Understanding the Health Care Needs of Canadian Immigrants

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01 Abstract

The purpose of this study was to better understand the health needs of new Canadians. The research was conducted in two phases: firstly, we examined the health needs and coping strategies of Edmonton Chilean, Chinese and Somali migrants; secondly, we elicited the perspectives of health professionals and decision-makers. Our methodology was qualitative and consisted of in-depth interviews; however, we used both qualitative and quantitative modes of data analysis.

Both groups of respondents embraced a holistic definition of health which included mental, economic, social and spiritual well-being. In essence, health status was linked with immigrant or refugee status and the attendent economic, cultural and social isolation. The experience of immigration manifested in the experience of stress which placed demands on individual and communal coping strategies, and which has important health implications.

Enhancing the health of newcomers may best be effected by the provision of support for coping resources—material, economic and social. Our results suggest that we must build on the strengths of newcomers and ethnocultural communities through the use of: cultural brokers; traditional healers and foreign-trained professionals; the involvement of ethnocultural communities in the development of health programs and resources; ethno-specific services; and enhanced cross-cultural understanding that can be facilitated by promoting student placements in culturally-diverse settings.

02 Executive Summary

The Purpose of the Study

The purpose of this study was to better understand the health needs of new Canadians with a view to making both theoretical and practical contributions to the area of immigration and health.

Methodology & Analysis

Immigrants and refugees from three Edmonton-area communities, Chilean (N=11), Chinese (N=11), and Somali (N=10) were interviewed using a semi-structured interview guide. The in-depth interviews focused on their immigration experience, the process of settlement in Canada, perceptions of health, use of health resources, social support, major challenges, coping strategies and recommendations for improvement of the health care system. In the second phase of the study, health professionals and decision-makers (N=12) were interviewed regarding their perspectives on immigrant and refugee health.

Data was analyzed both qualitatively, using QSR NUD*IST to assist in theme and content analysis, and quantitatively, utilizing the statistical software package, SPSS, to test hypotheses emerging from the qualitative information.

Findings & Recommendations

From an ecological perspective, health may be regarded as a measure of adaptation to one's environment. It is, as our respondents assert, more than the absence of disease, but encompasses mental, economic, social and spiritual well-being. The respondents generally agreed that the health of newcomers could be improved by:

01 encouraging greater cultural sensitivity in health care;

2. increasing the availability of cultural interpretation services and multi-lingual information;
3. advertising the presence of health and social services in countries of origin;
4. training more front-line workers from ethnic communities;
5. establishing community health centres with biomedical, alternative and traditional practitioners;
6. including alternative and traditional medical treatments, dental services and pharmaceuticals under the provincial health care insurance plan;

7. and making better use of foreign-trained professionals.

Our results confirm that the experience of uprooting and resettling manifests in the experience of stress which is the culmination of individual, socioeconomic and demographic variables, and the incongruence between expectations and the reality of life in Canada. Stress is known to have health implications; however, determining causal links between stress, coping strategies and health is beyond the realm of this investigation. We did discover that the greatest stress is experienced by younger migrants who have been in Canada the shortest length of time, who have large families and who rent their accommodation. Integration in Canadian society, however, may also have ill-effects; migrants who participate less in their own ethnic communities than in the larger society also experience considerable stress. The confrontation with structural, linguistic and cultural barriers and the process of finding suitable coping mechanisms are integral to a newcomer's integration in Canadian society and their health status. It is in this arena, the sustenance of well-being, that we must direct our efforts to best understand the health needs of Canadian immigrants.

These strategies can include:

1. enhanced dissemination of information;
2. increased involvement of ethnocultural communities in the health care system;
3. the establishment of culturally-appropriate services;
4. and increased collaboration between biomedical, alternative and traditional practitioners.

03 Introduction

In 1968, Canada opened its doors to an increasing number of immigrants from non-European sources. Presently, two thirds of Canada's newcomers are born in regions out of Europe, over 45% of whom are from the Asia Pacific region (Simmons 1990; CIC 1998). This so-called "new-wave" of immigration has brought new challenges to immigration, settlement and health services that continue to be addressed by community-based, individual and government resources.

Changes in immigrant and refugee profiles have necessitated a re-thinking of integration and assimilation theories. Assimilation theory proposes that all ethnic members of society will eventually adopt the values of the dominant culture; however, resistance to assimilation has been vastly underestimated. In reality, adaptation and changes in ethnic identity are quite complex (Drieger and Chappell 1987). Baker (1993) suggests that the primary factors which adversely affect an immigrant's response to immigration are a history of psychological problems, a large cultural gap between the home and host countries, and a change in socio-economic status. In contrast, knowledge of the language, preparation for immigration and a large existing community, all assist in reducing the impact of immigration on the individual.

Scott and Scott (1989) maintain that any analysis of adaptation to immigration must take into consideration gender, cultural and class variables as well as personal characteristics of the individual. These variables may include the presence or absence of environmental stressors, the individual's background, familial relations, cultural skills, personality, and reaction to the host country. They emphasize that adaptation is not a one-way process; people also have an impact upon their social environment. Moreover, migration can also be both stress-reducing and stress-inducing as immigrants may be leaving an undesirable situation, yet are confronted in their host country with a host of unknowns and a possible reduction in status. From their studies, they concluded that: "There is no single index of 'adaptation' that can be sensibly applied to all immigrants; instead, the level of adaptation achieved depends on the particular focus or domain of life events with which one is concerned" (Scott and Scott 1989:168).

Social support or ethnic affiliation has been credited with providing a buffer for individuals faced with a hostile host world where they may encounter racism or feel

otherwise marginalized. For instance, incidence of mental illness among refugees following World War II appeared to be mediated by the size of the receiving community. Ethnic organizations and institutions are believed to reduce the stress individuals face from contact with the dominant society as well as helping to maintain traditions (Nann and To 1982). In addition to formal organizations, each group has its own way of forming personal support systems which may differ in intensity, duration of ties, breadth of the network and frequency of encounters. These support system, however, are not necessarily what they appear. Some research has shown that intense social ties may contribute to an immigrant's feeling of distress—especially for women; and in North America, elderly Chinese have some of the smallest kinship support systems of any ethnic group in contrast to the cultural ideal (Sokolovsky 1990).

Immigrants also face economic challenges. In Canada by 1986, 85% of visible minority women were born abroad; these women are less likely to work full-time or even be in the labour force in comparison to their male counterparts (Boyd 1992). Foreign born women who do not speak an official language are more inclined to work longer hours for less pay than any other labour group (Boyd 1990). Immigrant women between the ages of 45-65 are less educated than Canadian born women despite the fact that before 1980, immigrants had more university education than Canadian born. Although immigrants tend to have more full-time work and are better educated than Canadian born, immigrants who arrived in the 1970s still have lower than average incomes (Beaujot and Rappak 1990). Immigrant women are more likely to be employed in the service occupations and food processing. As a group, they occupy a large percentage of the lowest paid positions in private domestic service, janitorial work, manufacturing and service industries (Basavarajappa and Verma 1990; Ng and Ramierez 1981).

While immigrants tend to report better health status than the average Canadian, this benefit appears to dissipate with integration into Canadian society (Chen, et al., 1996). In coping with a new country, immigrants must also confront a new health care system organized around the principles of biomedicine. Bhayana (1991) uses the term *healthshock* to describe the response to the interaction between biomedical beliefs and the

immigrant's indigenous health belief system. In such an encounter, both the practitioner and the patient may be affected.

Biomedicine is based upon the Cartesian dichotomy between the mind and body; the self is an isolated unit which can be treated in isolation (Rhodes 1990). The body is viewed as a machine—the physician is the repair person. The practitioner is required to maintain emotional distance in order to diagnose the disease as opposed to treating the person (Kirmayer 1988). This approach contrasts sharply many indigenous belief systems.

Moreover, in order to investigate the impact of immigration on health, a study must also account for the effect of global relations upon the individual. This includes learning about immigrants' motives for leaving their home country as well as the influence of political-economic processes upon their economic and social well-being in their host country. Many newcomers have experienced downward mobility due to lack of recognition of their credentials or lack of Canadian work experience. As a result, they may find themselves in low paying jobs under poor working conditions which adversely affect their health and leave them with limited choices to cope with the deleterious health conditions (Anderson 1991). Furthermore, social class has an enormous impact upon disease status and mortality rates regardless of ethnic identity (Graham and Reeder 1979; Syme and Berkman 1976) and behavioural risk factors (Marmot, Kogevinas and Elston 1987). According to recent studies, lack of control in the workplace and unemployment also increase health problems (Globe and Mail 1993); a situation many recent immigrants may find themselves in.

04 Purpose of the Study

The purpose of this study was to better understand the health needs of new Canadians with a view to making both theoretical and practical contributions to the area of immigration and health.

This study was conducted in two phases. First, we examined the adaptive strategies of three immigrant and refugee groups in Edmonton to ascertain how these strategies affected their health. Specifically, the study elicited information about the migration

experience, definitions of health, the barriers newcomers face in accessing health services and their recommendations for policies and programs that would help enhance the health status of migrant communities and individuals. In the second phase of the study, interviews were conducted with policy-makers, health professionals and settlement service providers to obtain their perspectives on the needs of Edmonton-area immigrants and refugees.

