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The Lived Experiences of Immigrant Canadian Women with the Healthcare System

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Abstract

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Dissertation Submitted in Partial Fulfillment
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Abstract

Immigrants to Canada report better health status than the Canadian-born population when they first arrive in Canada, a phenomenon called the Healthy Immigrant Effect. However, by the fourth year after immigration, immigrants report a health status that is worse than that of the Canadian-born population. Visible minority immigrant women report the largest deterioration in health. The purpose of this qualitative study was to explore the lived experiences of visible minority immigrant women with encounters with the Canadian healthcare system to examine the multiplicative impact of gender, ethnicity, and immigration on their health. This phenomenological study, guided by Crenshaw's feminist intersectionality framework, explored the perspectives of a purposive sample of 8 immigrant women in Ottawa, Canada, about their encounters with the healthcare system. Data were collected through individual interviews. These data were inductively coded and subjected to thematic analysis following the process outlined by Smith et al. for interpretative phenomenological analysis. Key findings of the study revealed that immigrant women define health more holistically and have expectations of the encounters with healthcare that are not met due to barriers that impact them accessing healthcare services, experiencing healthcare services, and following the recommended options. The positive social change implications of this study include recommendations for public health to consider immigration and racism as determinants of health; and for Health Canada to undertake system-level lines of inquiry to shed light on the ways structural discrimination and racism have had an impact on immigrant women's social and health trajectory.

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Chapter 1: Introduction to the Study

When immigrants first arrive in Canada they report a better health status than Canadian-born individuals. This is known as the Healthy Immigrant Effect (HIE) (Fuller-Thomson, Noack, & George, 2011; Ng, Wilkins, Gendron, & Berthelot, 2005). A good health status is a condition of admissibility to Canada and is usually determined by an independent practitioner in the original country and identified by Citizenship and Immigration Canada (Citizenship and Immigration Canada [CIC], 2013).

However, the HIE does not persist. Researchers have revealed that by the fourth year after immigration, immigrants report a health status that is worse than that of the Canadian-born population (Fuller-Thomson et al., 2011; Ng et al., 2005). Immigrants from non-European countries and who represent a *visible minority* appear to be at a greater health disadvantage than immigrants arriving from the United States, United Kingdom, and Europe (Rotermann, 2011). Visible minority refers to individuals who self-identify as non-Aboriginal; belonging to a race other than Caucasian; and having a skin color other than white (Government of Canada, 2012; Statistics Canada, 2012)

Over 260,000 individuals immigrated to Canada in 2014 and over 85% arrived from countries other than the United States and Europe and represented visible minorities (CIC, 2015a). With more than half the visible minority population in Canada settling in Ontario (Statistics Canada, 2013), the province where this study is taking place, it is imperative that the issue of deteriorating health be explored and addressed. As Canada has a universal health care system that is built on the values of social justice (Shi &

Singh, 2008), this phenomenon has implications for the principles of health equity and on resource allocation to healthcare.

In this chapter I will begin by providing the background to the study and building a case for clear purpose and problem statements. Based on this background, the research questions and the research approach are articulated. The conceptual framework and corresponding concept definitions follow. I will then briefly discuss the assumptions made and outline the scope, delimitations, and limitations of the study. I will conclude with a general overview of its significance.

Background

Researchers have extensively studied the decline in self-reported health status of immigrants to Canada (De Maio, 2010). It has been associated with several factors that include language proficiency (Ng, Pottie, & Spitzer, 2011; Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008); ethnicity (Kobayashi & Prus, 2012); gender (Fuller-Thomson et al., 2011; Pottie et al., 2008); experiences of discrimination (Brondolo et al., 2011; De Maio & Kemp, 2010; Facione & Facione, 2007); and barriers to access to healthcare at the social, economic, cultural, and geographic levels (Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2011). Researchers have also reported that, due to the barriers faced by the immigrant population, the availability of healthcare services does not always translate to accessibility, even within the universal healthcare system of Canada (Asanin & Wilson, 2008; Donelly & McKellin, 2007; Setia et al., 2011) leading to further deterioration in health.

