position that shaped the interview and interpretation process in a way that encouraged specific knowledge and in-depth information sharing.

### 3.7 Summary

This chapter provided an overview of the methodology that was used in this study, including the rationale behind these decisions. Eligibility criteria, recruitment procedure, interview process, data analysis, and reflexivity were discussed. The next chapter will present the results from this study.
Chapter 4

4 Results

In the interviews conducted, participants discussed barriers and difficulties that inhibited their ability to use healthcare services. All participants acknowledged the challenges that they, or others around them, as immigrant women faced in the healthcare system. Although not all barriers mentioned directly concerned the issue of preventative healthcare, many of these barriers impacted participants’ regular use of healthcare services, as well as their overall perception of the adequacy of the healthcare system. Their stories and their experiences helped to shed light on the distinct problems they encountered as immigrant women, as well as the circumstances through which they experienced difficulties and challenges.

Before delving into the interview data, it is helpful to provide a general overview of the findings. While participants spoke of the importance of health, the women in this study preferred individual and alternative health services for health maintenance. Many participants expressed frustration with the health services they had experienced in Canada. Specific challenges to their utilization of preventative health procedures included discomfort with male practitioners, as well as lack of knowledge about available health resources. In terms of overall challenges in the healthcare system, language barriers were highlighted to be an issue that was experienced by all participants in this study. Language difficulties were pervasive: from making an appointment to communicating to their healthcare provider about their health concerns. Cultural attitudes and preferences regarding health were also emphasized as important in shaping approaches for health maintenance. Many participants expressed their partiality for Traditional Chinese Medicine (TCM). This was due to the ease in usage, the cultural familiarity they had with the services, and their consideration of the practice as a distinct component of their cultural identity. Furthermore, adjustment to a new healthcare system was hard, especially for new immigrants, where many participants lacked information and knowledge as to how to locate health resources they needed. Information about health services was obtained either by way of luck, personal information seeking, or through conversations with friends and family.
4.1 Attitudes Toward Health

Interviews with participants began with questions about their perspectives on the importance of health in their lives. All participants without exception confirmed the importance of health. Discussions revolved around health as a vital necessity for all aspects of life.

Health? I think health is the most important to every people. If you are not health, you have nothing.
– Janice, age 37, Taiwan

Well, health, of course is important! You can only do things if you have health, without health, you can’t do anything. You can only do things if you have health.
– Yu Ming, age 46, China

Healthy? I think that’s… number one.
– Jackie, age 45, China

Several participants mentioned that health was becoming more significant to them as they got older. Health became increasingly important because participants realized that their bodies were becoming more susceptible to sickness and disease as they aged. They acknowledged that it was much more difficult now to recover from illnesses and ailments than compared to when they were young.

It’s very important – especially – I think when you’re getting older and older, it’s important thing. It’s very important – because when you young, so sometime you get sick you can recover right away, right? But old when you sick, it takes long time.
– Li Fen, age 47, China

The majority of participants mentioned routines that they regularly engaged in to maintain healthy living. Most of these practices involved eating healthy, exercising regularly, and living wholesome lifestyles.

Uh… do some exercise… and yeah, I participate in a dance class, I go every week, we have one night for dance.
– Joyce, age 45, China
Health… I eat healthy food… I do simple exercises… don’t have unhealthy routines, like don’t smoke, drink, those things, absolutely do not do those things. Health, drink water, things like that.
–Yu Ming, age 46, China

However, some women mentioned that engaging in healthy exercises and routines were difficult due to balancing work and their responsibilities with children. Although they acknowledged the importance of participating in activities that promote health, participants mentioned that they could not find the time to engage in such activities due to their responsibilities with children in the home.

To stay healthy? Um... to work out, maybe... do some work, or um... the... diet, health diet, and some... mm... sorry I didn’t go to any of the gym after my daughter... um, give birth to my daughter, I have no time to do that. So just busy, maybe some rest, yeah.
–Janice, age 37, Taiwan

Drink water, uh, I know exercise would help but I don’t have time for exercise ‘cause I have a little baby, so that is exercise, I have to take care of her.
–Jill, age 35, China

Regular health service use was not mentioned as an activity that respondents participated in to maintain health. All participants in this study mentioned that they would only access health services or see their doctor if they were extremely sick.

I never see a doctor if I have no any uncomfort.
–Janice, age 37, Taiwan

Well... only when I am in the like, the really bad, then I will go see the doctor. Even just the common cold and stuff like that, I don’t usually go.
–Ren, age 38, Taiwan

Wow, um, I don’t know. I go when I need it, when I’m sick, so I don’t do regular checkup although I know I – I am entitled to? Um, I’d say every…. 4, 5 times a year?
–Jill, age 35, China

Several participants did mention that they do see doctors for checkups, although it typically was normal to not go for a long period of time.
Doctor, very rarely I go see the doctor. Just only when I do checkups, sometimes once a year, sometimes once every two year years... actually, currently, it’s been around 3 years since I’ve seen one last.
– Yu Ming, age 46, China

Depends. I – I don’t – unless it’s really sick, but I haven’t had that for a long time. I usually go for the regular check or if I have some concerns about… something.
– Cecilia, age 37, Taiwan

Doctor? How often? Oh… very... seldom. Only for me, maybe only for some times is the... um... in flu? Or sometimes, maybe… 5 times in a year. I didn’t count, but I just guess, maybe less than 5 times a year. Um… usually for my daughter.
– Janice, age 37, Taiwan

It should be noted that life stage seemed to influence the rate at which participants go to see their doctor. For example, Janice and Jill both mentioned that they rarely see the doctor, however, their estimates approximate that they visit the doctor around 5 times a year. Both these participants have infants at home, which might account for their higher estimates. Janice explicitly mentions that when she goes to the doctor, it is often for her daughter. All other participants who had older children or no children approximated their visits to the doctor at around once a year, or less than once a year. It is very possible that one of the pathways through which participants see the doctor more often is due to their young children.

Overall, the attitudes expressed by participants indicated a conscious and active awareness of health and well-being, including participation in activities that promote disease prevention. However, for some women, obligations in the home and with children debilitated their ability to fully engage in health promoting activities. It seemed that for some, regular use of healthcare services for preventative measures such as checkups were not common for health maintenance.

4.2 Preventative Health Screening

In regards to preventative health screening, all participants in this study had participated in cervical cancer screening within the past 3 years. All participants were also supportive of this type of preventative health procedure. They considered screening as a useful
procedure that was beneficial for maintaining health and preventing disease and illness. When asked whether or not preventative health screenings were beneficial to them, Ren and Diep responded:

Yeah, at least you know what’s going on from the professional doctors, right? Because they probably know better about bodies, but... yeah.
–Ren, age 38, Taiwan

I think so, yeah. But I heard – I heard they say the more early you find out and the more treat you – it’s treat you better.
–Diep, age 44, Vietnam

Participants described several key facilitators responsible for their participation in cervical cancer screening. Doctor recommendation was the main reason why participants participated in cervical cancer screening. Many women credited their doctors for informing them about the Pap test.

CECILIA: I can’t remember if it was one year ago or one year and a half but I did regularly I think.
GN: And when you did it, was it usually doctors who recommended you to do it or would you ask?
CECILIA: Doctors recommend me to do it. I didn’t ask. Yeah.

GN: Do you usually wait for the doctor to ask you or would you ask your doctor to do it?
JACKIE: No, I wouldn’t, the doctor ask me.

Women also reported that they received letters inviting them to book a Pap test with their family doctor. Letters seemed to be effective for the purpose of informing women about opportunities for cervical cancer screening. However, despite receiving information from letters, many women still relied on their doctors to bring up the recommendation to screen.

JOYCE: Uh, I got a letter from the government. I don’t know – maybe some organization. Then, uh... when I make an appointment and I went the hospital, the doctor help me did that, and uh...yeah, I remember two or three, several, couple of months later, I got the results.
GN: Okay, so you got a letter, and you knew you had to do it, so you told your doctor?
JOYCE: Uh… no. I… I didn’t told the doctor. He recommend.
Phoebe critiqued the letters as ineffective and claims that in her home country, Taiwan, advertisements promoted screening, and that approach was much more effective.

They only mail you a letter, and usually people when they see the letter they don’t really read it – who will read it? And it’s so tiny, the letters, who reads it, right? Yeah, in Taiwan they do that [advertisements] quite a bit.

–Phoebe, age 49, Taiwan

Ren, also from Taiwan, shared similar sentiments.

So in Taiwan, ever since Taiwan, they educate the kids, teenagers actually, when you, they reach 18, they just started to do Pap smears once every year. So it was like, uh, a informative informational commercials you see on the TV and then they just promote these things, and try to just tell the ladies that you should take care of yourself, and this is not from school, this is just from the commercial, and they tell you to do this.

–Ren, age 38, Taiwan

Some women mentioned that it was not their family doctor who informed them of the screening, rather, it was their friends who shared that information with them.

I heard it from my friend, and... they don’t tell you. My family doctor didn’t tell me.

–Li Fen, age 47, China

In Li Fen’s case, her doctor did not ask her to participate in cervical cancer screening. It was her friends who told her such an opportunity was available. Other women also described how friends and family were an important source of information about cervical cancer screening.

For me… I think some of my friends do that [Pap test]… because maybe if some people… mm... close to me – like her friends, she got some news from her friends that one of her friends is – got that, and then maybe she will make decide to take the test.

–Joyce, age 45, China

I think new immigrant would not know they can do it [Pap test]. Unless you have friends here, or relatives here, they might talk about it, tell you about it, then you’ll know.

–Yu Ming, age 46, China
Although all women in this study acknowledged they were able to participate in cervical cancer screening through these means, they acknowledged that it would be common for women to not be aware of these opportunities.

Yeah, you don’t know unless someone tells you or you go to the clinic and they have a brochure, or if they have um commercials to like educate you… so how can the people know if they just like... I don’t know… they are not educating the people to remain healthy regularly, you know. They don’t make commercial, they don’t make adverts to let everybody know… so... what happen is… that a lot of people they don’t know the… steps, the procedures, in order to do certain things.
–Ren, age 38, Taiwan

You know back home, they never do anything like that [Pap test]. So if you haven’t and you – if you never do that, you don’t call, that’s why I never heard anything about it. It’s so strange for you to come here, you come here, and then I heard about it, and maybe I just go out, I don’t know, people don’t talk to me that much, you know what I mean.
–Diep, age 44, Vietnam

Interestingly, women in this study not only regularly participated in cervical cancer screenings, but a handful of participants also discussed their dissatisfaction regarding the infrequency of cervical cancer screenings. Some participants expressed their frustration at the long time they had to wait before being able to take the Pap test again.