Research results include an integrated set of recommendations, based on informant and researcher observations, directed to health, immigration and settlement service personnel and an emerging model that focuses on the relationship between migration, stress, coping and health status.

05 Methodology and Data Analysis

In keeping with mainstream anthropological principles, much of the research was qualitative in nature, utilizing participant observation and taped ethnographic interviews. Three communities, Chilean, Chinese and Somali were selected for study. As befits community-based research, the researchers had established professional and personal relationships with members of these communities, which facilitated access to respondents. The selected groups differ in length of establishment in the Edmonton area, ethno-specific infrastructure, reasons for migration and demographic profile. The Somali community is comprised of refugees; the Chinese community primarily of immigrants and the Chilean community of individuals who arrived under both categories.

5.1 Advisory Community

An advisory committee was struck to provide on-going input into the direction of the research project and dissemination of information. The committee included members of immigrant and refugee-serving agencies, health institutions and community organizations. The advisory committee's comments on issues regarding relevant questions, the definitions of an immigrant, finding ways of "giving back" to

research participants, the format and dissemination of research findings, among others, were essential. In addition, they aided tremendously in the recruitment of informants and helped us provide information to participants in our efforts to keep them apprised of research progress.

5.2 Sampling

The committee's initial task compelled us to examine our criteria for selecting informants for this study. When does someone cease being a "new" Canadian? Five years, ten years, twenty years after migration? Our question was confounded by our choice of communities, whose major periods of resettlement took place in the mid 1970s (Chilean), mid 1980s (Chinese) and 1990s (Somali). Our discussions led to conclude that all of us manipulate a variety of identities, of which foreign-born—immigrant or refugee—may be one. Moreover, even as long-term immigrants may feel "at home" in Canadian society, the behaviour of others towards foreign-born individuals, especially members of visible minorities, intercedes, leaving the most acculturated of us to feel alien. We, therefore, decided to include as immigrants and refugees in our sample migrants who arrived during each community's major wave of immigration.

5.2.1. *Community Profile and Selection Criteria*

We began by developing a profile of each of the three Edmonton area communities. Community leaders were consulted, as was census information, historical literature and any currently available studies. The profile provided an overview of the particular community and allowed us to consider which demographic attributes might be most common. From here, we developed our sampling frame. Importantly, we were not seeking to recruit or reinforce any notion of a modal Chilean, Chinese or Somali migrant, but were hoping to include in our sample the most well-represented groups. This purposeful sampling was guided by the criteria listed in Table 1.

5.2.2. *Recruitment Strategies*

Participants were recruited with the aid of members of the advisory committee and included network sampling, recruitment presentations at English as a Second-Language classes and settlement agencies and through the ethnic media.

5.2.3. *Interviews and Interaction with Participants*

The interview guide (Appendix 1), designed with input from the advisory committee, was finalized following several pilot interviews. Qualitative research focuses on rich, descriptive and reflective data elicited from a limited number of informants. This study included interviews with 34 community members (11 Chinese, 13 Chilean and 10 Somali migrants) and 12 professional staff.

Participants were provided with a description of the project and an explanation of consent prior to the onset of the interview (Appendix 2). Consent (Appendix 3) was obtained via writing or tape recording. Interviews were conducted in the setting and language of the participant's choice. Ms. Florence Pang, our primary research assistant, is fluent in Cantonese and Mandarin, and was aided by a fluently bilingual interpreter with social science training for the Somali interviews. The Chilean interviewees chose to be interviewed in English as were all of the health professional interviews. Demographic and personal information was collected at the end of each interview (Appendix 4). Tapes of the interviews were transcribed verbatim.

Project coordinators maintained contact with participants over the course of the project through several project update flyers. In addition to providing information about the progress of the research and to thank them for their participation, information about various programs offered by settlement agencies including names and contact numbers were included in each mail-out.

5.3 Analysis

5.3.1. *Qualitative*

Demographic information was collated and interview data was subject to both theme and content analysis aided by the qualitative data research software QSR NUD*IST. Both investigators analyzed interviews separately to ensure reliability of results. Results were discussed with research assistants to reinforce validity of our findings.

Table 1: Sampling Criteria

Criteria	Hong Kong Chinese		Somali		Chilean	
Education	some college education		elementary and some high school		some college education	
Sex	males 5	females 5	males 4	females 6	males 5	females 5

Employment: Homemaker	0	2	0	3	0	1
Professions	2	1	0	0	2	2
Small Business	2	1	0	0	0	0
Investor	1	1	0	0	0	0
Student	0	0	1	1	0	0
Clerical	0	0	0	1	0	0
Trades	0	0	3	0	3	2
Length of Time in Canada	10 years; since 1989		10 years; since 1990		20+ years; 1973-79	
Age of Immigration	30-45		20-70		20-35	
Support Groups	churches, friends, relatives		Somali women's group, mosque, settlement agencies		friends, relatives, churches, political and cultural organizations	
Family and living arrangements	extended families, own homes within the first five years		families may be extended, often diasporic, rental		nuclear families, own homes, co-op housing	
Reasons for immigration	political uncertainty, desire for stability		refugees fleeing civil war		refugees, political persecution	

5.3.2. *Quantitative*

Interview information was also analyzed using the program SPSS. Interviews were coded for variables relating to living conditions, coping strategies and health derived from the qualitative data. This technique aided the development of our stress model (discussed in concluding pages) which was grounded in the interview data and readily confirmed in the participants' narratives. This approach allows for further addition of data and more specific hypothesis testing.

5.3.3. *Combining Analytical Strategies*

In our experience, qualitative research provides an intriguing glimpse into the lived experience of one's informants; however, generalizability of qualitative findings has often been cited as a weakness of this strategy. Conversely, quantitative methods have been criticized as reductionist and for imposing unwarranted categories and priorities. While the dialogue between adherents of both methods must continue, we have chosen to experiment with combining both strategies. Triangulation of these methods may provide the strongest effect where the quantitative measures are grounded in and reflective of, the qualitative data. Furthermore, this approach may provide policy-makers with more readily useable information upon which appropriate decision-making can be based.

06 Findings

6.1 Chilean Community

6.1.1. Community Profile

On September 11, 1973, a military coup directed by General Augusto Pinochet overthrew the democratically-elected government of Dr. Salvador Allende. Ensuing measures taken to solidify power and exert social control included the incarceration, torture and murder of thousands of political opponents whose ranks included union leaders, professionals, students, government bureaucrats and professionals. Thousands of Chileans were driven into exile; however, the precise number has been difficult to measure as they include those who left under United Nations auspices, other official programs and some who left independently. The highest estimate produced by the Catholic migration organization in Chile (INCAMI) is one million people, an estimate that includes those who left for both political and economic reasons following the coup (Kay 1987).

Encouraged by church, labour and human rights organizations, Canada opened its doors to thousands of victims of the Pinochet regime (Sagaris 1996). Unlike voluntary immigrants, therefore, the Chileans came to Canada as exiles who had little control over the selection of the country of destination. For Canada, the Chileans were also the first group of migrants who were suffering the effects of direct and indirect torture. Many Chileans, especially, the political refugees, were reluctant to leave Chile, but were relieved by the ability to continue the political struggle abroad by participating in international solidarity campaigns.

The Chilean exiles, largely from the middle class, were escaping physical persecution as well as occupational, political and personal repression. They had wider horizons, more information and contacts abroad and also had access to channels such as the World University Services Scholarship Program which was unavailable to the working class (Kay 1987). Many Chilean exiles regarded their time abroad as transient and settled in Canada with the intention to return.

The 1991 census indicated there are approximately 3,890 Chileans in Alberta. 30% of the population has arrived in the past 24 years. Edmonton is home to over 1,500 Chileans; however, an accurate number is obscured by the inclusion of Chileans under

the rubric of Spanish speakers who comprise 16% of the total population of Edmonton (Statistics Canada 1992). Chileans in Edmonton have organized, with other Central and South American immigrants, social service agencies, businesses, social organizations, a newspaper and several housing co-operatives.

Cohesion and solidarity characterized the Chilean community from its inception. Settlement was eased by mutual aid provided by those who had already arrived. Community and political associations were formed for solidarity campaigns and to fundraise in support of political struggles in their homeland. Following the 1988 plebiscite in Chile that saw Pinochet step away from the government to allow for an elected body, the political agenda became increasingly fractious. Political activities have given way to a focus on Chilean culture and maintaining the Spanish language.

Since 1990, many Chileans have been weighing the decision to return to their homeland. Some are first generation Chilean immigrants who are choosing to go back to live or second generation Chilean-Canadians who were educated in Canada and, equipped with both Spanish and English languages, are choosing to explore employment opportunities in Chile. For others, their desire to return is countered by their children's wishes to remain in Canada. For those who choose to remain, issues arise about aging in the Northern Hemisphere. Many who immigrated to Canada in the 1970s are middle-aged; some have sponsored aging parents under the family reunification program. They wonder whether there will be sufficient support programs within the community to meet the needs of their changing responsibilities.