Furthermore, women comprised 52% of immigrants to Canada in 2014, 86% of whom arrived from areas other than the United States, United Kingdom, and Europe and, as such, represented visible minorities (CIC, 2015a). This percentage is reflected in Ontario, the province in Canada that receives the highest percentage of immigrants, and where this study is taking place (CIC, 2015a).

The intersection of many of the contributing factors to ill health that were identified above in the lives of immigrant women in particular, makes them especially vulnerable to the decline in health (Fuller-Thomson et al., 2011; Kobayashi & Prus, 2012) and to experiencing additional barriers in accessing healthcare services (O'Mahony & Donnelly, 2010; Wahoush, 2009). Kobayashi and Prus (2012) found that immigrant women between the ages of 45 and 64 years, regardless of ethnicity, report the worst health status. Little is known, however, about their lived experiences with the healthcare system, especially at the intersection of the contributing factors to ill health in their lives. In this study I seek to address this gap.

Problem Statement

Researchers utilizing quantitative methodologies to study the HIE phenomenon have examined the correlation between multiple factors and the self-reported measure of health while pointing to the need for qualitative research to further explore this phenomenon (De Maio & Kemp, 2010; Fuller-Thomson et al., 2011; Kim, Carrasco, Muntaner, McKenzie, & Noh, 2013; Newbold, 2009; Setia et al., 2011; Wang, 2014; Wang & Kwak, 2015). Qualitative studies, on the other hand, have examined the experiences of immigrants and immigrant women with the healthcare system in the presence of one or two of the determinants of health (Dastjerdi, Olson, & Ogilvie, 2012; Higginbottom et al., 2013; Hynie, Crooks, & Barragan, 2011; Pollock, Newbold, Lafrenière, & Edge, 2012; Wood & Newbold, 2012). There is a need, however, to explore the lived experiences of immigrant women with the healthcare system when there is an intersectionality of multiple factors in their lives. These include sex, gender, the immigration experience, and self-identification with a visible minority. Additionally, the descriptions of the experiences should cover the timeframe before, during, and after the encounter in order to explore immigrant women's perceptions of barriers to access to care that might differ across the three time points. Another section in this chapter will provide definitions for the concepts introduced in this problem statement.

Purpose of the Study

The purpose of this qualitative interpretative phenomenological study was to explore the lived experiences of immigrant women who self-identify as belonging to a visible minority with encounters with the healthcare system in Canada. It helped describe their lived experiences with the healthcare system when they were also experiencing the intersectionality of gender, immigration, and visible minority status. The narratives extended to three contexts of prior to, during, and after the encounter. This allowed me the opportunity to listen to the perspectives of the participants regarding their understanding of health and access to health care services. I was also able to explore the barriers that had an impact on them accessing healthcare services, experiencing healthcare services, and following the recommended follow-ups, interventions, and treatments.

Research Questions

The primary research question of this study was: What is the perspective of immigrant women in Ottawa, Canada, of their lived experiences with encounters with the healthcare system when there is an intersection of the factors of sex, gender, ethnicity, and immigration in their lives?

Additional subquestions included:

- What meanings do immigrant women in Ottawa, Canada, attribute to health, healthcare services, and access to health services?
- How do they describe the impact of the immigration experience on their experiences with healthcare services?
- How do they describe the impact of their ethnicity on their experiences with healthcare services?
- How do they describe the impact of their gender roles on their experiences with healthcare services?
- How do they describe barriers to access to healthcare services that they might have experienced prior to, during, and following the encounter with the healthcare system?

Theoretical and Conceptual Framework

The conceptual framework that guided the study was the feminist intersectionality framework (Bowleg, 2012; Hankivsky et al., 2010; McGibbon & McPherson, 2011; Viruell-Fuentes, Miranda, & Abdulrahim, 2012). I had conceptualized the intersection of the concepts of sex, gender, ethnicity, and the immigration experience and their impact on the lived experiences of immigrant women with encounters with the healthcare system through that lens. The essence of the theory is a commitment to social justice issues and the need to study the simultaneous and cumulative impact of multiple factors on social and health disparities (Hankivsky et al., 2010). As such, it was the most appropriate to frame and guide the study, including the articulation of the research questions and the development of the data collection tools. The framework will be explored further in Chapter 2 and development of the data collection tools will be explored in Chapter 3.