I say I want to do the Pap test and I try to keep it once every year, because in Asia, in Taiwan, they do once every year. I don’t understand, they do once every 6 months actually, 6 months or once a year, and then they just want you to do it regularly in order to… if there is something wrong, you can do the immediate treatment right, and so I don’t understand like why they push back to two years and now to 3 years, because if you think a 3 years gap, things can change.
–Ren, age 38, Taiwan

JOYCE: They should have to, we have to make the physical test every year [in China], but here, family doctor just told you should, it depends on your age… And he told me, like, I need to take the test every 2 years.
GN: So in China you take it every year and here you don’t.
JOYCE: Yeah.
GN: Do you feel like you prefer to do it every year here if they would let you?
JOYCE: Yeah, I prefer to do every year.
After checkup, they explain what the results are and how many years you can get examined again. I think they told me 3 years. Before it was 2 years! 2 years after, now it’s become 3 years.
– Yu Ming, age 46, China

Some of the participants in this study explained that because they were able to participate in cervical cancer screenings more frequently in their home country, they felt that the longer intervals in Canada between screenings could lead to longer delays in identifying potential problems and starting treatment early if needed. As a result, some participants were dissatisfied with the current timeframe for screenings since they felt that the longer period between screenings could exacerbate or worsen health outcomes.

### 4.3 Other Challenges

Other challenges to preventative health screening included making appointments and scheduling time. Time, especially for working mothers, was tight. Several participants mentioned that the hassle of making an appointment and taking time off work discouraged them from participating in the procedure.

> But I’m not going to say next year I’m gonna do it or... make it into a scheduled thing to do, even though I know it’s needed, I mean it’s supposed to, but my think... I understood is if I don’t do it every year, as long as I feel normal, which is wrong, and I know, but I just don’t have time to go for all that ‘cause you need to call, you need to make appointment, right, it’s not like you walk in the door and you gonna do it, even if you walk in the door, you still have to wait for it, right, to get in line and wait for it, which means I need to take time off work to do it. I think that was preventing me from doing it on a regular basis.
> – Jill, age 35, China

> And also – that also, little complicate, you have to make appointment ahead of the time, and then only very special time, so it... hard. Especially for women testing... If you miss that date, no, not this time, you have to wait next month.
> – Li Fen, age 47, China

Physical barriers such as transportation also proved to be a major challenge for some participants.

> Well, but I don’t know, see at least – over there, because Asia transportation are easier... Here, I imagine when I get old and I have to take a taxi ...– it costs me 20 bucks to get to the doctor, right? Yeah. So, yeah.
My doctor very good. But it’s just because of… sometime I have problem with car, you know…
–Diep, age 44, Vietnam

As a result of this difficulty, participants mentioned that they used health services less because they could not find adequate means to get to their family doctor. Their ability to use health services were reduced because there was no actual physical means to get to a doctor even if they desired to go see one.

4.4 Healthcare Providers

Women discussed how the gender of their doctor mattered to them, especially for preventative health screening. Women who had male doctors discussed hesitation and uneasiness when considering whether they should get a Pap test. Attitudes about modesty and comfort with their healthcare provider were particularly important.

She’s a female, that’s much better. My old, my… previous doctor was male, and he got retired, but then, I have to say like… I’m not very comfortable with that.
–Ren, age 38, Taiwan

Yeah, I think it’s okay, but I don’t know, it’s good, very good, uh… if uh, like women’s doctor is maybe best. Yeah (laughs)… maybe it’s best doctor is for that [Pap test].
–Sandra, age 44, China

Uh, to me, just sometime, the man… I don’t feel comfortable, with the uh… man, and that’s it… You know, how we are, we’re Asian. More private than that… but now, I’m getting used to… before, ah, so uncomfortable.
–Diep, age 44, Vietnam

Maybe I don’t know – maybe because I’m old-fashioned – he’s male doctor. He’s good looking, very handsome, so when he says you have to come in and do the Pap test, I’m thinking, ‘No no!’ (laughs) I’d rather go back to Taiwan and do it – do that.
–Phoebe, age 49, China

Jill discussed this issue and explained that her doctor offered her alternatives if she felt uncomfortable. In response to her preference of a female provider, she decided to go to a local health unit to complete her screening there.
I think when we visited, like our family doctor would ask, would say, ‘Your Pap test is due’, right, and would you like to do it here because regular family doctor can do it, or if you feel more comfortable with women doctor perhaps, then he can tell you where to go to get it done. Mhm, I didn’t – he didn’t do it for me, I went to the … health unit and went there to did it.
–Jill, age 35, China

Phoebe, on the other hand, expressed the same concerns as Jill, but felt that healthcare providers did not particularly care about her preferences. Her doctor did not offer her alternative options to get her screening completed. Rather, it was through her friends that she found out that she could get her Pap test completed elsewhere with a different provider.

But to medical people, they don’t care, they really don’t think it’s an issue. But to us... maybe some of us. I don’t know about you, I already gave birth, I’m more comfortable seeing a male doctor more than when I was single. When you’re single, you don’t feel comfortable…. My friends told me last time, I talk about - about the issue, my doctor is a male, and I don’t feel comfortable. And my friend said ‘Oh, you can always tell him I don’t feel comfortable letting you do this… maybe you can refer me to the female doctor to do the Pap test for you.’
–Phoebe, age 49, China

Other women who expressed the same issue of uncomfortableness felt uneasy, but tolerated it. Lois explained that back in Taiwan, she would choose to have the Pap test performed by a female doctor. But in Canada, she just left the issue alone.

LOIS: In Taiwan, in this clinic, there is more woman doctor inside. So it’s, yeah, it’s better in Taiwan. ‘Cause in here, there are not a lot of female doctors.
GN: Would you ever ask your doctor if you could have a female do it instead of him?
LOIS: No… just leave it.

Although tolerated by participants in this study, others may choose to forego the procedure if their only option was to having the screening completed by a male practitioner. The preference for female practitioners can serve as a barrier for individuals who are not comfortable with having screenings performed by a male practitioner.
4.4.1 Comfortability in Relationships with Providers

When asked if they would continue to regularly take Pap tests, participants explained that they did not often make requests with their doctor. They felt that they did not have the authority or the capacity to ask. The majority of participants reported that they waited for their doctor to recommend the screening.

Well, if the doctor requires me to, then I will. It’s uh… when I was pregnant, I… needed to do some blood work and stuff like that, and then I will go… to do it [Pap test]. But I wouldn’t… because they usually need to go to the family doctor, in order to do these tests and so like, but I cannot make a request and say I want to do this test unless the doctor says so.
–Ren, age 38, Taiwan

When asked if she makes requests to her doctor, Diep responded:

Yeah. Sometimes, but if my doctor comfortable… she will say no … but I’m not recommend, I’m not learned enough.
–Diep, age 44, Vietnam

Elaborating more about her relationship with her doctor, Janice described how she felt her relationship with her doctor was very one-sided. Her understanding of doctors was that they were the ones who had the final say on what goes, and she felt that she could not ask her doctor for any requests. Janice detailed her experience with doctors here in Canada:

You can’t ask any exams, you can’t ask any medical, just listen to doctor, and it’s not easy to see a doctor… yeah, so when I just coming here, um… when I coming here early – my husband told me, it’s not easy to, if you want to see the doctor… it doesn’t matter in here, (shakes head), it doesn’t work in here. You have to have appointment and tell doctor what happened to you, and doctor decide when and how they give you medical help.
–Janice, age 37, China

Other stories shared by participants regarding relationships with healthcare providers contained similar themes of dissatisfaction where there was a lack of mutual reciprocity. Joyce recounted her experience of how her previous doctor did not listen to her and did not spend enough time with her to answer her questions.
Yeah, I think he…now my new family doctor is good. Sometimes he will give me more advice. But my… ex-family doctor, uh… I think every time when I see him, it’s very quick, very hurry. I have no chance to say more, to discuss.
–Joyce, age 45, China

Ren revealed similar experiences with her other previous doctors.

Yeah, you know some of the doctors want to rush you, ‘cause they have someone next coming in, did they check everything, you’re fine, just Tylenol, you’re fine, just Advil, you’re fine, like everything is Tylenol and Advil, you know what I mean… but now my family doctor is fine, she’s better. She takes the time to talk to you and stuff like that, and she’s not rushing me.
–Ren, age 38, Taiwan

While the majority of participants recounted negative stories about their doctors, several individuals commended their doctors for their care. Satisfied participants described their doctors as patient, attentive, and considerate – willing to take the time to listen and thoughtfully respond to their needs and issues. Cecilia mentioned she was particularly happy with the way her family doctor provided care to her son.

And then… and the best thing I like about the health system is… I feel that my family doctor they are really really nice, for my – for my first child I didn’t even know what should I do or you know… a lot of, during pregnancy, but my family doctor gave me all the information I need and after my son was born, every step of his milestone, she talk to me and she even act more like a mom to my kid, it was like my son didn’t talk until he was 3 or something, and my family doctor has a concern about that so he refer me to the speech therapy, my son, when he was like one… years and 8 months, yeah. And I didn’t even ask for that you know because I thought you know, he understand… and then he… and the family doctor told me that he should… my son is fine, but he want to make sure so he ask me if I want to take him to the speech therapy and blah blah blah, so I think yeah, and then yeah. Just… and like, for my kid, they will just check. Like 18 months, what should they do and then, these kind of things… I think that’s the good part.
–Cecilia, age 37, Taiwan

The experiences recounted by participants demonstrate the importance of physicians and the vital role that they play in the provision of services. In this study, most participants seemed frustrated by not being able to have their requests considered and desired more reciprocity in their interactions with physicians. Some participants explained that due to
this dissatisfaction with healthcare providers, they were less likely to seek out health services when they had health problems.

4.4.2 Health Practitioner Characteristics

Other characteristics, including ethnicity and the ability to speak their language, had implications for health service use. Some women confirmed that doctors with the same ethnicity as them would greatly ease difficulties in communication.

Chinese doctor is the way. Another way, learning English is hard. So for doctors, seeing the Chinese doctor is better. Otherwise, we have to learn English, it’s hard.
– Jackie, age 45, China

Lois expressed similar sentiments as Jackie, but added that she felt more at ease and satisfied with the manner by which a Chinese doctor addressed her problems. Lois affirms:

Easier to talk – and their treatment – the treatment is more Chinese way.
– Lois, age 43, Taiwan

When asked to elaborate, she told a story about a particular health problem she had:

For example, recently I have uh... some part, has a big bump you know? Inside has uh… pus, or something inside. When I go to the Western – or my family doctor, he prescribe the antibiotic for me, but then... I – uh, how to say that. This problem not happen once… it’s antibiotic treatment, it’s okay, but something still inside. I can feel the bump…you know, harder. So I decide to go to the family doctor office on Saturday, but it’s not my family doctor, it’s the Chinese one. Then he… suggest to use the... warm compact – warm compact make it more… make it, the problem – increase the process you know. Yeah, for example, if your body has a bump, inside has pus, if you use the warm compact, then it makes it… bigger, then, when the pus come out, your problem is gone. It won’t keep coming back. You won’t feel the bump – something inside. Right, Chinese doctor, he suggest it. I feel that very good.
– Lois, age 43, Taiwan

Lois’ experience highlighted that the manner by which healthcare providers address their patients’ problems is important. Rather than merely prescribing antibiotics, the healthcare provider provided a solution to her problem that met her needs and expectations.
Although some participants preferred doctors of the same ethnicity, others mentioned that even merely having a doctor who was of a racialized ethnicity would improve their experiences. Because these doctors would more likely have exposure of being from a different country, they would have a better awareness of their patients who were from different countries as well. Ren felt that because her doctor was not born in Canada, she had a better awareness of different cultures. Several other participants also mentioned that they felt more comfortable with healthcare providers of racialized ethnicities who were from different countries.