6.1.2. Informant Sample

Table 2: Profile of Chilean Participants (N=11)

Year of Immigration		**Marital Status**	
1973-75	7	Married	8
1976-79	4	Divorced	3
Age		**# of Children**	
48-53	6	0	1
54-59	3	1-3	6
60-61	2	4-5	4
Occupation in Chile		**Occupation in Canada**	
professional	6	professional	5
clerical	2	clerical	1

trades	3	trades	4
student	0	student	1
Education		**Religion**	
elementary	1	Catholic	6
high school	1	Mormon	2
college / university	9	None	3

6.1.3. Results of Theme and Content Analysis

6.1.3.1. Life in Canada

All eleven of the Chilean informants have resided in Canada for over 20 years. Regardless of their status as either immigrants or refugees, political repression or persecution provided the most important impetus to leave their homeland. All migrated to Canada when they were young and married. Most were from middle-class backgrounds and have some post-secondary education.

Settling in the Edmonton area was aided by a cohesive and activist community that was bound in their opposition to the regime that had displaced the elected government of Chile. Still, linguistic barriers, cold weather, difference in lifestyle and lack of recognition of educational and professional credentials proved to be major challenges. In comparison to the other groups, the Chileans experienced the most dramatic decline in their status of living. While some have reclaimed some of that status, others have not had the opportunity to re-train in Canada and are still trapped in jobs that are not commensurate with their skills or credentials. Maintaining their cultural identity is important and although all speak English, most prefer to speak Spanish at home.

Chilean participants reported enjoying good relations with neighbours and co-workers; however, supportive relations provided by close friends and relatives are lacking. Currently, few acknowledged being the recipients of racist or discriminatory treatment; however, most respondents refrain from participating in larger community activities or decision-making. Interaction with other Chileans is often limited to close friends, religious activities and occasional cultural events.

6.1.3.2. Creating and sustaining health and well-being

Informants were in agreement with regards to definitions of, and strategies to sustain, health. Individuals were deemed responsible for self-care, although in some families, wives were commended for their role in maintaining the well-being of the entire household. Proper nutrition, moderation in alcohol and food intake, sufficient sleep and exercise were all seen as ways of creating good health. Mental health, however, was regarded as more significant than physical health in contributing to well-being. A positive attitude, self-knowledge, love, good human relations and peace of mind were essential.

Self-care then included taking action to reduce stress, such as turning to books, music, walks and friends for solace, budgeting effectively to reduce financial worries, taking vitamin supplements and regular exercise. While confidence in biomedicine remained high and the Canadian health care system was deemed praiseworthy, some respondents utilized alternative and traditional practices such as acupuncture, reiki and physiotherapy.

6.1.3.3. Barriers to health and well-being

While approximately half of the respondents felt that their health status improved in Canada due to relative lack of pollution, slightly more felt that their health status declined. This decline in health status was attributed to effects of torture and/or the physical and social environment. Financial stress, family problems, poor living conditions and dressing inappropriately for the weather were seen as important factors in contributing to poor health. The lack of light in the winter and the ensuing physical isolation wrought by the cold were also cited as barriers to health as it prevented both outdoor activities and much needed social interaction.

Complaints about the health care system echo those heard from the general public. The implementation of user fees, the high costs of medication, charges for accessories such as casts, increased waiting periods in emergency and abbreviated visits with family physicians were deemed unacceptable and representative of a deterioration of the health care system. Biomedical practitioners were criticized for being too narrowly trained, lacking an emphasis on preventative health and tending to over-prescribe medicine. Some who felt they would be better served by holistic practices were dismayed that such practices were not included under the Alberta Health Care Insurance Plan.

6.1.3.4. Coping strategies and their health implications

In Chile, individuals could rely on extended family and friends to provide a reliable source of social support. Wrenched away from familial and affiliative ties, Chilean exiles depended on one another for assistance in the early years of settlement in Canada. Eventually political differences disrupted these communal bonds. As a result, community members began to emphasize self-reliance, the nuclear family and the cultivation of inner resources to cope with life experiences. This focus on inner resources and the family is reinforced by well-articulated notions of self-care and proper nutrition which is conceived of as a familial (or feminine) responsibility. Notably, this emphasis on individualism, hard work, self-reliance and achievement are consonant with Canadian middle-class values and in this sense, Chileans have been able to adjust well to Canadian society.

The importance of sociality, however, to health and well-being was not readily addressed; instead focus was placed on the benefits of social isolation and privacy, which lend themselves to intellectual and artistic pursuits.

Social origins of ill health such as effects of torture and economic stress were linked specifically with both uprooting (political persecution) and re-settling (the decline in socioeconomic status). While these are obvious factors in describing the etiology of ill health, coping with these effects were seldom addressed in the discussion of maintaining health. A sense of pragmatic acceptance of issues beyond one's control no doubt helps individuals to cope with stressful events; however, the success or failure of this strategy must remain as an important element in self-reports of declining health status.

6.2 Chinese Community

6.2.1. Community Profile

Chinese immigrants were the earliest non-European settlers in Canada. Migration from China to Canada began in 1858 as the news of gold discovery on the Fraser River spread. The first group of Chinese arrived in Victoria, British Columbia (Con, et al., 1982). These Chinese migrants, mainly peasants, came predominantly from the two southern coastal provinces of Guangdong and Fujian. The majority of these settlers were males, uneducated, unskilled and unmarried. They spoke little or no English. Population pressure, political weakness and disruption of the Chinese empire, foreign intervention and a series of natural catastrophes drove the Chinese to leave their homeland in search of desirable living conditions overseas. Long before 1858, large scale migration of the Chinese took place to other parts of the world, particularly Southeast Asia. By 1850, there were already sizable and fairly stable Chinese settlements in Southeast Asia. In Canada, the early immigrants from China were engaged in providing cheap labour for construction jobs, especially in railway building and resource extraction.

Prior to 1947, the Chinese community in Canada was mainly a bachelor society. The Canadian government imposed a head tax and various immigration measures on Chinese immigrants thus discouraging these settlers to bring their families from China. It was only after 1947 that Chinese immigrants were allowed to bring their wives and unmarried children to Canada. In 1967, a series of changes in immigration regulations and their administration was introduced. A “point system” was used to assess potential immigrants regardless of ethnic origin, thus opening the door to a new wave of Chinese immigrants into Canada. Unlike the early generation of Chinese settlers, the new Chinese immigrants came to Canada after 1967 as unsponsored immigrants on the basis of the skills they possess. They were urban, well-educated, and English-speaking. The origins of these new wave migrants were no longer restricted to China. They came from various parts of the world, especially countries facing internal pressures and domestic issues such as Hong Kong, Malaysia, Singapore, Philippines, South Africa, Peru and the Caribbean area (Con, et al., 1982).

The most recent twenty year period has witnessed a rapid growth in the number of Canadians with Chinese as a mother tongue. The growth was largely due to immigration during the 1980s which jumped from 95,000 in 1971 to 517,000 in 1991 (Statistics Canada 1992). The total population of the City of Edmonton in 1993 was approximately 626,999 (City of Edmonton 1993). According to the 1991 Federal census, about 50% of the respondents identified their ethnic origins, with Chinese being among the four largest ethnic groups. The same census showed that Ontario, Quebec, British Columbia and Alberta have the most immigrant populations; moreover, these immigrants tend to live in metropolitan areas where occupational opportunities are more accessible. Within the City of Edmonton, areas with over 10% Chinese ethnic origin are: Castledowns (15%), Central (12%) and Southwest (12%) (Capital Health Authority 1996).

At present, there are about 60,000 Chinese living in the city; however, the community is quite heterogeneous. Chinese immigrants can be divided into five groups according to their countries of last permanent residence which include the People's Republic of China (PRC), Hong Kong, Taiwan, Vietnam and Southeast Asia. Among these five groups, immigrants from the PRC and Hong Kong were among the top ten source countries for migrants between 1990-94. Regardless of where the Chinese immigrants are from, their reasons for emigration are either economic or based on fears of political instability.

The country of last permanent residence has a great influence on the lifestyle, living / working habits, values, beliefs, customs / traditions, way of thinking, motive for immigration and health practices of immigrants. In addition, dialects further sub-divide the Chinese community into two major sub-communities, primarily Cantonese-speaking and Mandarin-speaking. A great number of Chinese immigrants from the PRC (especially those from northern China), Taiwan, and some Southeast Asian countries such as Malaysia, Singapore, Brunei and Indonesia, speak Mandarin. Those from Hong Kong, Macau, southern China and some from Vietnam and other regions of Southeast Asia speak Cantonese. The majority of Chinese immigrants in Edmonton are from the PRC and Hong Kong.

6.2.2. Hong Kong Chinese

Most of the Hong Kong Chinese came to Canada as Independent Immigrants; that is as either a) Skilled Immigrants; or b) Business Immigrants. The influx of Hong Kong immigrants to Canada began after the signing of the Sino-British Joint Declaration in 1984, which stated that the British Colony of Hong Kong will return to the sovereignty of the People's Republic of China by July 1, 1997. The signing of the Declaration caused some degree of concern for Hong Kong residents regarding their future in the colony. Surveys showed that the major reasons for emigration from Hong Kong were freedom to travel outside Hong Kong; fear for individual freedom after 1997; the desire to have children educated in Canada; and concerns over general, economic and political stability after the takeover by China.