Nature of the Study

I utilized a qualitative interpretative phenomenological approach in this study to explore the lived experiences of immigrant women with the healthcare system in Canada. An interpretative phenomenological approach allows the researcher an in-depth exploration of a phenomenon from the perspective of those who have lived and experienced it (Creswell, 2013; Smith, Flowers, & Larkin, 2009/2013). The choice of approach is also consistent with the recommendation of the literature in regards to studies framed by the intersectionality framework (Bowleg, 2012).

The purpose of an interpretative phenomenological study is to explore the lived experiences of participants with a particular phenomenon by listening to and interpreting their narratives of the experiences (Smith et al., 2009/2013). To that end, I conducted individual interviews with the participants in order to hear their narratives of the encounters. I utilized a purposive mixed sampling strategy (Patton, 2002) to recruit participants who met specific criteria. The participants were immigrant Canadian women who self-identified with a visible minority. The participants had to have been in Canada more than four years but less than 10; were between the ages of 18 and 64 years; had had an encounter with the health care system in the previous year; and spoke English, French, or Arabic. Smith et al. (2009/2013) proposed that a sample size for an interpretative phenomenological approach could be anywhere between five to 25 participants, with most studies reaching data saturation with 10 interviews. As I conducted data analysis at the same time as data collection, I was able to cease the recruitment once data saturation was achieved.

I had planned to recruit the first few participants through collaboration with the staff of the Ottawa Community Immigration Services Organization (OCISO) in the two sites in west and south Ottawa. A not-for-profit organization, OCISO provides support to immigrants in the Ottawa region through integration and settlement services (OCISO, 2016). Flyers with information about the study and my contact details were made available at the agency offices asking for volunteers to contact the researcher directly. I utilized a snowballing sampling strategy by asking the first few women who consented to the study if they could refer other women within their circle to contact me directly.

I collected data through semistructured individual interviews conducted in a location selected by the participants. This gave the participants a measure of control over the interview process (Creswell, 2013; Maxwell, 2013). I also gave the participants the option of being interviewed in English, French, or Arabic. The interviews were audio-recorded and were planned to be a minimum of an hour long each. The recordings were transcribed verbatim and shared with the participants to verify accuracy and to give them the opportunity to provide additional information should they wish to do so.

In addition to the interview transcripts, I asked the participants to complete a demographic questionnaire. The questionnaires were designed to take less than five minutes to complete and included questions about age, marital status, immigration status, employment, education level, country of origin, time in Canada, dependents, health status upon entry into Canada, current health status, and time since last encounter with the healthcare system. Additionally, I wrote field notes during the interviews and kept a reflective journal throughout the research process. The data analysis included the interview transcripts, demographic questionnaires, and field notes.

Definitions

Sex: Sex refers to the biological and physical characteristics that differentiate men and women, or male and female (World Health Organization [WHO], 2016). Only women were recruited for this study.

Gender: “Gender is cultural” (American Psychological Association, 2010, p. 71) and refers to the sociological and societal roles and behaviors that are deemed either masculine or feminine in any given society (WHO, 2016).

Ethnicity: Ethnicity is a characteristic that an individual self-identifies as her or his ethnic or cultural origin (Statistics Canada, 2015).

Members of a visible minority: Members of a visible minority are those individuals who self-identify as non-Aboriginal; belonging to a race other than

Caucasian; and having a skin color other than White (Government of Canada, 2012; Statistics Canada, 2012).

Immigrants: Immigrants are permanent residents who were born outside Canada and who did not have Canadian citizenship at the time of birth (Statistics Canada, 2015). The definition does not include temporary residents or refugees.

Access to health care: In addition to the availability of an adequate supply of health resources, access to health care refers to the physical and geographic accessibility, economic affordability, and social and cultural acceptability of health services (Gulliford et al., 2002).