But now my family doctor is really good, because I think she’s from a different country, she’s from India, so she have a different perspective from... yeah, so she understand not just Canadians, she understand people from different countries, such as Burmese... and in other country.

–Ren, age 38, Taiwan

As described by participants, the relationships that they had with their healthcare provider had implications for whether or not they felt comfortable asking for requests or additional services. Discomfort with their healthcare providers resulted in less opportunities for healthcare use, as well as contentment with healthcare services. Participants also explained that certain characteristics, such as ethnicity and gender, had the ability to influence their comfort levels with their healthcare providers. These considerations had implications for their likelihood to use health services and participate in preventative health screenings.

4.5 Language

Difficulties communicating in English were a common problem experienced by all participants. Participants explained the importance of language and how the ability to speak in English can affect the use of health services. According to Janice and Jill, language is one of the more challenging barriers when immigrants attempt to use health services.

And um... some of them [immigrants], first question is, ‘Do you know which doctors speak Mandarin?’ ‘Do you know which Canada doctors speak Chinese?’ But... um, it’s a little, a little silly because sometimes you can’t tell if a doctor is
good or not just depends on the language. But, language problem is very important when you are sick.
–Janice, age 37, China

I think people [who] need help are the ones with language barriers. I think those are the ones who need the help the most. People from English speaking countries, um, more or less they just need to be educated on how the health system works here… but the ones that don’t speak English as a first language or have the language barrier need more translator services, I mean interpreters, or whatever you call it. Um, I think those are the people who needs more help.
–Jill, age 35, China

While all participants in this study had proficiency in English, the varying levels of understanding made it more difficult for some to communicate with their doctors.

It’s harder, sometimes they talk a lot but I don’t understand anything, you know what I mean. I just understand a little bit, you know.
–Diep, age 44, Vietnam

Yu Ming explained that since she knew some English now, communicating was not particularly hard. However, she remembers that it was difficult when she first arrived in Canada.

How to say…. for me, English is not particularly hard because I know some English. But if someone does not know any English, then will be very difficult to communicate. But at the beginning… at the hospitals, they needed to translate for me.
–Yu Ming, age 46, China

Timing seemed to be particularly important for the issue of language. All participants in this study mentioned that during their first couple of years in Canada, language proved to be the most difficult problem they faced. Translation services were also accessed most frequently in their early years of arrival.

In particular, the use of medical terminology or finding words to describe health issues was a problem. Participants revealed that since they had grown up speaking a different language in a different country, it was difficult to find English terms for the words they were accustomed to in their own language. Understanding and using medical terminology was particularly difficult since these were words that they did not regularly use in their daily lives.
Of course, to use my own language it’s easier, by a lot. For example, when we go see specialists, everyone speaks English, so we have to speak English. When we speak regular English, and they speak regular English, we still understand. But when they use their particular terminology, we don’t understand, we don’t know those words or what they’re saying. But they will try to explain in simpler terms, to help us understand… yeah, those medical terms, words we don’t regularly use or see, we don’t know or understand.

–Yu Ming, age 46, China

Because the language you know … you know we grow up in Taiwan a lot of … disease or symptom or language we use is in Mandarin, and in Canada, a lot of them… you have to think about it, and we might need to Google it and then, like, yeah. It’s very different.

–Cecilia, age 37, Taiwan

Joyce mentioned an interesting aspect of language barriers she faced when accessing health services. She explained that not only was language a difficulty in her interactions with healthcare providers, it also served as a barrier when she made appointments.

JOYCE: Mmm… yeah, when I – at the beginning when I come to Canada… that second year I was pregnant and um… it’s difficult for me to communicate with the doctor. But um… fortunately I got a …translator when I go to the hospital. Yeah, just when I was pregnant. Yeah, I went to… mm… three times, I cannot remember, and every time I got a translator
GN: And the translator made it easier?
JOYCE: Yeah, I think so. The translator service was a bit better. Um, but sometimes… you still need some uh… the language to communicate because when you make an appointment, you – it’s um there’s the lady uh I don’t know the word…
GN: The receptionist?
JOYCE: Yeah, the receptionist, speak – speak English.

The increased difficulty of communicating in English discouraged several participants from regularly seeking out health services. I asked Joyce if she used health services less since immigrating to Canada.

Umm… the main reason just the because of the language
–Joyce, China, age 45

Overall, language was the most common barrier experienced by all participants in this study, and was pervasive in all aspects of using services in the healthcare system. For all participants in this study, language difficulties created communication barriers which
made using health services more challenging, as well as lessened their inclinations to use health services.

4.5.1 Mitigating Language Barriers

Although some women used less health services in response to this issue, others described various ways through which they tried to mitigate these language barriers. Many had strategies to respond to this challenge and took it upon themselves to deal with the issue. For example, numerous participants stated that they would write words down when they did not understand certain words that their doctor was using. They would write down difficult words and then go home later to look them up.

It’s just sometimes I uh… if something important, I tell them to write it down, and then I’m looking in the dictionary on my own.
–Diep, age 44, Vietnam

For some doctors they tell me, but I don’t know what they talking about. So because they are – they have some … specific – some words, right? I don’t know. And sometimes doctor write down – write me some, I check.
–Jackie, age 45, China

I think he knows [that English is difficult]… I have to write down some – I think – critical words, so I write down.
–Li Fen, age 47, China

Others mentioned that they would ask doctors to speak slower for them when they spoke too fast for them to understand.

For now… communication is okay because the doctor will see that my English is not that good, so he won’t speak that quickly. He will speak slower. If he doesn’t remember and speak quickly, I will ask him to speak slower.
–Yu Ming, age 46, China

However, several women explained that asking doctors to speak slower still presented problems. Jackie described her situation:

I think the most, they understand. Then, another part, they have to guess. Most, they understand. Some, maybe difficult for them because the language difference, right, they have to guess. Yeah, they have to guess what you say, what you talk about, so sometimes they asking you – repeat, repeat, and repeat again to ask. But um… sometime, myself, if doctor say something to me, the doctor they will say
very slow, because I tell them my English limited, right. Just a little bit slow – they very slow, slow… sometime they forgot, they fast. ‘Okay, I don’t, please, I don’t understand.’ ‘Okay’. But really sometime, I don’t understand, but I don’t want to ask because they continue to – I don’t want them to stop. Then they finish, they talk and finish, and I forgot what they – what questions I have to ask them, before what you say to me, then I’m not stop you right, you continue to saying right. Then after when you finish, I forgot what I have to ask them before. Yeah, that’s just language problem, for me here.
–Jackie, age 45, China

Lois described similar experiences.

LOIS: Uh, I think the most problem – my language is not good. Not perfect. Uh… language. Probably sometime when the doctor say something, and then I don’t know.
GN: Do you tell him, or ask him to explain more? How do you deal with that?
LOIS: Yeah, although he explain more, he explain more, but still, I don’t know… more. It’s a problem for newcomer, you know. Yeah, yeah, I check Internet, you know, I don’t know anybody. It’s a problem for me.

Jackie’s and Lois’ experiences mirrored a lot of other participants’ experiences.

Understanding doctors was difficult in many cases, and although doctors would attempt to speak slower or explain more, a lack of understanding still persisted among participants. In Jackie’s situation, although she attempted in the beginning to make sure she could understand by addressing the issue with her doctor, her doctor would forget, and Jackie would end up not pursuing the issue, leaving her problems and concerns unresolved.

Another method of addressing language difficulties was to seek a healthcare provider who could speak their native language. Several women discussed that they now have healthcare providers who could speak Mandarin, making communication much easier for them.

My – now my family doctor is uh... he can speak Mandarin. Yeah, yeah, I transferred to him for about more than one year. Yeah… communicate more easy.
–Joyce, age 45, China

Uh, uh, my friends, my friends introduce the family doctor because he speaks Mandarin, I think it’s uh, sometimes if the newcomer, it’s difficult for them to go to family doctor.
–Sandra, age 44, China
Several participants also stated that their friends would sometimes help them with translation.

If I have an important question, I – my friend is uh, um - help me, translation.
–Wang Li, age 45, China

However, although this was a noted solution for some, participants also described the difficulty involved in finding and bringing along people who could interpret.

Newcomer will have language problem… you can tell someone to come with you, they can translate for you. But sometimes, we don’t have that. Or your friends are not available. In hospital, they did provide the interpreter, yeah, they ask you if you need it. When I did the exam last time, they did ask if you need.
–Lois, age 43, Taiwan

Lois mentioned that hospitals had translation services available, and other participants also reported that they had used these services. However, the lack of availability of translation services for their visits to their family doctor meant these services were often useless to them.

Because especially the... words, the English words... for your body or some treatment, sometimes yes, I think it’s very difficult. I heard that some hospital they have uh for example Chinese... social worker? A translator. You can ask, but you have to make appointment to ask – in hospital, right? But in family doctor, they don’t, so yeah, it’s difficult.
–Li Fen, age 47, China

Jackie explained that her doctor asked if she could bring a translator with her. She could do little with this suggestion as she explained that it was difficult to bring someone along with her to her appointments.

GN: So she [doctor] knows that sometimes there’s a language barrier.
JACKIE: Yes. Sometimes, she ask me to bring a translator.
GN: Is it easy or hard to find someone to come with you?
JACKIE: Yeah, it’s very hard.

It is evident that although many participants attempted to ameliorate problems caused by language barriers, language was still highlighted to be among one of the most pressing concerns when attempting to access health services.
4.6 Culture

Discussions revolving around culture and the impact it had on health service use were prevalent in interviews with participants. Participants in this study acknowledged that they had different cultural attitudes towards health compared to their family doctors.

They’re very good! My doctor very good. But it’s just because of me. I want, just the way I want. Some… they’re different, Canadian, they’re different.
–Diep, age 44, Vietnam

When asked whether or not her culture has different health beliefs, Joanne and Phoebe agreed that they felt there were some differences.

Mm... sometime, I don’t think so. But Asian maybe, I don’t know. A little bit conscious, different, yeah.
–Joanne, age 43, China

Health? Oh here? Yeah, we – the Chinese, we have a lot of uh – you’re not supposed to drink cold water… don’t drink ice water, and after you gave birth, don’t take a bath right away, don’t take a shower… all this. It’s different, yeah, yeah.
–Phoebe, age 49, Taiwan

The participants in this study all acknowledged their different perspectives toward health. They recognized the role that their culture played in influencing the way they conceptualized health, as well as the health practices that they engaged in.

4.6.1 Traditional Chinese Medicine (TCM)

Many women had a preference for using alternative healthcare, such as TCM due to its holistic approach to health. Ten out of the fourteen women that were interviewed reported that they regularly used TCM services for their health needs. Although most women reported that they regularly used TCM, women also reported that TCM services were often used in conjunction with Western health services. TCM was described by participants to be a less harmful and much more effective approach to address health issues.