A study jointly conducted by Alberta Career and Economic Development, Canada Employment and Immigration, and the Hong Kong Institute of Personnel Management showed that the majority of the Hong Kong immigrants landed in Canada between 1986-1988; most were between 30-39 years of age, married with children, and possessed post-secondary education; many had a fair to good command of spoken and written English. They tended to be leaving management, supervisory and administrative occupations. The same study indicated that these immigrants had little or no difficulty in adjusting to Canadian life and the primary source of help for their adjustment in the new country was family or friends. The study also revealed that most of them had no problems in finding employment after settling in Canada. They were, however, unable to find work in the same occupation as they had in Hong Kong and also experienced a drop in rank / grade of their current employment status and disposable income (Alberta Career and Economic Development 1991; Hong Kong Institute of Personnel Management 1991).

The introduction of the Business Immigrant Program in 1986 created a different wave of immigration in terms of economic power. The Program was implemented under the Independent Immigrant category by which immigrants may enter Canada as self-employed, entrepreneurs or investors. 16,591 entrepreneurs, 3,346 self-employed and 12,592 investors (from all sources) arrived in Canada in 1993. Alberta received 555 business immigrants in the same year. In 1992, 150 entrepreneurs indicated Edmonton as their intended destination. Information from the same sources indicated that Hong

Kong ranked as the number one country of last permanent residence in the last five years; Taiwan and South Korea were second and third. In 1993, Hong Kong and Taiwan accounted for 83.5% of the Chinese immigrant investors and 66.8% of the entrepreneurs (Mah 1995).

Due to the unfavourable economic climate and tight labour market in Canada, many of the Hong Kong Chinese immigrant families, especially those who came under the Business Immigrant Program, are headed by a single parent. The breadwinner, usually the male, having spent some time in Canada, sometime chooses to return to Hong Kong for employment or business to secure financial resources for the family. The mothers usually stay in Canada with the children. These mothers, besides adjusting to a new environment, play an additional role as father, taking care of children without support. They are often lonely, isolated and helpless. Some immigrant children are without adult supervision as both parents return to Hong Kong for employment or business. The children are left behind to be looked after by relatives or servants or they remain alone if they are teenagers. Parents might spend a short period with them during the year, but most of the time the family is apart. Parents compensate their children with plenty of material comforts such as deluxe vacation packages, a large house, car, expensive audio/entertainment equipment, brand name clothing and a large amount of spending money.

Attitude towards traditional customs and values have changed or are changing as more and more young immigrants are favouring the nuclear family. Many dependent family members such as parents, parents-in-law, and grandparents are forced to stay by themselves after landing in Canada. These elderly immigrants often lack the basic language skills for their daily living. Due to the language barrier, they are not always able to exercise their rights or to access and utilize the services offered by the government or mainstream organizations. Moreover, many of these elderly immigrants, due to their short length of stay in Canada, may not be eligible for old age benefits. Their livelihood depends on their children who sometimes also have difficulties in securing their own living; therefore, many of these elderly immigrants are living in poverty and isolation.

Within the Chinese community, many immigrants are facing difficulties in adjusting to the new land, securing employment, family separation, couple relations, parenting, isolation and poverty. Though Chinese immigrants are of one ethnic background, they have different goals and values, different sets of ethics and different lifestyles.

6.2.3. Informant Sample

Table 3: Profile of Chinese Participants (N=11)

Year of Immigration		**Marital Status**	
1988-94	8	Married	11
1995-98	3	Divorced	0
Age		**# of Children**	
30-39	1	0	0
40-49	8	1-2	9
50-60	2	3-4	2
Occupation in HK		**Occupation in Canada**	
professional	4	professional	3
clerical / technical	3	clerical / technical	3
homemaker	2	homemaker	3
student	0	student	1
business	2	retired	1
Education		**Religion**	
elementary		Christian	3
high school	6	Buddhist	1
college / university	5	None	7

6.2.4. Results of Theme and Content Analysis

6.2.4.1. Life in Canada

Fear of political instability in Hong Kong with the return of the territory to the PRC in 1997 served as the major impetus for emigration from Hong Kong. Canada was the destination of choice due to perceived economic opportunities, its reputation for honouring human rights or personal contacts. All of the respondents immigrated as independent class migrants; six of the eleven fell into the entrepreneur or investor category and were aided in their move by paid immigration consultants. The migrants were from primarily middle-class backgrounds and many experienced a decline in

socio-economic status as business or investments were less profitable than anticipated or as meaningful employment eluded them.

Despite economic disappointments, most felt heartened by the friendliness of neighbours and the relative cleanliness and quietness of Edmonton and environs. Few reported experiences of racism or differential treatment; however, incidences that were shared occurred when in anonymous situations rather than in one-to-one relationships. Compared to Hong Kong, life in Canada was deemed less stressful due to its slower pace, lower crime rate, smaller population and cleaner environment. Language barriers, the paucity of meaningful and lucrative employment and overall loss of status tainted the otherwise satisfactory portrait of Canadian life.

Despite the well-established infrastructure provided by the extant Chinese community in Edmonton, respondents were hesitant to participate fully with long-standing Chinese Canadians. These newer migrants felt tension between themselves and the cohort of earlier migrants who arrived with fewer resources and worked to improve their economic and social status in Canada. The more recent migrants saw themselves as working equally hard to achieve material and economic security in Hong Kong as others were doing in Canada. Respondents also reported a fairly well-developed class structure within the Chinese community in Edmonton, with a considerable emphasis on status and wealth. This produced a significant amount of alienation on the part of those newcomers who are not wealthy or who must accept low-paying and low-status jobs.

These barriers to communal solidarity are reinforced by the desire to avoid a loss of face in the event that outside assistance is required. People, therefore, relied upon extended family, close friends and neighbours in times of need rather than approaching Chinese community organizations.

6.2.4.2. Creating and Sustaining Health and Well-Being

The Chinese informants' definitions of health focused on balance and holism. Mental and physical well-being were regarded as integrated and supported one

another. Primary to the maintenance of good health is food, thus a balance of foods and a healthy diet were of greatest import.

Most used both Traditional Chinese Medicine and biomedicine. Their interactions with the health care system were positive as they enjoyed the quality of care and universality of the system. Overall, they reported improved health status in Canada, attributable primarily to the quality of the environment.

6.2.4.3. Barriers to Health and Well-Being

While self-care focused on nutrition and maintaining balance in one's life, which are perceived as being under one's own control, some medical problems require the attention of biomedical personnel. Like the Chileans, Chinese informants complained of long waits for emergency and specialist services as well as the price of pharmaceuticals; however, they also felt they had limited knowledge about the health care system. This was particularly problematic when first arriving in the country. Most received information from a family physician or from personal experience, which invariably constrained the range of information about health care services that they obtained.

6.2.4.4. Coping Strategies and their Health Implications

The Chinese sample demonstrated a strong in-group orientation, relying on family and kin for support. In the context of immigration, however, these bonds may be somewhat tenuous, as families are as likely to be transnational as they are local. The paucity of support and avoidance of service organizations whose aid might engender loss of face may be mediated by the ethos of self-reliance, individualism, hard work and tolerance. This tolerance translates into a form of positive thinking as exemplified by the tendency to attribute uncomfortable, ostensibly racist, encounters with Euro-Canadians to something other than discrimination, or a determination not to be bitter about their loss of financial investments in Canada.

Like the Chileans, the values inherent in the coping strategies employed by Chinese migrants are congruent with mainstream middle-class Canadian values. The emphasis on self-care and self-reliance coupled with a sense of improved health status suggest that these coping strategies are effective.

6.3 Somali Community

6.3.1. Community Profile

One of the largest single ethnic groups in Africa, Somalis reside in the Horn of Africa region identified by the nation-states of Somalia, Djibouti, parts of Ethiopia and Kenya (Simons 1995). Kinship, more specifically clan organization, forms the basis of Somali society. The four major patrilineal clan families, Dir, Isaaq, Hawiye and Darood, are comprised of a number of patrilineages with membership that ranges from 20,000 to 130,000. Lineage affiliations serves as the organizing vehicle for political and social alliances (Lewis 1988, 1994). Clan affiliations provide an impressive social support network especially for women who may draw on both natal and affinal clan kin (Lewis 1994; Opoku-Dapaah 1995). Clan affiliations, although potentially divisive, are powerfully united through common Somali and Islamic identity.

Clan divisions, however, have been ultimately responsible for the civil war which precipitated the current Somali diaspora. At its inception in 1969, the Somali Democratic Republic led by Mohammed Siyad Barre forwarded a Pan-Somali identity and a style of indigenous socialism (Lewis 1988; Samatar 1988; Simons 1995). Despite numerous advances in education, health and literacy—made possible by the development of a Somali orthography, Barre's leadership degenerated into a morass of festering inter-clan power struggles. Armed opposition, the Somali National Movement was formed by Isaaq clan members in northern Somalia and the struggle for power eventually erupted into a violent civil war (Simons 1995).