Education level, employment status, and language proficiency were used to determine the socioeconomic status of the participants. Though these do not fully reflect the economic status, they were used in order to avoid collecting sensitive information that the participants might be uncomfortable providing, such as bracket of annual income.

Assumptions

This study made three assumptions. First, the study generalized that the female participants had a traditional feminine gender role that includes caregiving for children and elderly parents. A traditional gender role usually translates into a higher potential for accessing the healthcare system, not only for themselves, but also for those in their care.

Second, one of the inclusion criteria for the study was having been in Canada more than four years, but less than 10. This was based on research that had identified this period as the time during which immigrant women who were members of a visible minority report the decline in their health status (Lebrun, 2012; Setia et al., 2011).

However, the rate of acculturation differs from one person to another, leading to a difference in the length of time before which women experience deterioration in their health. This study, nevertheless, made the assumption that the rate of acculturation and the length of time before experiencing deterioration in health were uniform for the participants.

Third, the purpose of the study was to explore the lived experiences of immigrant women from visible minorities with encounters with the healthcare system in Canada. The participants excluded women who had immigrated from Europe, the United Kingdom, or the United States of America under the assumption that they would not have self-identified as visible minorities.

Scope and Delimitations

The study was limited to immigrant women between the ages of 18 and 64 years, who self-identified as belonging to a visible minority, who had been in the country more than four years but less than 10, and who had had an encounter with the health care system within the previous year. As the study aimed to explore the lived experiences of the participants with the healthcare system, the scope of the encounter included (a) caring for or being a patient in the hospital, (b) undergoing a procedure or caring for a family member who had, (c) visiting the family physician or a healthcare clinic for oneself or a family member, or (d) accessing care in an emergency or urgent care department for oneself or a family member.

Additionally, the age group of the participants was limited to women between the ages of 18 and 64 years to avoid the need for additional ethical approvals to include women less than 18 years of age. The age limit of 64 years was based on the findings in the literature that women who were 65 years and older reported a general health status better than the Canadian-born women within the same age group (Kobayashi & Prus, 2012).

To allow for the transferability of the study to other settings and contexts, I am providing detailed descriptions of the data collection and data analysis procedures in the following chapters (Miles, Huberman & Saldana, 2014). I am also presenting an enhanced description of the participants in the demographics section of Chapter 4.

Limitations

The design required the voluntary participation of immigrant women in the study. Because of the narrow inclusion criteria, there was potential for difficulty in recruiting participants. To mitigate this problem, I utilized a snowballing technique to recruit additional participants once the first few were recruited.

Even though the validity of the data cannot be fully guaranteed in qualitative research (Maxwell, 2013), I used several strategies to ensure the trustworthiness of the data and the findings. In addition to a more comprehensive description of strategies to address the credibility, transferability, dependability, and confirmability of the study in Chapter 3, Creswell (2013) and Maxwell (2013) had outlined five strategies that I followed and that are described here. First, the quality of the data collected was ensured by spending a prolonged amount of time in the field with the participants and by taking detailed and extensive field notes. Second, the interviews were planned to be one hour long, semistructured, and face-to-face. The length and structure of the interviews allowed me the opportunity to probe further for additional information and helped ensure a level of richness to the data collected. Third, the interviews were transcribed verbatim and the transcripts were verified with the participants for accuracy. Fourth, to mitigate personal bias, I bracketed and documented my experience as an immigrant woman from a visible minority in a reflective journal that I kept and updated throughout the data collection and analysis phases. Lastly, I verified the emerging themes and subthemes or findings with the participants in the study to ensure that I had, indeed, captured their stories.

Significance

The reality of healthcare disparities and their impact on the health of immigrants, especially within the first 10 years of immigration, have been an important topic of research and health care discourse in Canada for decades (Lebrun, 2012). These disparities are even more evident among immigrant women, especially those women from a visible minority as they have to deal with the intersection of gender, socioeconomic factors, and cultural factors in their lives that have a negative impact on their health (Hankivsky et al., 2010). With the current and projected increase of the immigrant population and especially the visible minority population in Canada, it becomes essential to explore the factors that have an impact on their lives and, subsequently, health, as these will help guide public policies and health programs (Lebrun, 2012).