Participants explained that the use of Western health services, and in particular, the use of Western medicine, was sometimes not helpful for their specific health
problems. They often preferred the holistic nature of TCM for addressing their health issues. Their main praise and reason for using TCM was that not only does it target their particular issue, the goal and effects of TCM are centered on healing the whole body. This includes focusing on the source of the problem, which they believed was not necessarily the case with Western medicine.

Yes, because, the medicine from TCM doesn’t harm the body, or have bad side effects, but the Western medicine does. Sometimes, if you take the Western medicine, you can fix the digestive, but it might harm other parts of the body, it might not be good for the liver, etcetera. It’s not good for the whole body. But TCM, there’s no bad counter effects. And sometimes, they can’t even really help with the issue, like for digestive issues. Sometimes, they’ll just give you painkillers, which doesn’t do very much to help with the issue.
– Yu Ming, age 46, China

Well, Western medication and Chinese medication are very different. Yeah, but the... Western medication is pretty much give you painkiller, all this stuff. So I – I don’t know. Unless I’m really in pain, otherwise I prefer, I prefer Chinese – Chinese doctor… for me, I believe in Chinese doctor. Most people I know - a lot of people I know, they switch to Chinese doctors, especially for kids, because they – we believe that Western medicine is not that good for kids. We’re pretty much, we do both.
– Phoebe, age 49, Taiwan

We all use herbs, because any antibiotics or medication, they have the negative parts – the herbs, probably, probably, there’s no such research to testify it has negative parts or positive parts, so we think something edible is better than chemical.
– Joanne, age 43, China

I think Chinese they try to um, uh, not to – for example, you got sick right, they try to look – look at the... root cause, and help your body… everything, just.. go … to recover, and I think Western they have – you have this one, kill this one, you have that one, kill that one, what’s the consequence? What about the root? Um.. I don’t know.. sometimes I think they don’t look at the root cause and they just go, ‘there you have some problems, kill that one, you know, found a way to treat it’, but maybe this problem is some other problem caused this problem…
– Li Fen, age 47, China

Most of the participants in this study felt that the effects of Western medicine were more harmful to their overall body system, and only addressed the manifested symptoms of the issue, or provided a quick fix without addressing the underlying problem. Women
described their use of TCM and how it had the ability to address health issues that Western medicine couldn’t solve.

I think over here is more Western, right. In Taiwan like, people have the – we don’t like to take antibiotics over there. And then if you – you see for myself, because my daughter has a very severe allergy, we tried like Western medicine for a couple months. But after a while, sometimes you find it not helpful. For my daughter, it was not. She just took antibiotics all the time. I think it’s not good for her body. So we switched to Chinese medicine. It helped, it helped a lot, so we just stick with that for her, unless she is having fever or something that is very severe, then we go to Western doctor.
–Phoebe, age 49, Taiwan

I have a big experience before that Western medical cannot uh… cure my… illness. I’m – that’s the – there was very old Chinese doctor and he bring something… and just recover after one or two months – I have been sick for over a year now but cannot recover and uh… he helps – just the… two, three months, one or two months – and done! So that’s uh… I’m very, yeah, grateful… thankful for him.
–Li Fen, age 47, China

Participants explained a common experience where they would try to use Western services and take Western medication, but find it ineffective, then use TCM services and take herbal medicine instead.

Well, it’s different. When you see family doctor and take Western medicine, you might feel better for a couple of days, but sometimes even if you don’t take it, it doesn’t seem to make much of a difference, you feel the same. So you try the Chinese traditional doctor.
–Yu Ming, age 46, China

Women also preferred to see TCM doctors due to the ease in communication, the more considerate nature of the providers, as well as the mutual understanding of cultural needs. Janice was one of the several participants who expressed that they relied on TCM services much more frequently their family doctor. When asked which health provider she used most frequently, she replied as follows:

Oh, Chinese herbal doctor... mm... one is for the uh... easy communication, another one is the uh …the medical and the doctor’s style is… Chinese people, very um… it’s, uh, similar. They know that, at least I understand why they give me that medical, I understand why they uh… suggest me to do this, or to not do
this. That’s the same, the same mm… same to the Asian as I’m in China. …. They will understand you. They will know how to think about… and uh… decided from them, you can accept it easy… they will care. You will feel they care. But if another doctor… um.. you will feel they doesn’t care.
–Janice, age 37, China

Some women even acknowledged that TCM was an important aspect of their culture and considered it necessary for their approach to health maintenance.

You know us, since we’re Chinese, we’re used to TCM. TCM is focused on continually nurturing and making the whole body better. Holistic. Here, people who grow up here in Canada don’t have this idea, but since we come from Chinese, we still focus on that and need that.
–Yu Ming, age 46, China

Joanne expressed a similar sentiment:

Yes, yes, it is my experience because it is part of the culture. It plays very important role in Chinese people… and we do have some different… medication or belief or habit, right.
–Joanne, age 43, China

Li Fen explained her understanding of the two types of services and her experiences with both.

What I’m understanding is – the Western you know… the... medical system versus the traditional Chinese medical system um... it’s not that quite the same because here, I think Western is… more high technologist equipment, they do test first, right. They got the information, the data, then they will base on the data to determine the... sick or something or treatment - what treatment should be. For the traditional Chinese medical system, you know the herbs… Chinese medical stuff is more – more based on experience… From the family, you know the many generations come through, one family, they have some special… I don’t know the word... some secret.
–Li Fen, age 47, China

Her sentiments described two services with different characteristics and approaches. However, both were integral to provide an all-encompassing approach to her specific health concerns. Other participants expressed similar sentiments, where they would see different practitioners for different needs.
If I get, if I have... back pain or something, or if like I had a kink in my neck then I would have gone for the Chinese massage, you know the acupuncture and all that. But if it was cough or... cold or anything and I would’ve gone for the family doctor. Yup.
–Jill, age 35, China

Well, Western medication and Chinese medication are very different. Yeah, but the... Western medication is pretty much give you painkiller, all this stuff. So I – I don’t know. Unless I’m really in pain, otherwise I prefer, I prefer Chinese – Chinese doctor.
–Phoebe, age 49, Taiwan

An interesting dilemma was presented by those who regularly accessed both types of services. Several participants mentioned having conflicts with their family doctor about their use of TCM services. Ren described how her doctor did not want her taking any Chinese herbal medicine for her cold while she was pregnant.

For example, when I was pregnant, I took some sort of herbal medicine, Chinese herbal medicines right, and then uh, I said just to, because I’m pregnant, I don’t want to take any Western medications, it’s too strong, I’d just want to, I’d rather take the powder. More natural. And I talk to my doctor, and he said, he’s like he looks at me, ‘I want you to stop taking that thing.’ He doesn’t want me to take anything... Chinese medicine like during the pregnancy ‘cause I had a cold and I don’t want to take any like, Tylenol and stuff, right... actually herbal medicine is better than... safer too, right, but it’s like no... I don’t want you to take that, it’s just because they [doctors] don’t study that part of the education, they don’t understand how that works, so they don’t want you to take any of this.
–Ren, age 38, Taiwan

She went on to explain that she complied with the doctor’s orders because he was quite adamant and she felt that she could not say no to her doctor.

GN: So did you listen to your doctor? Or did you continue taking –
REN: Oh, I did, I listened to him. Cause he’s the doctor. I was like, ‘Okay, sure’. When he said ‘Stop’, then I was like, ‘Okay’, and I stopped.

Phoebe explained a similar situation where she did not want to tell her doctor about her use of TCM.

My doctor so far he didn’t [know about the use of TCM], because I didn’t tell, I’m afraid he will get mad... I’m afraid he will get mad.
–Phoebe, age 49, Taiwan
These experiences highlight an interesting facet of the immigrant experience. For those who engaged regularly in alternative health services, they found it difficult to communicate openly about their health service use and needs. This exacerbated communication problems and cultural gaps between healthcare practitioners and participants.

Phoebe goes on to explain that she did not experience this problem in her home country of Taiwan. The healthcare practitioners there were much more aware of the use of alternative health services.

In Taiwan, people are more half-half [who use TCM], and it’s very common, Chinese medicine, in Taiwan. So I think over here is more Western, right. In Taiwan like, people have the – we don’t like to take antibiotics over there… most of the doctors, I think they know. In Taiwan, even you go to Western doctor, they will tell you, okay, there’s certain foods you’re not supposed to eat, certain foods when you’re having a cold. It’s more implied to Chinese doctor side. They know what the patient will usually think.

–Phoebe, age 49, Taiwan

Although the majority of the participants in this study reported that they used TCM services regularly, several participants stated that they did not use it.

It tastes terrible. The Chinese medicine tastes terrible. But some people believe that – it’s slowly right. But I don’t like slow things – I want to quickly solve my problem.

–Lois, age 43, Taiwan

In Lois’ case, she pointed to, again, how TCM services and Western health services were different in their approaches, and individuals could choose one or the other according to their preferences. In her case, she preferred to have her health issues addressed immediately, so she sought the use of Western health services as opposed to TCM services.

4.7 Adjustment to a New Healthcare System

Many of the issues highlighted by participants were caused by their unfamiliarity with the healthcare system in Canada. One of the more challenging aspects of adjusting to a new
Janice explains her uncertainty of the norms and procedures in her interactions with her doctor.

JANICE: Sometimes I want to ask some questions but I don’t think maybe to um… I will doubt is it reasonable or not. For example… um... when I’m pregnant, when I’m early pregnant, I ask my family doctor is there any exams I should do in Canada. Uh, and they – she told me nothing because, because you look good, and just to do some blood test and I ask them blood test – which –which kind you want to check, to tell me, one, two, three. And I think maybe have four or five? Because in China, if you do some blood tests, they will give you one, two, three, four, five, six, seven! Yeah, just the one time do the blood, maybe seven or eight uh… exams. Umm… my doctor said… you don’t need to do that. I… have the.. question about that. Because I… I feel some uh…crass, so I stop to ask. It’s not because of language, maybe, maybe it’s not, maybe some offend to the doctor, maybe they have some reason… but I still can feel the why, and after I give birth to my daughter, after one month, usually they will do some exams to make sure you – you good, and don’t have any problems. But the doctor have appointment to me and just look at me, and didn’t even do any exams. Said, You look good, so you don’t need to do that.’ Okay… but I think umm... are you sure… you just look at me?

GN: Sometimes, you’re unsure to ask questions because you don’t know if it will be appropriate or not…

JANICE: It’s good or not, can I ask that, or… that offend to the doctor? I don’t know the – the border, where is the border. So you know… how can… but still have questions.

Participants’ experiences with the health services in Canada were very different from what they were used to in their home countries. For example, several women described how their doctors rarely gave them medication in response to their problems, but provision of medication was a common occurrence in China. This often left them feeling unsatisfied when they were not afforded or provided the same type of care in their new country. Participants felt that they could not rely on their doctor to receive adequate care. Although this may not necessarily the case, participants’ perceptions were that they could not acquire full use of the health resources they desired.

JOYCE: You know in China, sometimes when you just catch a cold, doctor will give me some medicine to get rid of uh – when you catch the high fever, and they
will give you some medicine. But in Canada, doctor won’t give you. Like, uh, two
days ago, my son – he mm.. cough. So I bring him to see family doctor and doctor
check with him, with his lungs and uh – and uh – look his throat. And – and he
said nothing! Just take more rest.
GN: Oh okay, do you feel he should be offering more than just ‘take a rest’?
JOYCE: Yeah, he gave some advice. But no medication.