Currently, 70,000 Somalis reside in Canada, comprising one of the top ten sources of refugees (Affi 1997). Most refugees have settled in Toronto with over 22,500 Somalis in 1991 (Kendall 1992) or the Ottawa area which is home to approximately 13,000 Somalis (Affi 1997). Despite government wranglings, the outbreak and vehemence of the civil war was abrupt, forcing Somalis to flee with little preparation and under horrific stress. A Toronto study suggests that more than 50% of Somalis settling in the area required medical attention; many of them suffering the effects of torture and trauma (Opoku-Dapaah 1995; Simalchik 1992). Compelled to adjust to a new environment, physical and

social, has not been easy and nearly 50% of respondents in the Toronto survey felt they are not accepted by their neighbours (Opoku-Dapaah 1995).

The settlement of Somali refugees must be contextualized by Canadian immigration regulations which have adversely affected select refugee groups—notably Afghanis and Somalis. Bill C-86, passed in 1993, requires refugees who cannot produce identity documents such as a passport to wait for five years until qualifying for permanent residency status. Without landing status, migrants are unable to sponsor relatives, pursue post-secondary education or qualify for various settlement assistance programs. Somali society has been predominantly oral—the writing system is less than 40 years old—and it has never emphasized the importance of written documentation. Women, who comprise the majority of Somali refugees, are less likely to possess a driver's license or passport than men. Moreover, governmental infrastructure that provides such documents collapsed early in the course of the civil war, leaving thousands of refugees without the documentation now required by Canadian authorities (Affi 1997).

The most recently available census data indicated there were only 125 Somalis in Alberta (Statistics Canada 1992). While this figure is clearly an artifact of small sample size and rapidly changing demographics, the actual number of Somalis in Alberta and Edmonton is unknown. We developed a networking survey (Appendix 5) for use by Edmonton Somalis to allow them to gain a clearer picture of the community and its needs; however, the survey was met with strong resistance as many contacted feared that the information might be used in an untoward manner and was discontinued.

Presently, the only Somali community organization is the Somali Women's Group that provides support, training, information and organizes social events. Several of the settlement agencies have Somali staff to liaise with community members. The Arabic school and the mosque are also sites of communion with other Somalis and co-religionists.

6.3.1. Informant Sample

Table 4: Profile of Somali Participants (N=10)

Year of Immigration		**Marital Status**	
1988-94	8	Married	8
1995-98	2	Single	2
Age		**# of Children**	

20-29	2	0	0
30-39	6	1-3	6
40-49	2	4-6	2
Occupation in Somalia		**Occupation in Canada**	
professional	1	professional	0
clerical / skilled	3	clerical / skilled	3
homemaker	0	homemaker	2
student	5	student	2
business	1	unskilled	3
Education		**Religion**	
high school	5	Muslim	10
college / university	5	Christian	0

6.3.2. Results of Theme and Content Analysis

6.3.2.1. Life in Canada

Fleeing the violence that erupted in their homeland, most of the Somali respondents either arrived as refugees or were sponsored by relatives who had claimed status earlier. While Canada provided a safe haven, language and weather provided challenges—albeit ones that can be practically addressed. Notably, more men than women spoke conversational English prior to arrival, and here, women find access to English-as-a-Second-Language classes difficult, especially if taking care of infants.

Most importantly, life in Canada means starting from scratch and learning to survive in a new environment. Some had businesses or a career in Somalia; they owned their own homes; they knew everyone in the neighbourhood and beyond. Women either had household help or could afford to hire someone. Life in Canada affords few of these opportunities.

Financial worries are compounded by concern over family members left behind in Somalia, in refugee camps or in other regions of the Somali diaspora. For this kin-based society that is inculcated with values of family care, these worries are never far from the forefront and five years is a long time to wait before being able to apply for the status that is required to sponsor other family members.

One of the greatest challenges for Somalis lies in the radical transition from residing in a homogeneous society to a culturally-diverse one. While lifestyle changes are

obvious, Somalis are now facing new phenomena such as racism and discrimination. While a minority of respondents never experienced racism, others spoke painfully about the changes in body language or false conviviality they witnessed when they approached Canadians. Several reported that their children experienced hostility in school, both from children who taunted them or refused to sit near them, or teachers who apparently overlooked their academic achievements. With regards to the larger community, most did not report much interaction with their neighbours save superficial greetings, although people mentioned that their neighbours were respectful of them.

For most, the term, "community," referred to the Somali community, a group bound by ethnic and religious ties, but neither geographically coherent nor cohesively unified. Although attempts are being made to unite the community, efforts have been most successful for the women who have their own women's group located at the Centre for the Survivors of Torture and Trauma at the Mennonite Centre for Newcomers. Women are seen as more capable than men of putting aside clan differences to socialize and engage in mutual aid, however, men are able to unite in the context of Islam. Still, efforts continue and all felt that they were capable of asserting themselves in the Somali community.

6.3.2.2. Creating and Sustaining Health and Well-Being

Health is seen as the purview of God, but it is also influenced by good nutrition, regular exercise, a good job, sufficient financial resources and a clean environment. Eating and dressing appropriately, being emotionally stable, being happy, socializing, playing with your children, exercising, and trying not to do wrong, all contribute to good health.

Somalis used biomedicine exclusively, although only one respondent mentioned seeing a physician for regular examinations. Contact with the health care system is often through family physicians who are also the source of most information about the health care system. The Canadian system was seen as having numerous advantages including: good access to practitioners, specialists and services, higher quality and more technologically sophisticated services than in Somalia and the possibility of obtaining a subsidy for provincial health care premiums.

6.3.2.3. Barriers to Health and Well-Being

With a single exception, the Somali interviewees felt they are less healthy than in Somalia. Racism, family problems, overwork, stress, loneliness, worry, poor nutrition, genetic factors, weather and lack of self-care contribute to poor health status. Thus many of the characteristics of life in Canada are viewed as contributing to poor health. As one woman said: "Being a housewife is a disease in itself," indicating, as others have that being housebound and isolated is linked with ill-health.

More than members of the other communities, Somali informants reported significant communication and cultural barriers in accessing the health care system. They cited other problems including: long waits for doctors' appointments or in emergency; cutbacks to services; cultural misunderstandings especially with regards to women's health concerns, including female circumcision; expensive insurance payments and the high costs of both pharmaceuticals and dental services.

6.3.2.4. Coping Strategies and their Health Implications

In Canada, Somalis may rely on family, clan and religious affiliation to provide both instrumental and emotional support. In Canada, a different situation ensues as people are separated from kin and must negotiate inter-clan differences which contribute to low community cohesion.

Somalis responded, however, continue to build upon strengths to enhance their resilience in face of adversity. Four dominant coping styles were uncovered. First, some people demonstrated tolerance, particularly with regards to experiences of racism and differences in the community. To a lesser extent, some more established Somalis hoped to actively challenge racism from the vantage point of a new Canadian citizen. Thirdly, religion proved an important avenue for coping with life in Canada. Often problems were conceived as challenges set forth by God that provided opportunities for learning. Fourthly, most emphasized the need for greater self-reliance and worked to become more financially-independent and better educated in order to enhance their opportunities in Canada for themselves and their children.

6.4 Health Care Providers and Decision-Makers

In the second phase of our study, we interviewed health care providers and decision-makers (n=12) regarding their experience with immigrants and refugees and their recommendations for program development and policy changes.

6.4.1. Sampling

Several relevant categories including governmental, non-governmental organizations, practitioners (alternative and biomedical), managers and front-line personnel were established in consultation with the advisory committee. Names of potential respondents within each category were suggested and contacted. As with client interviews, discussions were taped and transcribed following consent of the interviewee.

6.4.2 Informant Sample

Table 5: Profile of Health Care Providers & Decision-Makers (N=12)

Government/Institution	**Community-Based**	**Practitioner**
Program Manager, Federal Government	Program Coordinator, Capital Health Authority	Family Physician
Multicultural Program Manager, Hospital	Manager, Infectious Disease Clinic	Psychiatric Social Worker
	Supervisor, Settlement Agency	Nurse in Independent Practice
	Case Manager, Capital Health Authority	Naturopathic Physician
	Community Worker, Social Issues	
	Executive Director, Settlement Agency	

6.4.3 Results of Theme and Content Analysis

The health care providers interviewed represent a broad cross-section of community service organizations and professions. All of them espoused a holistic definition of health, emphasizing the importance of emotional, and spiritual well-being, in addition to physical health. There was also a strong emphasis placed on the impact of external factors such as social relations, financial condition, education, and employment on

health status. Even individuals with physical ailments can be considered healthy if they are able to exercise control over their own lives and have the resources to pursue their goals in a constructive fashion.

Everyone seemed to acknowledge that the Canadian health care system, with its emphasis upon being free and accessible to everyone, is one of the best in the world. They spent more time, however, elaborating upon its disadvantages. In general, their analysis has a high degree of correspondence with that of the immigrants interviewed. Accessibility, the health professionals cited, is often an ideal and is not fully realized for some segments of the population. In particular, immigrants—especially those who have poor command of English—are not aware of available services or how to use them. Other complaints include long waiting lists, an emphasis upon crisis management rather than prevention, the high cost of drugs and alternative treatments, and the constant threat of privatization.