The study findings have implications for practice, research, academia, and policy. By understanding the experiences of immigrant women with the healthcare system, we can tailor the care provided to improve access to healthcare and the encounters with the providers. Furthermore, as intersectionality framework has not been well utilized in healthcare research, this study helps build the evidence for its use and provides recommendations for future research into this field. In addition to informing future research, the study helps inform future academic curricula. Lastly, findings from this study can have an impact on policies on the health of immigrants and the translation of availability of health services in a universal health care system to accessibility.

The unique perspective of this study in exploring the experiences of immigrant women with the healthcare system lies in its focus on the simultaneous experiencing of the intersectionality of multiple factors that have an impact on their health. As advised by Lebrun (2012), in order to address issues of access to and utilization of health care services, we must first understand the perspective and experiences of this population. The themes emerging from the data helped build the stories of the immigrant women and clarify the issues they were facing. These stories have the potential to help guide provincial and federal health policies that govern the funding and distribution of, and access to, health and social services (Bowleg, 2012; Viruell-Fuentes et al. 2012).

Summary

In this chapter, I focused on introducing the research problem that necessitated a research study. Highlights from the literature in regards to the health status of the immigrant population in Canada were presented and the case was built for the need to explore the lived experiences of immigrant women who self-identify as members of a visible minority with encounters with the Canadian healthcare system. The use of the intersectionality conceptual framework was justified considering the intersection of multiple factors in the lives of immigrant women to Canada that have an impact on their health. Each of the concepts included in the framework was defined, and the scope, delimitations, and limitations of the study were outlined. I concluded the chapter with the potential significance of the findings to practice, research, academia, and policy; and consequently, to social change.

In Chapter 2, I will provide an expanded view of the literature in the discipline around this topic and will build the case further for the need for research and the choice of conceptual framework. The methodology for the study, including ethical implications, will be shared in Chapter 3.

Chapter 2: Literature Review

Immigrants to Canada, in general, are healthier than the Canadian-born population when they first arrive in the country (Fuller-Thomson et al., 2011; Ng et al., 2005). This health advantage was attributed to three reasons. First, to ensure that they do not have infectious and chronic diseases, potential immigrants to Canada are required to undergo a physical assessment by an independent practitioner selected by Citizenship and Immigration Canada (CIC, 2013). The granting of a landed immigrant visa is dependent on the outcomes of the physical examination. Second, as the immigration process is costly and rigorous, there is a natural self-selection process that takes place that ensures that only those who are strong, skilled, and young apply (Statistics Canada, 2013). Lastly, immigrants, as a group, are younger than the Canadian-born population, and as a result, tend to be healthier (Statistics Canada, 2013). Unfortunately, this HIE diminishes with time. In fact, empirical evidence from population surveys revealed that immigrants start reporting a deteriorating health status as soon as two and four years after immigration (Kim et al., 2013). Kobayashi and Prus (2012) reported that the portion of the population that is most impacted by the decline in health is that of immigrant women, between the ages of 45 and 64 years, who self-identified as belonging to a visible minority. They posited, however, that the impact on health of demographic, economic, and lifestyle factors start at a much earlier age and should be studied within that context.

Researchers studying this phenomenon and utilizing quantitative methodologies have examined the correlation between multiple factors on one hand and the self-reported measure of health on the other, while pointing to the need for qualitative research to further explore this phenomenon (De Maio & Kemp, 2010; Fuller-Thomson et al., 2011; Kim et al., 2013; Newbold, 2009; Setia et al., 2011; Wang, 2014). On the other hand, researchers utilizing qualitative methodologies have examined the experiences of immigrants and immigrant women with the healthcare system in the presence of one or two of the determinants of health (Dastjerdi et al., 2012; Higginbottom et al., 2013; Hynie et al., 2011; Pollock et al., 2012; Wood & Newbold, 2012). There is a need, however, to explore the lived experiences of immigrant women with the healthcare system when there is an intersectionality of multiple factors in their lives. These factors include sex, gender, the immigration experience, and self-identification with a visible minority. Additionally, the descriptions of the experiences should cover the timeframe before, during, and after the encounter in order to explore the immigrant women's perceptions of barriers to access to care that might differ across the three time points.