Interestingly, Jill, a long-term immigrant, explained her viewpoint of how she got used to
the norm of not receiving medication after residing several years in Canada.

Because I’m here a long time now, maybe the first year or two when I’m here, I
am more like some recent immigrants who think, ‘Oh, my doctor didn’t give me
any medicine, but I do feel sick, I do need medicine, but how come you don’t give
me any medicine’, I could be... like I think I’m probably like that the first few
years, the longer I live here, the more understanding I gain... of why they’re not
giving medicine right away. You just need time, you just get used to it. To
understand the system better and to educate yourself better perhaps, right.
–Jill, age 35, China

Jill described that the process involved in understanding the healthcare system required
time and education. She clarified that education would be important for new immigrants
to understand the system, but the acceptance of differences in expectations required time
and experience.

4.7.1 Long Wait Times

Participants also expressed frustration with wait times and limited convenience of seeing
the doctor. In particular, making appointments with family doctors was a constant
struggle for many participants.

Our family doctor, I would say he’s really good, like in terms of appointment, like
you have to book appointment, and he does have a walk-in time, but it’s not... always
there, you always every time when you want to go see him you always
have to get appointment, and then when you want to get appointment, he may not
be... available, right? It’s – it’s that kind of a dilemma thing... you have to work
with, but hey, I guess that’s the way it is, you just have to get used to it, accept it.
–Jill, age 35, China
Janice further expressed her feelings about the long wait times. She recounted an experience where after waiting for several hours, she wanted to tell her doctor about her issue, but was reluctant to because the doctor did not seem open to listen to her concerns.

I waiting for this doc – I – it’s very hard to get the appointment. And… when I come to the things on time, but they ask me to waiting for maybe one hour or two hours, uh… and I want to tell her my – my uncomfort. But the doctor is very busy and look umm… not very… patient.
–Janice, age 37, China

For these reasons, participants explained that they were more disinclined to see the doctor. Jackie explained that she often decides not to see the doctor for her issues and prefers to deal with issues on her own.

JACKIE: Some need it urgently, maybe, I don’t know, in China, maybe I get cold – in China, no need the appointment, go see doctor, very fast. You have to waiting here, so that’s why it’s hard to see the doctor.
GN: In China, if you get a cold, you just go see the doctor.
JACKIE: Yeah!
GN: Because it’s so easy. But here it’s hard to make an appointment…
JACKIE: Yeah, appointments, doctor out already… ahh, so that’s why – small things I take care of myself.

Every participant in this study expressed extreme dissatisfaction at the waiting times needed to see a specialist or for hospital services. Having experienced the extremely long waiting times for service, participants were more reluctant to utilize health services when needed.

When you’re sick and you call, they usually will let you have an appointment within a few days. If you’re very urgent, then they’ll probably just tell you to go to emergency. But emergency room, it’s not even an emergency room. You can’t call it emergency. When you go there, you still wait for so long. One time, my son had a fever, but he got better, but I still, I brought him to the walk-in, the doctor needed to go, it was, I think it was 5pm, but I told him, my son has a fever, he said, ‘Family doctor has to end his shift now’, they were already closing. ‘You need to go to emergency room’. But if I go to emergency room, we’d have to wait 10 plus hours! Okay, let’s not go see anyone, we’ll just go home, and but some fever relief medicine. Buy some fever relief medicine, for children, just buy them medicine, only if the fever don’t go down, then you should be scared – but we dealt with it ourselves.
–Yu Ming, age 46, China
Well, China is more… right away. Right, you get — to see the doctor, you get to see whatever type of the doctor right away… after I give birth, I had a horrible rash and I needed to see — I went to see my doctor and then my doctor few times give me like some sort of cream that didn’t help and I kept on going back, and in the end he referred me to a dermatologist, and I waited for 7 months. Mhm, I waited for 7 months. By the time I get there, I mean — and then the dermatologist spends like 5 to 10 minutes with you, it’s not gonna solve the problem, right, cause sometime I think it’s more like, if it’s not gonna kill me then you know what, forget it.
—Jill, age 35, China

These types of stories were prominent in discussions with participants about healthcare experiences. Because the length of time needed to use services was simply not time-sensitive, practical, or responsive enough, participants developed a habit to rely on themselves to address their health issues whenever possible. Such a routine reduces the rate at which health services are utilized in the healthcare system.

4.8 Transnational Healthcare Use

The inadequacies of the services found in Canada prompted several participants to regularly use health services in their home country. The convenience and speed of health services abroad also made it easier for participants to utilize preventative health services in their home country.

Okay, yeah, and I’m going back home now, like next week. So… and then, I’m going to go see my doctors over there, and I’m going to do the Pap test there.
—Ren, age 38, Taiwan

For me, I usually go see — I go back to Taiwan during summer, when I go back during summer, that’s the time I see my doctor — where I do the checkup. Because it only takes like — you make appointment on the Internet, then you see the doctor, and then usually they will have the exam for you that day or they will make appointment within that week to make the exam, and then the results comes out, like the latest two weeks, or usually the next week you come back and they will tell you what’s wrong- and that’s like, x-ray or ultrasound all this stuff – but over here I know it takes half a year – to get to the next step for the – for the next checkup – so, it takes too long.
—Phoebe, age 49, Taiwan

Phoebe goes on to explain that some of her friends had difficulties finding a family doctor, and would go back to Taiwan for health services instead.
PHOEBE: Even two of my friends, I referred my doctor to them, right, uh I think about before Christmas, they went to my family doctor, and he become their family doctor. They been here 3 years – they never get any family doctor.

GN: Because they don’t know or can’t find one?

PHOEBE: They cannot find one. And they said, well, anyway, nothing severe, and it takes too long, they say may as well, just take our own medication or go back to Taiwan… yeah during summer or winter and they will see their doctor.

Other participants who did not directly use health services in their home country also spoke of others who would participate in transnational health service utilization. It appeared to be a common phenomenon among Asian immigrants.

Yeah, and sometimes.. is uh… so Chinese people, my friends Chinese people, and uh, they all think maybe it’s just small things you can just go to family doctor, but if you have chronic disease or some serious disease, you head back to China. Got the medical support and ( unintelligible). Don’t wait because wait is not good for you.

–Janice, age 37, China

But I do hear from... little community, or my friends, if they have big issues, the… slow response and appointment system, which makes the system worse, for example cancer, they prefer to go back to China to see the doctor. And they got the doctor appointment, not the appointment – if they went to hospital, they would be able to see the doctor right away and they could have the choice of different…. um different physicians, it’s not – it’s by referral, but it’s right away.

–Joanne, age 43, China

It seemed that regular transnational health service use was more common among immigrants from Taiwan. Most participants from Taiwan in this study mentioned they had traveled abroad back to Taiwan to use health services there recently. Li Fen explains what her friends from Taiwan typically do when they have a family member with chronic health issues.

Yeah ‘cause all my friends, they – they, whenever, you know it’s very many Taiwanese immigrate to Canada, but once there’s a family member who has the, you know, need to consistently take – they move back right away. The whole family will move back just for the health. Yeah, a lot of them. They will criticize, ‘Oh we wait until you dead and then your doctor…’ and then blah blah blah.

–Li Fen, age 47, China
The frustrations associated with waiting too long formed the basis for participants’ decisions to use health services abroad. Urgency was important in addressing healthcare problems, and the Canadian healthcare system did not offer the immediacy that participants desired.

### 4.9 Acquiring Health Information

Another common challenge faced by participants was locating relevant health information in order to use health services. Many women explained that although information was available, they had trouble finding pertinent and relevant health information, especially during their early years in Canada.

> Maybe there is support, but they don’t give you the information right away, oh we have information in… health centre, but who will go to the …health centre to do this? They should be giving out the information as soon as you receive the health card, and say what’s going on, what’s covered and stuff like that.
> – Ren, age 38, Taiwan

For some, like Li Fen, finding information continues to be a challenge. Li Fen explained that she still does not know quite how the system or services really work in Canada.

> So they [immigrant centres] tell that information they tell the health card, but they don’t talking about hospital or doctor, so I don’t really – so far I still don’t know (laughs). How or what to…
> – Li Fen, age 47, China

Immigration centres were highlighted as an important information hub for immigrants. However, some participants mentioned that immigrants may not know these centres exist.

> I know, they have the newcomer centre, I think. Immigration centre. Yeah, but most people, they come here, they don’t know they have centre there, that’s important.
> – Jackie, age 45, China

> Go to... there is immigration that open, that help you... there is Chinese, especially help Chinese people, including Mandarin or Cantonese, there’s office there.
> – Li Fen, age 47, China
While some participants mentioned they knew that websites had information available online, these sources were noted to particularly unhelpful for new immigrants with language difficulties.

I know there’s a lot of the websites, but those websites is – is still have no any Chinese translation… so to… it’s not only for me, to the immigrant, to immigrant, they just doesn’t, and exit. For example, you look at French, all French, that says nothing for me, I can’t tell any information about that.
– Janice, age 37, China

Location also proved to be a consideration that several participants acknowledged to be influential on their ability to acquire information. Various comparisons were made between the Southwestern Ontario city that they lived in and Toronto. Participants felt that information about health services in Toronto were easier to locate and access.

Yeah, maybe they wouldn’t know where to go… Like in Toronto, they have information centres, to help Chinese immigrants, they help them.
– Yu Ming, age 46, China

‘Cause I do have – find Toronto adults who don’t speak a word of English, they’re in the Chinese community, but they want to move… but they’re scared of – if they come here, they don’t speak English, how can they go to the doctor, how can they… get a bank, you know, the – it’s, the language is the biggest barrier, I would say.
– Jill, age 35, China

Some participants even mentioned that they had no knowledge of needing to find a family doctor upon arrival to Canada.

Who tell me – nobody tell me. We just hear about that from friends… from other – maybe from the – we go ESL, uh… LINC class, maybe … classmates, maybe they talk some – yeah, nobody just taught - tell me, ‘Oh you have to find family doctor’, or ‘blah blah’, no.
– Jackie, age 45, China

No, no, nothing. They didn’t tell me you have to find a family doctor. No, nothing, you just go, have certain times, you go take a picture, that’s it. Then they mail it [health card] to you.
– Phoebe, age 49, Taiwan

Although, participants explained that they eventually understood that they needed to find a family doctor, it was a difficult process for them. Most women acknowledged that they
were fortunate enough to have a family doctor and thus, could more easily access preventative health services such as cervical cancer screening. Many recounted stories where they, or others around them, still continue to have difficulty finding a family doctor.