There was lack of consensus concerning the health of immigrants compared to the Canadian population in general. Some of the differences revolve around the circumstances surrounding immigration and how long the immigrant has been in Canada. For example, most respondents acknowledged that refugees who have experienced malnutrition or torture in refugee camps are not likely to be in good health when they arrive, especially since the immigration process itself can be quite stressful. After adjusting to Canadian life, however, the health of such individuals improves. Many immigrants, especially if they have good command of English and a good education, do not find the process as stressful, find jobs quickly, and enjoy average or above average health. In fact, some immigrants are believed to be healthier than the general population because of a healthier life style (such as better eating habits) and strong family ties. Notably, the disparate circumstances brought by refugees and immigrants may produce different health issues; yet the distinction between categories of newcomers are readily glossed over by professionals and institutions.

Barriers emphasized by the health care professionals and decision-makers have a high degree of correspondence with those stressed by immigrants themselves. The greatest barrier identified by far was that of language. Lack of language competence is regarded as not only frustrating, but results in things failure to find jobs, social isolation,

inability to read signs and food labels, and a reluctance to ask others for help because of the fear of being misunderstood. The second most important barrier was difficulty understanding the culture and ways of doing things in Canada. Conversely, problems arose from misunderstandings and prejudice on the part of other Canadians. Other significant barriers are the lack of information (or incomplete information) about available services, financial problems, separation from family and friends, culturally inappropriate health care, and transportation difficulties.

Coping strategies used by immigrants to reduce barriers and stress involve developing community networks for exchanging information, services, and social functions, as well as minimizing the discomfort involved in dealing with service providers who do not understand their language or culture. For example, immigrants tended to search for physicians from their own ethnic group or to use home remedies if such physicians could not be found. Many immigrants find individuals, such as their children, who can accompany them and provide interpretation services when visiting health care professionals. In addition to these kinds of individual strategies, there are also community strategies. The larger communities, such as the Chinese, have been innovative in developing ethnic newspapers and radio programs, as well as programs to meet the needs of different age groups in the community. Smaller communities often lack the resources to develop a full range of services.

Mainstream service organizations also have developed a variety of programs involving cultural brokerage, community support groups, orientation programs, language training, pre and post natal support, parenting courses, and counseling, only to mention a few.

There was some skepticism about the credentials of traditional healers, but all of the respondents agreed that they play an important role in immigrant communities in terms of providing services that immigrants are accustomed to and feel comfortable with. It appears that a majority of immigrants use alternative therapies. Some health care professionals stressed the need for greater collaboration between biomedical practitioners and alternative healers, as well as the desirability of incorporating useful knowledge and techniques from alternative therapies into the official health care delivery system.

07 Analysis

7.1 Coping with Integration: A Stress Model

7.1.1. SPSS Results

Qualitative data is rich with detail and meaning; however, quantitative methods are often necessary to create predictive models. We have chosen to triangulate these two approaches in order to test several hypotheses and develop a systematic approach to our understanding of coping and health amongst immigrants and refugees that is grounded in the lived experience of our informants. Thus, we have utilized the statistical package, SPSS, to aid us in the quantitative analysis of this data. The original hypotheses that were tested using this method were as follows:

1. Immigrants who have been in Canada the longest are better integrated and suffer less stress than newcomers.

2. Different stress levels result in different coping strategies.

3. Different coping strategies are associated with different kinds of health-related behaviors.

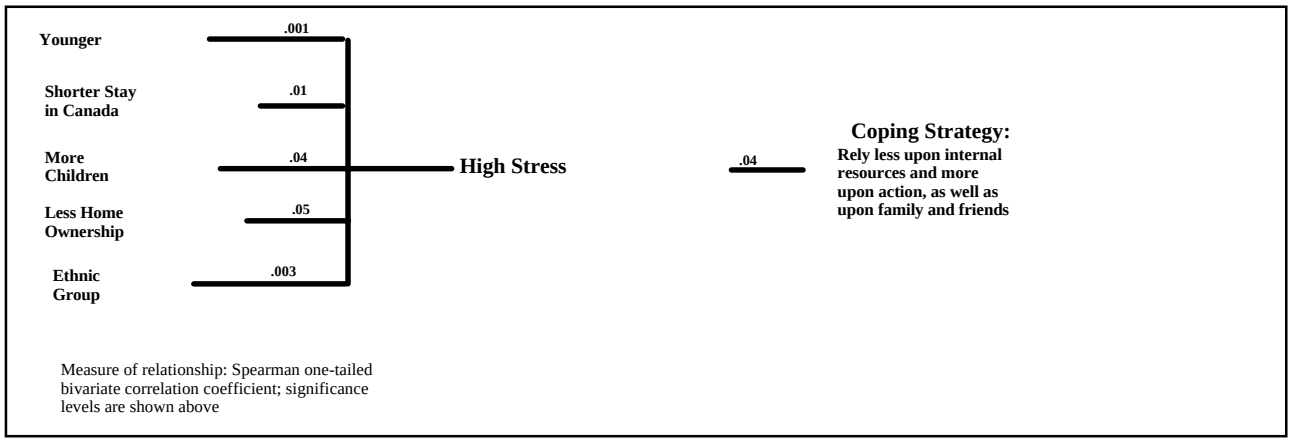
4. All of the above (integration, stress, coping strategies, and health-related behavior) are influenced by cultural background.

The 30 interviews with community informants were coded using 25 variables (Table 6). In addition, each respondent was scored for two composite variables: integration and stress. The variables were then run against each other for all 30 cases, using Spearman one-tailed bivariate correlation co-efficient—a non-parametric measure of strength of relationship. The most significant results are shown in Figure 1.

Table 6: Variables Used in SPSS Analysis

01	Gender
02	Ethnic Group
03	Length of Stay in Canada
04	Reason for Immigration
05	Age
06	Marital Status
07	Number of Children
08	Educational Level
09	Occupation Prior to Immigration
10	Current Occupation
11	Change in Occupational Status
12	Home Ownership
13	Major Challenges in Canada
14	Main Language Used at Home
15	Perceived Work Conditions
16	Level of Perceived Stress
17	Relations with Neighbours
18	Relations with Members of Own Ethnic Group
19	Main Source of Social Support
20	Perceived Health Status
21	Primary Determinants of Health (According to Respondent)
22	Primary Type of Health Care Utilized
23	Number of Visits to a Physician in the Past Year
24	Evaluation of the Canadian Health Care System
25	Primary Way of Coping with Challenges

Figure 1: Stress and Coping



7.1.2. Discussion of Results

As predicted, the greatest stress is experienced by younger immigrants, those who have been in Canada the shortest length of time, those with the most children, and those who rent rather than own their own homes. Also as predicted, different stress levels are associated with different coping strategies. Those with minimal stress tend to rely on their own internal resources in time of need; those with moderate stress tend to take some kind of concrete action to improve their situation; and those with the highest stress levels tend to rely on others such as family and friends.

Not predicted is a weak association between integration and stress. Those who participate less in their own ethnic communities than in the larger society experience the greatest amount of stress. As predicted, these associations, based on individual data, have some correspondence to cultural patterns summarized in Table 7. For example, the Chileans are the oldest, have been in Canada the longest, have the highest degree of home ownership, are moderately integrated, experience the least amount of stress, and tend to rely on their own internal resources. The only variable that does not fit the individual stress model refers to the number of children. In contrast, the Somali and

Chinese, who experience higher stress levels, are younger, have been here less time, own their own homes less often, and depend more on action or upon family and friends in time of need. Not all of the cultural patterning is predictable on the basis of individual patterns, however. For example, the Chinese, who are more affluent than the Somali, own their own homes more often, and encounter covert rather than overt discrimination, nevertheless experience higher stress than do the Somali. As recent refugees fleeing a violent civil disturbance, Somalis may both weigh the trauma of resettlement against the traumas they witnessed at home. Moreover, they are less likely to regard their arrival in Canada as a permanent change in residence.

Interestingly, stress levels and resulting coping strategies were not significantly associated with health related behaviours as predicted in our third hypothesis. Nevertheless, some of the findings associated with health behaviours were salient. Almost everyone, regardless of cultural affiliation, thinks highly of the Canadian health care system, visits a doctor at least once a year, and has the same complaints about the health care system as do many Canadian-born residents. Biomedicine is the preferred method of treatment in all three communities, but especially popular with the Somali. In addition, Chileans and Chinese use home remedies and alternative treatments a good deal. Chileans are divided in their opinions of whether their health has improved, stayed the same, or declined after immigration. The Somali tend to feel their health has declined; and the Chinese feel their health has improved.