The purpose of this study, therefore, was to explore the lived experiences of immigrant women who self-identified as belonging to a visible minority with encounters with the healthcare system in Canada. It helped describe their lived experiences when they were also experiencing the intersectionality of gender, immigration, and visible minority status. Their narratives encompassed the three contexts of prior to, during, and after the encounter. This allowed me the opportunity to listen to the perspective of the participants regarding their understanding of health and access to health care services and to explore the barriers that might have had an impact on them accessing healthcare services, experiencing healthcare services, and following the recommended follow-ups, interventions, and treatments.

This chapter will present the result of a critical analysis of a comprehensive review of the literature available about the HIE and the decline in health of immigrants, especially immigrant women. I will present the search strategies I utilized and the findings outlined in the literature. I will then give an analysis of the resources that I had reviewed and will provide the theoretical lens and resulting conceptual framework that guided the study.

Literature Search Strategy

In order to conduct as comprehensive a search as possible, I utilized Google Scholar as the first search engine. I adjusted the settings to include Walden University Library in the search for full-text articles. I also used Walden University's Library search engine, Thoreau, in order to search multiple databases at the same time. As Thoreau does not search all of the Library collection, I conducted additional searches in the following databases: EBSCO host (CINAHL, MEDLINE, and other databases), OVID Nursing Journals, ProQuest (Health & Medical Complete, and Nursing & Allied Health Source), SAGE, Science Direct, and Dissertations and Theses. I then connected with a librarian at the academic health sciences center where I work in order to expand the search to the hospital's collection and that of the health sciences library at the University of Ottawa.

Additionally, I surfed through the websites of government and other agencies and organizations for statistical reports, policies and laws, technical reports, and grey literature. These included Statistics Canada, Citizenship and Immigration Canada (CIC), Health Canada, Public Health Agency of Canada (PHAC), Ontario Ministry of Health and Long-Term Care, Ontario Public Health, Ottawa Public Health, Human Resources and Development Services Canada, Ministry of Labour, and Government of Canada Laws.

The search terms included Canada, immigrant, healthy immigrant effect, health, healthcare, access to healthcare/health access, immigrant women, ethnicity, visible minority, race, intersectionality, gender, barriers to healthcare/health barriers, provider bias, discrimination, cultural competence, cultural sensitivity, and racism. I used these terms in the databases and government websites in different combinations until the resources started repeating. I limited the search in the academic search engines and databases to peer-reviewed articles, research about healthcare in Canada, articles written in English or French, and those published after 2009.

I then reviewed the citations and abstracts of each of the resources for relevance using a critical analysis strategy. I retained the resources if they met the following criteria, (a) the study was either conducted in Canada or compared Canadian findings to those of other developed countries; (b) the study reported findings about the health of immigrants, immigrant women, or visible minorities; and (c) the study reported results from the statistical analysis of data from one of the national or Ontario-specific population surveys. I also retained articles that reported the results of scoping or systematic reviews or utilized an intersectionality framework.

As articles were downloading from Walden University Library, the Science Direct database would make suggestions about similar articles. I reviewed the suggestions and retained the resources that were relevant. I also searched the references section of each of the articles that were retained for potentially relevant articles.

Similarly, in Google Scholar, I followed the “Cited by” and “Related articles” links and retrieved potential references.

I searched government and government agencies websites for reports that were relevant to the topic of study. These included any census reports from Canada, Ontario, and Ottawa; immigration reports; demographic reports; reports about the health of immigrants, in general, and immigrant women, in particular; and reports on visible minorities, health and social disparities, and racialized populations. Government policies on immigration and provincial health insurance plans were also retrieved to shed light on aspects of the structural context within which women access healthcare.