Right, if she [family doctor] hadn’t said that to me, I wouldn’t know, right? And I wouldn’t know the policy... the government benefit etc., I wouldn’t know [about cervical cancer screening]. I’m lucky, I have a family doctor. But... someone who don’t have a family doctor, they might not know from the walk-in clinic, and I think that’s another feature again, in Canada, all through Canada, especially for new immigrants, it’s so hard for them to find a family doctor.
–Joanne, age 43, China

Well, to me, because I’m lucky, I found him like probably when I’m here like maybe a half year – but my other friends they’ve been here 2 to 3 years, they haven’t found one. Yeah, they didn’t find anyone. Because usually you need someone to refer right, but they don’t know any – and – or the doctors are full, they don’t accept any new patients.
–Phoebe, age 49, Taiwan

Yeah, I haven’t have family doctor until 4th… or 5th year. I couldn’t find one. One reason was I’ve been lazy and by that time, I don’t have… car, so I don’t really want to – when they – when I see one available, but it’s so far from me and by that time, I don’t have any concerns so… if I need to see doctor… I just go to walk-in clinic. But, when I… pregnant, I feel I need to find one, and... yeah.
–Cecilia, age 37, Taiwan

In particular, participants discussed how new immigrants face increased challenges in the beginning of their residency in Canada. Because new immigrants are busy adjusting and transitioning into a new country, the priority to seek health services and acquire health information was of lower importance.

Yeah... I – I guess if you Google you probably can find it but you just – you don’t know, like when you know, when you first move here, there’s a lot of things you need to do, so that’s probably another... depends on your situation.
–Cecilia, age 37, Taiwan

I think yeah, it’s uh, at that time, because the immigrants are actually, it’s very challenging. So people when they first come… I do remember when I first time, it’s challenging for life, looking for job, settle down, all that stuff. They may haven’t… even think about health yet. But maybe because it’s stressful that time, maybe... very important for them to – to know that health services in Canada, how they run or something, yeah. I think we need more information for them, yeah.
4.9.1 Friends and Family

Friends and family were crucial sources of information for participants. These contacts were especially important if participants had specific preferences or were seeking particular services. Joyce explained that she was able to locate a Mandarin speaking doctor through her friends.

JOYCE: Uh... mm... it’s not difficult to find any family doctor, but if you want to find like my family doctor, he can speak Mandarin, it’s very difficult.
GN: Okay, so how did you find your doctor?
JOYCE: My friends told me. Yeah, I always ask my friends. And uh, mm... one day, my friend told me there’s a new doctor here, and he can speak Mandarin.

Numerous stories were shared by participants where they acknowledged the support of their friends and family in helping them find the health services they needed. Without these key contacts, many of them would not have known what to do or where to go for health information or services. Participants anticipated that individuals who did not have close contacts would have had much more difficulty acquiring the health resources that they needed.

When I came here, uh... I didn’t have too many problems, and I had a husband who was here. But some people who are new here will sometimes have problems, but for me, didn’t have any problems because I had someone here. He was like, ‘I’ll take you to my family doctor, I’ll help bring you there.’ But for those who do not have relatives or close family members here, they would probably have some problems.
–Yu Ming, age 46, China

All participants in this study highlighted the importance of social networks in the distribution and attainment of health information. Having friends or family that they could talk to meant that they could more easily acquire information that they might find difficult to locate on their own. Many participants shared their thoughts on whether or not they felt immigrants receive the support and information they need when they first arrive.

Do they? I don’t know, because my family already here before me, and so I get help from my family. But whoever came here, and then without... maybe there’s help... I don’t know.
–Diep, age 44, Vietnam

My husband live in Canada for many years, so everything he understands He is my… (laughs) teacher. He let me know what I should do and what not to do. Don’t ask question about this, just follow this, appointments… err… I think, it’s not everyone has the teacher husband.

–Janice, age 37, China

Yeah, yeah, when first time when I come here, because I don’t understand anything… for anywhere, nothing, and… my friend take me to the walk-in for… uh my finger? My finger is uh… has some broken, the finger is broken, my friend take me to the walk-in.

–Sandra, age 44, China

When we first got – when we landed in Canada. Actually, we don’t know that much. But luckily we live with my husband’s cousin, yeah, they told us something about where to apply and something like that, they let us know.

–Lois, age 43, Taiwan

Wang Li specifically stated that her first resource was to ask friends for help.

Friends. Ask friends, friends help me.

–Wang Li, age 45, China

Time mattered, particularly for the acquisition of information. Discussions with recent immigrants who had fewer years of residency in Canada needed to rely on contacts to help them establish themselves. All participants in this study mentioned that when they first arrived, it was reliance on their friends and family that helped them gain the knowledge they needed.

Participants shared their sentiments about the importance of friends when trying to acquire information.

Yeah, definitely, otherwise you don’t know all this information!

–Phoebe, age 49, Taiwan

I don’t feel that the information is very… at least, back in my time, there wasn’t that many information. But I was lucky because I had my boyfriend, now is my husband, if I have any… question, I ask him you know, how do I, and his family would tell me something. So I guess, I didn’t feel that hard, but if you know, you’re alone and you… you might feel it’s difficult to… to get, yeah.

–Cecilia, age 37, Taiwan
Because I think my husband, he is um, he was here for a long time so I get information from him. So my family doctor is his family doctor. So I don’t really have to look at that information.
–Li Fen, age 47, China

Throughout discussions with participants, it became clear that friends and family were crucial in offering guidance that helped them acclimate to a new country. They provided social support that assisted them in navigating a new system, allowing participants to feel more easily integrated, and better able to acquire the information they needed to use services in the healthcare system.

4.9.2 Technology

In addition to friends and family, online resources were consulted and used as a strategy to acquire health information. In particular, social media was explained by several participants to be a popular tool for new immigrants to find information. WeChat and QQ, popular Chinese social media apps provided a platform for immigrants to discuss their questions and concerns.

JANICE: How can they get information? Hm, I know a lot of them ask this medical information from maybe Chinese WeChat, do you know WeChat? Just like Facebook. Very famous in China. And um... some of them, first question is, ‘Do you know which doctors speak Mandarin?’ ‘Do you know which Canada doctors speak Chinese?’... yeah, it’s just like Facebook group, you can join some group in your WeChat, so there’s lots of Chinese WeChat – uh Chinese groups in WeChat. Yeah, they’ll ask uh... information or questions, and some people will give them answers or other suggestions.

GN: About living in Canada?

JANICE: Yeah, yeah. ‘Where can I um... uh, get a good, which doctor do you suggest or, what’s – what’s the, what’s the... how can I… wash my car… in the group you know? (laughs) That’s very funny, but they communicate in that. But the communicate from that is helpful I think. But it’s only depends on personal experience. It’s not a professional, professional suggestion. It’s only personal opinion.

JOYCE: Um, uh... yeah, before I came to Canada, because I... uh got the information from my friends, they told me the beginning, 3 months at beginning we haven’t the... card.
GN: Oh, so that was good, so you knew before you came here, you were ready. So I guess it makes a big difference that you have friends here. Did that help you in the beginning?
JOYCE: Actually, the... friends, I – I didn’t know, I didn’t even meet them. That was from the internet. We have a group.
GN: Oh, was it WeChat?
JOYCE: No, like WeChat, QQ, you know?
GN: Oh, yes, so you would go online and you would ask?
JOYCE: Yeah, we have a group because we are the same immigration. We have a group on QQ.
GN: Okay, so the group was the same people immigrating that year?
JOYCE: Uh... almost, the recent years.
GN: So people would just ask questions in that group?
JOYCE: Yeah, and they share the information.

The use of these online groups was explained by participants to be very informative and useful. Participants mentioned that those who did not have established contacts in Canada could rely on online information as a resource. Because the insights shared through these social media applications were based on other immigrants’ personal experiences, participants found that they could relate and have a sense of community based on their shared experiences.

4.10 Summary
This chapter provided an in-depth look into the experiences of cervical cancer screening among Asian immigrant women, as well as their experiences of healthcare services in the Canadian healthcare system. It is evident that numerous barriers and obstacles exist for this group when attempting to use health services in Canada. While a variety of challenges exist, participants were also active in circumventing obstacles that limited their health service use.

Although the sample is small, it bears value to highlight some notable factors that seemed to exacerbate challenges to health service use in Canada for participants in this study. The significance of time in Canada emerged an important factor that impacted participants’ experiences using health services. Recent immigrants themselves explained their troubles understanding a new healthcare system, and long-term participants recounted the difficulties they faced in their early years in Canada. Participants, especially long-term...
immigrants, were aware of the benefit of time, and several participants explained how difficulties eased over time, although some challenges do remain. Friends and family were key in mitigating the increased challenges recent immigrants faced when they first arrived in Canada.

Participants who had young children seemed to use services more frequently, however, most often for their children. Interestingly, when asked about their personal experiences in the healthcare system, participants often described the experiences of their children in the healthcare system. While participants with young children had increased interactions with the healthcare system, they seemed to have less time for personal health service use, and less of an expectation to utilize health services for themselves. Overall, the presence of children made regular health service use more difficult, mainly because of increased obligations and responsibilities, often resulting in lack of time.

In the next chapter, I will discuss both the sociological and policy implications of these findings. Limitations to this study and directions for future research will also be presented.
Chapter 5

5 Discussion

The aim of this study was to explore the preventative health behaviours of Asian immigrant women, as well as the challenges that they experience in the Canadian healthcare system. Overall, discussions with participants revealed common narratives surrounding their experiences accessing and utilizing healthcare services. In-depth interviews revealed factors associated with cervical cancer screening behaviours, as well as barriers and difficulties that affected engagement with health services in Canada.

The interviews conducted with participants sought to answer to the following questions: (1) What are the challenges that Asian immigrant women encounter when accessing resources in the Canadian healthcare system? (2) How does culture and other related challenges affect Asian immigrant’s women decision to participate in cervical cancer screening? (3) What are the strategies by which Asian immigrant women use to navigate these challenges to maintain health in Canada?

While the results of this study are not generalizable to the experiences of all Asian immigrant women living in Canada, they offer deeper insights into the some of the experiences of this population. I begin this chapter with an overview of the results discussed in the last chapter. I then discuss the implications of these findings within the context of the existing sociological literature, followed by the impact they may have on policy decisions. I conclude this section with an examination of the limitations of this study, and directions for future research.

5.1 Overview of Findings

Respondents discussed a common belief that health was a matter of importance for them in their lives. Many engaged in routines that fostered healthy living, although several participants mentioned the difficulty involved in engaging in these activities due to their responsibilities with children at home. Although maintaining health was an important
priority, for many the utilization of allopathic health services to achieve this goal was seen as a last resort option, only used for serious health issues and concerns that arose.

Participants spoke of the numerous challenges and barriers that they faced in the overall healthcare system which affected their utilization of health services. Relationships with healthcare providers were sometimes described as poor and visits to the doctor were often unsatisfactory, where health concerns were sometimes not addressed. Several participants also mentioned uncertainty regarding the proper norms and procedures when interacting with their doctor. Some of them did not entirely trust their doctors, or their advice. Language was described by most respondents as an extremely troublesome barrier when attempting to use health services. Communication was problematic for many respondents because of their varying levels of proficiency in English. Different cultural attitudes toward health also proved to be an important factor influencing participants’ health seeking behaviours. Participation in alternative health services, such as TCM, served as an important cultural component of their identity and reflected their distinct cultural attitudes towards health.