Table 7: Summary of Cultural Patterns

	Age	*Length of Stay in Canada*	*# of Children*	*Home Ownership*	*Integration*	*Stress*	*Dominant Coping Strategy*
Chilean	**Oldest (41-60) 100%**	**Long (20 years or more)**	**Most (Mean = 2.3)**	**Highest (50%)**	**Moderate (Mean = 3.0)**	**Lowest (Mean = 1.3)**	**Internal Resources (40%)**
Somali	**Youngest (20-40) 100%**	**Short (10 years or less)**	**Least (Mean =1.9)**	**Least (20%)**	**Low to Moderate (Mean = 2.5)**	**Intermed-iate (Mean = 1.8)**	**Action (60%)**
Chinese	**Intermed-iate (31-40) 30%**	**Short (10 years or less)**	**Intermed-iate (Mean = 1.6)**	**Intermed-iate (40%)**	**Moderate (Mean = 3.1)**	**Highest (Mean = 2.10)**	**Action + Reliance on Family and Friends (50%)**

Note: Most Chinese respondents did not disclose their ages.

Key to Composite Variable Categories:

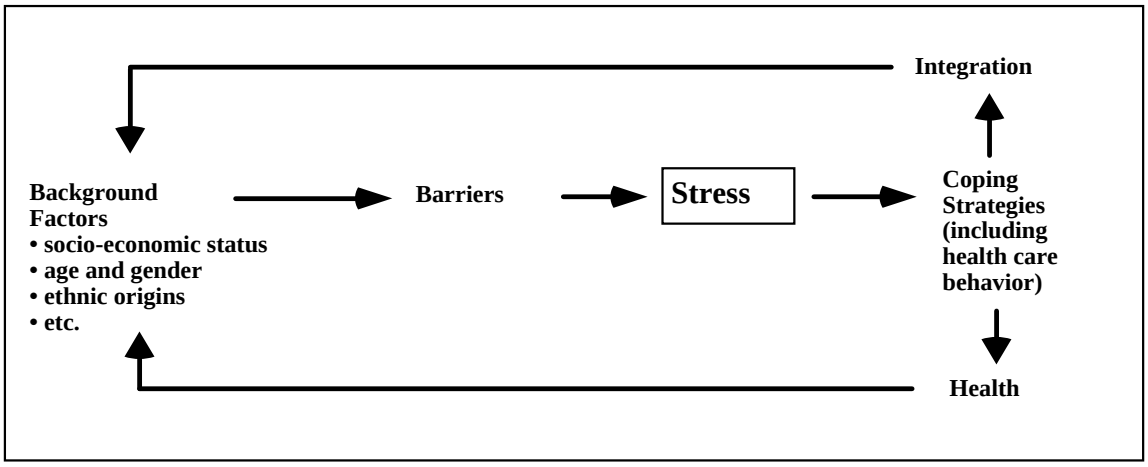
Integration:
1 = minimal
2 = low
3 = moderate
4 = high

Stress:
1 = unstressful
2 = moderately stressful
3 = highly stressful

7.1.3. The Stress Model

To understand the health care needs of Canadian immigrants, we have sought to explicate how members of three immigrant and refugee communities conceive of their health and how they choose to improve their well-being. The holistic impression of health and well-being that encompasses social, economic, spiritual and physical wellness suggests that self-appraisal of health status, coping, and healing strategies are interlinked with the overall status of immigrants and refugees settling into the Canadian environment.

Figure 2: The Stress Model



From both our qualitative and quantitative analyses, the experience of uprooting and resettlement manifests in the experience of stress which is the culmination of individual, socioeconomic and demographic variables and the incongruence between expectations and the reality of life in Canada (Figure 2). The choice and effect of coping strategies reflects both cultural and personal adaptation to the Canadian environment. Although we did not have the data to establish a causal link between coping style and health (as posited in the stress model), we have noted that health maintenance requires changes in coping styles. For instance, Chileans tend to rely on internal resources whereas in Chile, they might have obtained support from more external sources. The confrontation with structural, linguistic and cultural barriers and the process of finding suitable coping mechanisms are integral to a newcomer's integration in Canadian

society and their health status. It is in this arena, the sustenance of well-being, that we must direct our efforts to best understand the health needs of Canadian immigrants.

08 Recommendations

8.1 Recommendations from Respondents

Informants from ethnocultural communities and the professional and policy sector shared a large area of consensus regarding steps to improve the overall health and well-being of newcomers to Canada. These include:

1. Encouraging greater cultural sensitivity amongst health care personnel;
2. Increasing the availability of cultural interpretation services and multi-lingual written information;
3. Advertising the presence of health and social services beginning in countries of origin;
4. Training more front-line workers from ethnic communities;
5. Creating greater awareness of traditional and alternative medicine and encouraging more collaboration between biomedical personnel and alternative healers, as well as between communities and alternative healers;
6. Establishing community health centres with biomedical, alternative and traditional practitioners;
7. Including alternative and traditional medical treatments under the provincial health care insurance plan;

8. Including dental services and pharmaceuticals in the provincial health care insurance plan;

9. Making better use of foreign-trained professionals;

10. Emphasizing preventative and holistic care;

11. Advocating for the maintenance and improvement of quality universal health care;

12. Adapting existing programs to the requirements of immigrants;

13. Involving ethnic communities in the planning and administration of health care programs;

14. Increasing the availability of psychological and spiritual counseling for refugees;

15. Encouraging greater flexibility on the part of immigrant training programs, service organizations, and institutions such as schools;

16. and encouraging greater political involvement by members of ethnic communities in order to influence politicians and bring about useful changes in policy.

8.2 From the Researchers

Many of the recommendations forwarded by our respondents are directed towards specific changes in the health care system and the local community. What policy changes and program adaptation could support the types of innovations needed to enhance the health status of newcomers?

A. Dissemination of Information

1. Make available multi-lingual information on health and social services at Canada Immigration Centres and Consulates in target countries.
2. Provide physicians who have foreign-born patients with up-to-date information on public health services in a variety of languages.
3. Use Basic English for all health information and translate written materials as required (c.f. Spitzer, et al., 1998).

B. Involvement of Ethnocultural Communities in the Health Care System

1. Establish local advisory groups to provide on-going input into the development of health programs and priorities. Ensure that representation is attentive to intra-ethnic variation.
2. Use ethnic media on a consistent basis to not only transmit, but to receive comments on issues of health, social and economic well-being.

C. Culturally-Appropriate Health Services

1. Encourage the development of ethno-specific services that are derived from perceived community needs.
2. Assist foreign-born professionals with obtaining rights to practice in Canada or with re-training in an adjunct field.
3. Require medical, nursing and schools of allied health to include cultural difference in their curriculum and encourage practicum placements with culturally-diverse populations.

D. Collaboration between Biomedical, Traditional and Alternative Practitioners

1. Establish a model clinic that incorporates a plurality of healing modalities.
2. Require medical, nursing and schools of allied health to include an overview of various healing traditions in their curriculum.

09 Conclusion

This research involved experimenting with ways to combine qualitative and quantitative methods. We are pleased with the results. We found that a qualitative approach is useful in eliciting information from individuals. It encourages respondents to talk freely and it provides an emic (insider's) perspective on immigrant experience. A quantitative approach is useful for translating emic data into a form that can be used to test hypotheses which may be relevant in other situations.

Quantitative analysis also highlights weaknesses in the quantitative data. For example, although most aspects of our general stress model are supported by the quantitative analysis, we were unable to confirm a correlational link between coping strategies and health. This brought to our awareness the need to ask respondents more specific questions concerning their health, what problems they have consulted health care providers about in the past year, what kind of medications and treatments they are currently receiving, etc. We will attempt to rectify this weakness in future research.

In terms of findings, many of the conclusions come as no surprise. Immigrants and refugees from all three groups share common challenges such as difficulties stemming from language difficulties and loss of status. Other findings were not expected. For example, some new Canadians found that greater integration was associated with greater stress levels. In such circumstances, it may be adaptive to reduce social contact with the larger community and emphasize values such as self-reliance or reliance upon spiritual values and cultural pursuits. Such a finding challenges common perceptions about the nature and value of integration.

We believe our general stress model has received enough support from our findings that it is worth developing in greater detail. It seems clear that coping strategies are critical for the health of both individuals and groups. It is not possible, however, to produce a list of "successful" coping strategies—strategies that will result in health, happiness and a positive contribution to Canadian society. Many coping strategies are designed to reduce stress and buffer individuals from the pain of economic hardship and racism. If they function in this way, they can be regarded as "successful" from the point of view of the individual without being necessarily "successful" from a social

point of view. Much more research is needed on the determinants and results of coping strategies.

Finally, we believe we have provided several concrete recommendations, based largely on insights provided by community members and health care providers, that would help ease the transition for immigrants and refugees. A number of these recommendations pertain to the need for more culturally-responsive health care, the need for greater involvement of ethnic communities in helping plan and deliver health care to their own communities, and the need for more collaboration between biomedically-oriented health care providers and newcomers with useful health care skills and knowledge.

We have had the benefit of insights from our advisory committee throughout the course of this research. We will continue to rely on this committee for insights concerning how to make our findings relevant to both immigrants and refugees and policy-makers.