The final count was 278 articles, reports, theses, dissertations, and book chapters that were retrieved and retained as part of the literature review. I housed those resources in a Mendeley database for easy access and citation. I entered relevant information from each resource into a spreadsheet. The categories within the grid included: decision to use (Yes, No, or Maybe); full reference in APA format; year of publication for quick access; type of publication (e.g. peer-reviewed article, thesis/dissertation, statistical report, government report, etc.); theoretical or conceptual framework guiding the work; research question, hypothesis, or purpose of the study or report; methodology used; analysis and results; limitations and implications for future research; implications for practice; potential quotes relevant to the conceptual framework; comments, synthesis, and relevance; and the potential section of the proposal that the reference could be used in.

Literature Review Related to the Concepts

The initial literature review and my personal interest in the topic led to the development of a preliminary conceptual framework that guided a more comprehensive literature search. The visual representation of the framework is presented in Appendix A. The following sections highlight the findings from the literature related to the concepts and present them in a way that situates the issues within the Canadian immigration and healthcare contexts, which will help define the gap this study was designed to address. They also justify the selection of the theoretical lens selected for the study and present the revised and refined conceptual framework.

Immigration Policies in Canada

In 2002, Canada revised its immigration regulations and replaced the Immigration Act of 1976 with the Immigration and Refugee Protection Act (CIC, 2015a). The new Act governs immigration policies in Canada and is based on three specific objectives: (a) family reunification, (b) economic development, and (c) the protection of international refugees (Government of Canada, 2016). As a result, the classes of permanent and temporary residents reflect these objectives. Applications for permanent residence fall into three categories: family class, economic class, and refugee class. Family class applicants have to be sponsored by a close relative or family member residing in Canada. Economic class applicants are granted permanent residence visas based on six selection criteria that are assigned a point system (CIC, 2015b). For a total potential point value of 100 points, the selection criteria include: English and/or French language proficiency (28 points), education (25 points), work experience (15 points), age (12 points), arranged employment in Canada (10 points), and adaptability (10 points). This selection process places an emphasis on education and skills and encourages women applicants to apply for immigration within the economic class rather than as dependents within the family class (Sethi, 2013). Economic class applicants are considered principal applicants and fall into four categories: skilled workers, entrepreneurs, government nominees, or those applying for the Live-in Caregiver Program (CIC, 2015a). Refugees seeking asylum in Canada could be government sponsored, privately sponsored, or those who had independently landed in Canada and their dependents.

The Immigration and Refugee Protection Act (IRPA) also governs the temporary entry of individuals as foreign workers, international students, and visitors (Government of Canada, 2016). In 2008, the IRPA was amended to include a Canadian Experience Class that would allow those who have worked in Canada or who have graduated from a Canadian postsecondary educational institution and have gained Canadian work experience to apply for permanent residency. Because of the variations by which health care coverage is allocated to permanent versus temporary residents, only permanent residents or immigrants were considered for the purposes of the study.

Demographics: Immigrants to Canada

The annual report from CIC (2015a) revealed that in 2014 alone, over 260 thousand permanent residents entered Canada and represented 0.7 percent of the population. Of those, 52% were women, 25.6% entered within the family class, and 63.4% within the principal applicant economic class. Of interest, women were more likely to be sponsored to enter within the family class (28.1% of the women) as compared to men (22.9% of men), and less likely to enter as principal applicants within the economic class (61.3% of women as compared to 65.7% of men). Sixty-six percent of those over the age of fifteen were 25 to 44 years of age, and 63.9% reported being able to communicate in either of the two official languages, English or French. Immigrants from Asia and the Pacific represented over 51% of the immigrants in 2014, followed by immigrants from Africa and the Middle East at 23.9% and Europe and the United Kingdom at 11.6%. Consistent with previous immigration cohorts, Ontario received the largest percentage of immigrants at 36.7%, the majority of whom settled in Toronto and Ottawa. Close to 25.5% of those who settled in Ontario in 2014, spoke neither English nor French, the two official languages in Canada.

This section of the chapter will present the latest demographic data for the population of Canada based on the 2011 National Household Survey (NHS), the results of which Statistics Canada published in 2013 (Statistics Canada, 2013). I will share the results for Canada, in general, and then narrow it down for the Province of Ontario and the city of Ottawa, where the study took place.