Adjusting to a new healthcare system was discussed as a major challenge for participants. Previous experiences in their home country, where they would be able to see their doctor immediately, left participants unhappy at the length of time it took for appointments to be made with their doctor in Canada. Detailing their experiences as immigrants, participants mentioned that very little information was provided to them upon arrival to Canada. Several participants who had immigrated many years ago mentioned that when they first arrived to Canada, there was less information available to them than there is offered now, although recent immigrants in this study still described difficulties in acquiring information.

Aside from information regarding acquiring health cards, almost no information was given regarding how to find a family doctor, or explanations as to how health services worked in Canada. New immigrants had difficulties finding a family doctor and this inability limited their access of health services. Recent immigrants were noted to be a distinct group that faced increased challenges, as those who arrived without contacts or
individuals close around them to offer support would lack important information needed to find and use health services.

These health system barriers also shaped decisions around cervical cancer screening. All respondents reported participating in cervical cancer screening within the past three years, but emphasized that challenges still exist when using this particular resource. These challenges included discomfort with the gender of the doctor performing the procedure, as well as lack of information about alternative locations to have the screening completed. Several individuals also noted that their family doctor did not inform them that the procedure was available. Participants also felt that immigrants without family doctors would not have access to screening.

The various difficulties experienced by participants prompted many to create strategies to better navigate and use healthcare services. Among these strategies included asking healthcare providers to speak slower, bringing friends to assist in translation, or using online sources to acquire additional information. The support of husbands, friends, and acquaintances were important in offering guidance and assistance.

5.2 Relation to Existing Literature

Although traditional, complementary, and alternative medicine users may be less likely to use mainstream cancer screening programs, immigrant groups are typically conscious of and active in maintaining their own health and well-being, including disease prevention (Gesink et al., 2014). Participants in this study demonstrated knowledge and understanding of their own health and well-being, and actively sought their own strategies for health maintenance.

Several factors encouraged their participation, mainly doctor recommendation and discussions with friends. Existing studies have also demonstrated the importance of physician recommendation in encouraging screening participation among patients (Crawford, Ahmad, Beaton, & Bierman, 2015; Madadi, Zhang, Yeary, & Henderson, 2014, Todd, Harvey, & Hoffman-Goetz, 2011). A specific study from Crawford, Ahmad, Beaton, & Bierman (2015) emphasized the need for physician recommendation, where
utilization of health resources was highlighted to be concentrated on physician support and their responsibility to provide information, explanation, and recommend screening.

Findings reveal that Asian immigrant women in this study had a strong preference for female providers to perform Pap tests. Existing literature points to the importance of female doctors for screening procedures, and studies document physician gender as a significant determinant of screening among Asian immigrant women (Donnelly, 2008; Hyman, Cameron, Singh, & Stewart, 2003). Primary care physicians can serve as both facilitators and barriers to cancer screening, particularly to under-screened groups such as immigrant patients (Lofters, Ng, & Lobb, 2015). Although patients should have the opportunity to find a family doctor they are comfortable with, experiences revealed from interviews demonstrate that even the task of finding any family doctor is difficult, let alone a family doctor with specific characteristics.

The literature has documented that Asian immigrant women in Canada have significantly lower participation rates in cervical cancer screening (Latif, 2010; Xiong, Murphy, Matthews, Gadag, & Wang, 2010; McDonald & Kennedy, 2007; Woltman & Newbold, 2007). However, all participants in this study reported to have participated in cervical cancer screening within the past 3 years. Participants in this study expressed that it is common for women to return to their home countries to utilize health services. Several participants mentioned they had their Pap tests done in Taiwan and reported going back to utilize health services regularly. This finding suggests that current rates of health service utilization may underestimate the actual rates of preventative health screenings among immigrant women. For example, numerous studies determine cervical cancer screening rates based on data from Ontario physician services or data from provincial healthcare registries (Borkhoff et al., 2013; Lofters, Moineddin, Hwang, Glazier, 2010; Lofters, Glazier, Agha, Creatore, & Moineddin, 2007). This study indicates that there are women who choose to seek services outside of Canada.

Transnational healthcare as a trend has been an emerging phenomenon. Transnational activities are known to be prevalent among immigrants, and on a global scale, transnational health service use is not an exception (Lee, Kearns, & Friesen, 2010;
Thomas, 2010; Messias, 2002). Research has documented that transnational activities can even have an ability to affect health status and it is important to incorporate transnational theory when investigating immigrant health experiences (Amoyaw & Abada, 2016). Although typically common among individuals to travel abroad to seek healthcare services that are more expensive in their resident countries such dental care (Calvasina, Muntaner, Quiñonez, 2015), studies have demonstrated that transnational health service use has also been a strategy employed by immigrants to address health problems in response to barriers that exist in their country of residence (Gideon, 2011). Generally, literature regarding the use of transnational health services abroad among immigrants Canada is sparse and limited.

Participants in this study expressed similar feelings to current existing studies, that using transnational healthcare was an appealing option for their needs as it was provided in a culturally familiar context. Some participants even pointed out that it was significantly easier and more convenient to use health services in their home country given that they travel there often. Given the limited literature surrounding this topic, future research and explorations into the prevalence of this phenomenon, as well as the experiences of these individuals who engage in these activities, would serve valuable in identifying the extent of this trend, including the possible implications that this phenomenon may have for health maintenance and well-being.

This study confirms that many of the factors in the existing literature that affect access and utilization of health services continue to be important and relevant for immigrants in Canada. For example, language and healthcare provider preferences are commonly highlighted in existing studies examining immigrant challenges in the healthcare system. While many of the issues discussed by participants are prevalent in the existing literature, this study contributes to the literature by identifying several additional issues that have rarely been examined in the literature. For example, findings revealed that transnational healthcare utilization for preventative health services was common among several women in this study. Furthermore, insights gathered through discussions with participants showed that tensions and cultural gaps existed between participants and their healthcare providers due to their use of alternative health services. This study also found that
participants turned to social media networks to acquire information about health resources in the healthcare system.

In comparison to many of the existing studies in the literature, this study is also contributive to the literature due to its inclusive examination of different factors affecting health service usage. Many studies tend to focus on single factors that do not capture how the combination of challenges can shape health experiences. From transportation, to language, to alternative health service use, this study investigated how the accumulation of these challenges affected individual experiences in the healthcare system.

5.3 Implications for Immigrant Integration

As mentioned previously, access to healthcare and utilization of healthcare services can be a critical element for enabling the integration of immigrants in Canada. There are currently not enough studies that examine the importance of healthcare access and use in the process of immigrant integration.

Specific to this study, while all participants expressed support for preventative screenings, many participants reported that they relied on doctors to recommend the procedure to them. Several participants expressed uneasiness at asking for requests from their family practitioner, unsure of whether or not requests were appropriate. Failure to communicate openly with doctors may leave health concerns unaddressed, preventing opportunities for productive health visits with healthcare practitioners. The participants in this study felt like they were not entitled to ask for resources, or that they had no authority to offer suggestions. As a result of this perceived power imbalance, many withdrew and did not consult Western medical doctors. Thus, even when immigrants have access to physicians, they may not utilize their services, because they do not feel comfortable. Furthermore, communication was a prominent problem that emerged in interviews: finding words to describe health issues, as well as understanding medical terminology was particularly challenging. This in turn, limits immigrants’ ability to participate fully in the healthcare system.
The results presented in this thesis establish that acquiring health information is difficult for this group. Although participants reported that information was available on websites or through immigration centres, the information provided was not pertinent or practical enough to truly help participants navigate the system. For example, information on how to acquire a health card was well-known, but more nuanced information such as how to properly use services, the workings of the Canadian health system, or the appropriate expectations one should have with a family doctor, was sorely lacking and made the process of navigating a new healthcare system much more difficult. This has implications for integration. Participants found it hard to gain knowledge about their country and how the healthcare system works, which is an integral component to Canadian life. Most of the important information that participants needed about the healthcare system in Canada was gained through friends and family. Countless stories were shared about how friends and family guided them in their search for health services and information. For individuals with no established contacts, integration becomes much more difficult as they face increased difficulties to become familiar with the healthcare system.

The various difficulties experienced by participants prompted many to create strategies to better navigate and use healthcare services. In attempts to bridge the communication barrier between their healthcare provider and themselves, participants mentioned that they would ask healthcare providers to speak slower or explain more when they did not understand. Other efforts to address this issue were to write down words that respondents did not understand and look them up at when they got home. Various respondents also stated that they used interpretation services at hospitals and some revealed that they would occasionally bring their friends along for translation. These experiences demonstrated that participants were active in the negotiation of health resources and vigorously worked around the obstacles they encountered in order to acquire the health services they needed. However, this is a lot of work. If obtaining the full benefits of healthcare requires all these additional measures, it then becomes very difficult for immigrants to fully gain the advantages that the healthcare system has to offer.
In light of these experiences, perhaps integration not only means being able to acquire and fully use resources within the healthcare system, but integration for this group should also be seen in terms of ability to use culturally sensitive services, without loss of opportunity for preventative screening. As revealed in this study, while immigrants used alternative health services in response to structural challenges in the healthcare system, others also used these alternative health services as a result of their distinct cultural preferences and attitudes toward health. Preferences for culturally sensitive services should not lead to missed opportunities for screenings. However, given the current structure of the healthcare system, this seems to be a very possible and real reality for immigrants, which has consequences for health disparities to be perpetuated. Good integration should allow for differences without leading to health inequalities, and steps need to be taken to recognize the unique needs of immigrants, including the diversities that exist among immigrants in their health service use.

5.4 Policy Recommendations

Most policies aimed at addressing health maintenance and health service delivery target the general population and may not consider the differences that exist in subgroups. Measures to carry out policy objectives and goals may fail to address the specific needs of immigrants, rendering programs and initiatives less effective for this particular population.

As revealed by participants in interviews, Asian immigrant women face a myriad of challenges, some of which have been attempted to be addressed by programs and initiatives. However, discussions with participants demonstrate the failures and inadequacies of some of these programs. Participants in this study mentioned receiving letters that informed them about opportunities for cervical cancer screening. Cancer Care Ontario, an organization that acts as the Ontario government’s advisor on disease prevention, screening, and access to care services sends invitation and reminder letters to eligible women regarding cervical cancer screening. These letters are sent with the goal of encouraging Ontarians to speak to their healthcare provider about their screening options, as well as support healthcare providers in their efforts to increase screening rates (Cancer Care Ontario, 2017).
As made evident in discussions with participants, many did not find the letters they received to be particularly useful in encouraging them to contact their doctor for cervical cancer screening. Participants in this study explained that those with English as a second language experience literacy and communications barriers. Letters that remind or inform women about cervical cancer screening may be effective for the general population who are fluent in the English language. However, as letters are in English, this particular initiative is typically less useful for individuals with limited English language proficiency. This study suggests that letters might be useful as an informative measure, but further considerations are necessary to develop programs that effectively encourage screening participation among immigrant groups.

Discussions with participants established that obtaining useful health information was difficult. This study revealed that participants used online technologies to aid their search for health information. Social media was commonly used to acquire health information. Participants joined online groups to ask questions about health topics that mattered to them, for example, asking members in the online group where they could find a doctor that speaks their language. These informal sources of information allowed them to form solidarity with others who also experienced challenges, and these methods served as an extremely useful tool for guidance. However, the use of web resources may not provide particularly reliable or accurate information. When creating efforts to improve online information distributed to immigrants, the technologies used by practitioners should be in a medium which people will access. In this case, participants had preference for social media outlets. Practitioners should consider offering more online resources in this format in order to more likely access and reach this population. These resources should also be available in multiple languages whenever possible.