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11 Appendices

11.1 Interview Guide

Guide to Interview Topics: Understanding Immigrant Health Needs
Community Participants

General

1. Tell me how you immigrated to Canada.

2. Tell me about your living conditions. How does it differ from your living conditions in _____?

Work

1. Tell me about your working conditions. How does it differ from your working conditions in _____? (If applicable). If not working, tell me about your daily activities, how do they differ from your daily activities in _____?

2. What has been your experience regarding Canadian recognition of your credentials (educational & employment) and life experience? (If applicable).

Community Affiliation & Support

1. How would you describe your community?

2. What language do you speak at home?

3. What language do you speak with your friends and family?

4. Do you or your family members belong to any organizations or partake in any community activities?

5. When you first came to Canada, did you know anyone? What about now?

6. Have you seen any changes in the community since you arrived? If so, what?

7. Do you feel you have a voice in what happens in your community?

8. How many people do you have to call on if you: a) need a ride somewhere; b) need childcare (if applicable); c) need to borrow money?

9. Do you feel that you or your family members have received differential treatment in Canada? If so, how did you deal with it?

Health

1. What sorts of things make for a healthy individual?

2. What sorts of things make for an unhealthy individual?

3. What do you think are the major factors affecting your health and the health of your family members?

4. What do you do to maintain your health or that of your family members?

5. If you or a member of your family is ill, what do you do?

6. Do you ever use any home remedies you learned in _____?

7. Have you seen a physician in the past 3 years? Can you tell me about it?

8. Have you seen any other type of healer or practitioner in the past 3 years? Can you tell me about it?

9. How did you find out about accessing health care services (biomedical and complementary)?

10. Have you ever accompanied anyone who was using health care services? What did you do for them?

11. Did anyone ever accompany you when you were using health care services? What did they do for you?

11. In general, do you think you and your family are healthier or less healthy since coming to Canada?

12. What do you see as the major advantages and disadvantages of the Canadian health care system as you have experienced it?

13. What kind of changes do you think could be made to the Canadian health care system so it could provide better service for you and others from _____?

Wrap-Up

1. What are the main challenges you and other members of your family (if applicable) have encountered since you came to Canada? How are you attempting to deal with these challenges?

Guide to Interview Topics: Understanding Immigrant Health Needs
Health Professionals and Decision-Makers

Personal Questions

1. What is your job title? Can you tell me about what you do?

2. What services does your organization / institution / office provide?

3. How long have you been working at your current job? How long have you worked with the health care system and / or Canadian immigrants and refugees?

4. What is your educational background?

5. What is your ethnic and / or religious background?

6. Do you define yourself as an immigrant to Canada? If so, what country did you emigrate from? When did you come to Canada?

General Questions

7. How do you define health?

8. What do you see as advantages and disadvantages to the Canadian health care system as it currently exists?

9. How regularly would you say you (and your family) visit a health practitioner? What kinds of health practitioners do you usually see?

Questions relating to Immigrant Health

10. In general, do you feel that Canadian immigrants are more healthy, less healthy or have the same level of health as other Canadians?

11. What strengths or resources do you feel are provided by immigrant and refugee communities for maintaining the health of their members? For contributing to the health of Canada as a whole?

12. What barriers do you believe exist for Canadian immigrants and refugees attempting to access health care in Canada?

A) What strategies for dealing with these barriers have you observed among Canadian immigrants? Do you believe these strategies were culturally-based?

B) Were the strategies they were using successful in your opinion? If so, why? If not, why?

C) Are there other coping skills which you think *might* be employed by Canadian immigrants and refugees to overcome these barriers?

D) What changes could be made to reduce or eliminate these barriers?

13. Is there anything else you can think of that could be changed to make the health care system more accessible to Canadian immigrants and refugees?

14. Are there any other things that could be done or changed that could contribute to the health of Canadian immigrants (e.g. alternative programs/services, changes in policy, etc.)?

15. Do you feel the recent restructuring of health care in Alberta has had an impact on Canadian immigrants and refugees? If so, can you describe this impact?

16. Are you aware of any programs or services that are aimed specifically at making health care more accessible to Canadian immigrants or connecting Canadian immigrants to health resources?

17. Do you make referrals to those programs or services?

A) If so, do you think the individuals followed-up on them? Why or why not?

B) If not, why not? What makes it difficult? What could make it easier or more straightforward?

18. What do you think might help to increase the usage of programs or services geared directly toward Canadian immigrants?

19. What role (if any) do you think traditional, ethnic or alternative healers or healing practices can play in the health of Canadian immigrants? In the health of individuals in general?

20. Do you feel there are opportunities for Canadian immigrants to provide input into health care?

A) If so, what are they? Do you feel that these opportunities are adequate?

B) If not, what could be changed to create such opportunities?

21. What do you feel you can do, personally, to impact the health of Canadian immigrants? To improve their access to health care?

22. In what ways do you feel the Canadian health care system can benefit from the knowledge and skills from other countries? Can you provide some examples?

11.2 Project Outline for Participants

Understanding the Health Needs of Canadian Immigrants
Centre for the Cross-Cultural Study of Health & Healing
University of Alberta
Dr. David E. Young, Principal Investigator
Dr. Denise L. Spitzer, Co-Investigator

Project Outline

We are interested in learning about the experiences of Chinese, Chilean and Somali immigrants in Edmonton. In particular, we are interested in how you maintain your health and that of your family. We are also interested in your living and working situation, what kinds of challenges you have faced in Canada and how you have dealt with these challenges. There are no right or wrong answers to the questions we have, only your experience and your ideas. We hope that by learning more about your experiences, we can help health care personnel and policy-makers help you, your family or future newcomers to Canada.

To learn about your experiences, we would like to interview you. The interview will be taped and transcribed. The tapes will be kept in a safe place and destroyed after the project is finished. If you agree to participate in the study, we will ask you to sign or tape record your consent. Any information you provide will be confidential. We will give you another name that will be used on all papers and in anything we write or present about the project. If necessary, we will change some of the details of your life, so you cannot be identified. Any interpreter or translator working with the study has also agreed to keep your identity secret.

If you have any questions or concerns, please feel free to call:
Centre for the Cross-Cultural Study of Health & Healing 492-0135
or Denise Spitzer (Co-Investigator)XXX-XXXX

11.3 Consent Form

I have been interviewed by _____ on _____ place _____.

I understand that I can stop this interview at any time. I will inform the interviewer if I talk about anything confidential. Confidential information will not be shared with anyone else. I understand the purpose of the research, and I am willing to have non-confidential information used for educational purposes (publications and public presentations). The only people who may listen to the tape of my interview will be myself, a typist and the investigators.

Please indicate one of the two following options:

(1) I understand that my identity will remain confidential. ( )
(2) I would like to have my name used in publications and public presentations. ( )

If you prefer Option 2 above, would you like to see any manuscripts in which your name is used prior to publication or public presentations?

(1) Yes ( )
(2) No ( )

_____
Printed Name

_____
Signature

11.4 Demographic and Personal Details

Name:_____ Date:_____

Address:_____ Tel:_____

Date of Birth:_____ Place of Birth:_____

Country of Last Residence:_____

My hometown is:
Large urban centre _____ Small urban centre ____ Town _____

Ethnic Identity: _____ Religion: _____

I moved to Canada in _____

Marital Status: _____ # of Children:_____ Age(s): _____

Occupation in Home Country: _____

Occupation in Canada:_____

Spouse's Occupation in Home Country: _____

Spouse's Occupation in Canada:_____

Highest Level of Education you have completed:

Elementary School:____ High School: ____ College: _____ University:____

Graduate School: _____ Vocational School: _____

Highest Level of Education your spouse has completed (if applicable):

Elementary School:____ High School: ____ College: _____ University:____

Graduate School: _____ Vocational School: _____

Accomodation:

Single house:_____ Townhouse:_____ Apartment: _____

Owned: _____ Rent: _____ Other:_____

Family Structure:

Nuclear: _____ Extended: _____

11.5 Somali Community Networking Survey

Somali Networking Project

1. Have everyone write down the name of every Somali in Edmonton that they know. Include the telephone number if possible. Ask everyone to complete the survey questions as well.

2. Collect the names and pass on to the Centre; Florence will generate a single list.

3. Call people on the list and fill out the survey forms while collecting more names.

Edmonton Somali Community Networking Project

The Somali community in Edmonton is relatively new. In order for community workers and researchers to know what members of the community need, and what challenges they face, we need to have a better of understanding of who is here. This project is being undertaken by the Somali Women's Group in conjunction with the Centre for the Cross-Cultural Study of Health and Healing at the University of Alberta. All of the information is confidential and will remain with the Somali Women's Group. The Centre will be provided with the basic information; they **will not** be in possession of your names and phone numbers. This will help the researchers with a study that focuses on the health needs of immigrants in Edmonton. Thank you for your cooperation.

Name		**Phone Number**	
Sex		**Age**	
Year of Immigration		**Highest Level of Education**	
Occupation in Somalia		**Occupation in Canada**	
Living Arrangements: Who do you life with? (i.e. children)			
What is the main challenge you have encountered since you came to Canada? How are you attempting to deal or cope with this challenge?			
Please name all the Somalis you know in Edmonton. (Include phone number if possible).			