Furthermore, knowledge made clear and simple, as well as practical, is needed for this particular population. This includes logistical information, such as how to make an appointment, and cultural understanding, such as appropriate expectations of the Canadian health system. This type of information would be informative for immigrants, especially new immigrants, and help to mitigate dissatisfaction with health services. Tips and guidelines regarding how to navigate the healthcare system will go a long way in
assisting immigrants to feel more confident and comfortable in reaching out and acquiring the services they need. If individuals have specific knowledge as to what they need to do, and how they should go about doing it, there is a higher likelihood they will be able carry out the proper procedures needed to use health resources. Also, attempts should be made whenever possible to provide resources in languages that are accessible to this group.

There was also much consensus about preferences for female practitioners among participants in this study. Given that it is not logistically feasible for immigrant women who have a preference for female practitioners to always acquire one, existing family doctors should be aware that attitudes surrounding modesty and comfortability may be important considerations among immigrant women. Increased training of cultural awareness would be useful in attuning healthcare practitioners to the different needs of various groups in society. Family doctors should also be routinely making clear that alternatives for screening are available if individuals are uncomfortable, even if it is not evident that discomfort exists.

The provision of interpretation services in hospitals was highlighted as beneficial and used by numerous participants. However, language barriers were pervasive in the healthcare system, not just at the point of care. One participant mentioned although translators would be helpful, the act of making an appointment would still be difficult because receptionists also speak English. In interactions with a regular family doctor, which is typically the most frequent interaction any individual has when using health services, interpretation services are not available. Numerous participants acknowledged that this service would be advantageous if implemented, but participants were also aware of the lack of feasibility. The implementation of additional interpretive services for family practitioner appointments may perhaps be a useful initiative to consider.

Collaboration among various stakeholders in the community and in the healthcare sector will be important when addressing issues facing immigrant women. There may be resources available at the community level with various immigrant local associations and organizations that may be able to coordinate efforts with healthcare providers to offer services for those who use health services less as a result of language difficulties.
Since recommendation from doctors was key in encouraging participants to participate in cervical cancer screening, cultural preferences for TCM can have strong implications for regular health service use, which can influence regular participation in preventative screenings and tests. Regularly utilizing alternative health services limits opportunities for knowledge to be gained about preventative health screenings, as well as regular interactions with family doctors who encourage participation in such procedures. Physician support, including frequent contact with the healthcare system, increases opportunities for healthcare providers to educate and inform women about the benefits of screening (Vahabi, Lofters, Kumar, & Glazier, 2015). Participants in this study had preferences for alternative health services and some women even mentioned that they used these services much more regularly and frequently than Western health services. For women who prefer TCM, doctor recommendation as a strategy to facilitate participation in cervical cancer screening may not be as effective.

The importance of TCM practitioners to Asian immigrant women points to several important implications for preventative health screening. Policies regarding health service delivery should consider greater collaboration between practitioners in alternative healthcare services and mainstream healthcare services. This increased coordination may prove useful and advantageous to better inform and encourage women to participate in preventative health screening procedures. Recognizing that TCM practitioners also play a role in promoting the health and well-being of their patients, it seems likely that preventative health strategies would be well-endorsed. Initiating greater understanding and engagement between these two different sectors can promote efforts to better foster immigrant women’s health and well-being in Canada.

5.5 Limitations and Future Research

The goal of this thesis was to provide an in-depth examination and exploration of the lived experiences of Asian immigrant women in the healthcare system, including the specific challenges and difficulties they faced when utilizing preventative health services. It was therefore important to have a small and purposively selective sample, driven by the existing literature and the objectives of my research questions. This methodological
decision allowed me to focus on data collection and analysis that would be feasible within the confines of a MA thesis study, but it created various limitations.

Most evidently, a small, purposive sample limits the study’s generalizability. It also limits the study’s ability to investigate the role of ethnicity. Given the difficulty in recruitment, this study was dependent on whoever was interested and wished to participate. Although this study targeted the overarching Asian ethnicity, various subgroups exist within that population. Different cultures and specific ethnic backgrounds of women were not able to be captured in this thesis and the effects of culture could differ among sub-Asian groups. Therefore, to fully capture the specific nuances within each ethnic group, future studies may decide to target more specific ethnic subgroups to investigate any nuances that may exist among these various populations.

Several other limitations are also evident within this sample. The participants in this sample all had relatively high levels of education. Although participants in this group all described barriers to healthcare and preventative screening, perhaps barriers among participants with lower levels of educational attainment are more potent. The experiences of individuals with lower levels of education were not captured in this study. Furthermore, the participants in this sample had all participated in cervical cancer screening. Although barriers still existed for this group, participants in this study were able to, through one way or another, participate in these screenings. This study was not able to explore the experiences of individuals who had not participated in screenings, which might have been able to reveal interesting insights as to when the barriers that have been identified in this study actually prevent the utilization of such services. Lastly, this study focused largely on the experiences of immigrant women with children. The selection of this specific group was to investigate the experiences of Asian immigrant women within a particular life stage, which also ensured that any challenges or barriers identified would more likely be informed by similar shared life experiences. However, due to the age and cohort of this sample, this is a select group of women with specific life experiences which again, limits very much the ability of this study to generalize their experiences to all Asian immigrant women.
Future research should also consider focusing on an important insight revealed in this study. Several participants mentioned that they travel abroad for healthcare services as a regular routine. The importance of transnationalism in the experience of immigrant healthcare is relevant and important given the well-documented transnational ties and histories of immigrant experiences. When seeking to examine the healthcare utilization of immigrant populations, this consideration can expose important information regarding the extent to which immigrants are utilizing the full capacity of the healthcare system in Canada, which may be useful for future directions in monitoring of the health of immigrants, as well as the performance of the health system.

Future studies regarding technological support networks will also be valuable as technology use becomes more widespread by individuals in society. Exploring the implications of the social media as a tool for providing health information to groups and its effectiveness may be an important exploration for programs or initiatives targeted in aiding immigrants navigate the health system.

Geographic location will also be an important consideration for future research. A number of participants in this study mentioned the differences in the availability and accessibility of health resources between the southwestern Ontario city they lived in and Toronto. As health services are regional to the area they serve, larger metropolitan cities such as Toronto offer a much more diverse range of services that immigrants may find ease their ability to acquire the services they need. It would be an interesting exploration for future studies to examine the differences that may be experienced by the immigrants who live in those areas.

5.6 Conclusion

Access to healthcare is a major right for individuals who live in Canada, and it is problematic if immigrants do not feel that they are being provided adequate opportunities to use health resources. An inability to fully utilize resources in the healthcare sphere affects one’s ability to fully integrate in Canadian society.
The stories and narratives shared by all participants demonstrate that the intersections of immigrant status, ethnicity, and gender combined together to influence their understandings and experiences of health, including barriers that affected their utilization of health services. The culmination of these characteristics created inequalities in health resource use. While participants acknowledged the importance of their distinct perspectives on health as a result of their culture and immigrant histories, they recognized that it was these differences that contributed to increased difficulties in the Canadian healthcare system. The healthcare system needs to be more aware of immigrant populations in Canada, which may require different considerations in the future delivery of health services.

The findings drawn from this study can help health service providers and policy makers to gain a greater understanding of the lived experiences of this population, guiding them in future efforts to ease their challenges and improve their ability to effectively acquire and utilize the health services they need. Efforts made to ameliorate the difficulties experienced by this population will contribute to the integration of immigrants in Canadian society, consequently also fostering immigrant women’s health and well-being in Canada.
References


providers’ experiences in meeting Somali women living in Finland. *Journal of Immigrant and Minority Health, 14*(2), 330-343. doi:10.1007/s10903-011-9465-6


Appendices

Appendix A: Ethics Approval Form

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The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the NMREB Initial Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Human (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB #D002914.
Appendix B: Interview Guide

Thesis project: Accessing Healthcare: Influences on Utilization Among Asian Immigrant Women

Dr. Tracey L Adams (PhD) & Gwynne Ng (BA)

Part 1: General attitudes/Approaches to health

1. Tell me about your health in general.
   • What are some things that you do to maintain good health (stay healthy)?
2. How important is health in your life?
   • Is staying healthy important to you?
3. How often do you go to the doctor?
   • When do you go to see the doctor? (Ex: When an illness arises, when you have questions, checkups, screenings, etc.)
   • What kind of healthcare providers do you see? (Ex: Medical doctors, nurse practitioners, TCM practitioners, acupuncturists, naturopaths, others)
4. Where do you get information about health/health services?
5. How do you make decisions regarding health?
   • Do you rely on yourself? Family members? Professionals?
6. What do you do when you have illness or disease?

Part 2: Healthcare experiences

1. Have you experienced any challenges or difficulties in the healthcare system?
   • Examples?
2. Have you had any difficulties in accessing health services?
   • Examples?
3. Do you have any difficulties when communicating with a healthcare provider?
   • Examples?
4. Are you comfortable with your healthcare provider?
   • Why or why not?
5. Have you been able to get the health information/services that you need?

Part 3: Preventative healthcare

1. Have you ever used any type of preventative healthcare/service?
   • Which types?
2. Have you ever heard of cervical cancer screening (also known as a Pap test)?
   • If yes, what do you know about cervical cancer screening?
3. Is participating in this screening of any benefit to you?
   • Why or why not?
4. Are there any negative consequences from participating?
5. Have you ever participated in cervical cancer screening?
   - If no, are there any particular reasons why?
   - If yes, when was the last time?
     - How did you hear about cervical cancer screening?
     - Did you experience any difficulties accessing the screening?
     - Were there any difficulties during the procedure?
     - Did anyone influence your decision to participate in cervical cancer screening?
     - Do you see yourself getting a screening in the future?
     - Do any of your cultural beliefs or values support or oppose cervical cancer screening/getting a pap smear?

Part 4: Culture

1. Do you feel that your doctor shares/respects your cultural values?
   - Why or why not?
2. Do you think other healthcare providers take your cultural beliefs into consideration?
   - Why or why not?
3. Are your experiences different in Canada, compared to your home country?
   - How so?
   - How do you feel about that?
   - Does Canadian healthcare conflict with your cultural values? If so, how?
4. Have your notions/ideas about health changed since you arrived in Canada?
   - How so?
5. Are there any cultural values or beliefs about being a woman that is related to health?
   - Women’s bodies and health, etc.

Part 5: Opinions/Perceptions

1. Do you have any suggestions on how to improve the health services that you receive?
   - What do you think could be improved?
2. Do you have any suggestions for the healthcare system overall in Canada?
   - What do you think could be improved?
3. What are some things that the healthcare system is doing right?
4. Do you think immigrants are provided the support they need to access health services?
   - Why or why not?
5. Do you have anything else you would like to add or ask me?
Curriculum Vitae
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Master of Arts, Sociology
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CONFERENCE PRESENTATIONS