Canada is one of the very few countries in the world that actively seeks immigrants as a means of population and economic growth (Cymbal & Bujnowski, 2010). The 2011 NHS revealed that 20.6% of the population or one in five, is foreign-born, with 17.2% of them having entered Canada between 2006 and 2011 (Statistics Canada, 2013). Canada has the highest proportion of immigrants in the G8 countries to be followed by Germany at 13% and the United States at 12.9% in 2010.

Statistics Canada (2013) reported that in 2011, the provinces of Ontario, British Columbia, Quebec, and Alberta were home to 94.8% of the foreign-born population in Canada. Ontario had the highest percentage at 53.3%, followed by British Columbia at 17.6%. Seventy percent of the immigrants in Ontario live in Toronto. The second highest percentage in Ontario and fifth overall in Canada is in Ottawa, which is home to 3% of the total foreign-born population of Canada. Immigrants represented 25% of the total population of Ottawa in 2014 (Ottawa Public Health, 2014).

With the introduction of the point system and the added emphasis on welcoming asylum seekers, the source of immigrants to Canada shifted in the later part of the twentieth century and into the twenty-first from Europe and the United States to countries in the Southern Hemisphere, Asia, and the Middle East (Hudon, 2015; Statistics Canada, 2013). The reporting of visible minority status in the Census of 2011 reflected this trend. Statistics Canada follows the Employment Equity Act definition of visible minority as "persons, other than Aboriginal persons, who are non-Caucasian in race or non-white in colour" (Government of Canada, 2012, p.2). In 2011, 19.1% of the population of Canada self-identified as a visible minority. This represents an increase of 2.9% from the Census of 2006 (Statistics Canada, 2013). The largest visible minority groups are South Asians, Chinese, and Black, comprising 61.3% of the total visible minority population in Canada.

In 2011, over 52% of the visible minority population of Canada lived in Ontario and comprised over 25% of the people in Ontario (Statistics Canada, 2013). As with immigrants, the majority of the members of a visible minority group lived in the Greater Toronto Area (GTA), making up 47% of the population of Toronto. The three largest groups in Toronto were South Asian, Chinese, and Black. The second highest percentage of visible minority population in Ontario lived in Ottawa and comprised over 19% of the total population of the city. Unlike Toronto, the three largest groups in Ottawa were Black, Arab, and Chinese.

The diversity of the Canadian population was also reflected linguistically with more than 200 mother tongues reported in the 2011 NHS (Statistics Canada, 2013). Close to 75% of the foreign-born population reported being able to converse in more than one language, usually English or French and one other language. Only a small portion--less than one percent--of the overall immigrant population could not speak in either of the official languages. This is more reflective of the population that had arrived in Canada prior to 2006 as the same survey reported that, among those who had arrived in Canada between 2006 and 2011, the percentage climbed up to nine percent (Statistics Canada, 2013).

Demographics: Immigrant Women

In a statistical report based on the 2011 National Household Survey (NHS), Hudon (2015) reported that immigrant women were estimated to comprise 21.2% of Canada's female population. This number is projected to increase to 27.4% in 2031 based on the current trends in immigration. Additionally, 79% of recent immigrant women were members of a visible minority, with 60% of the women having immigrated to Canada from Asia and the Middle East (Hudon 2015). Hudon also reported that immigrant women were more likely to be married than Canadian-born women and more likely to be married at a younger age.

The 2011 NHS also revealed that the percentage of immigrant women who had a university degree was 38 %, higher than that of Canadian-born women (26.6 %). This rate is even higher among recent immigrant women at 49.6 % of those who arrived between 2006 and 2011 (Hudon, 2015). Unfortunately, this does not translate into better employment rates as those who have received their education in countries other than Europe, North America, or Australia have a harder time matching their credentials to the Canadian requirements (Plante, 2010). The rate of employment for immigrant women over the age of 15 was 51.3% in 2011 as compared to 58.9% for Canadian-born women; and a higher percentage of immigrant women worked part-time as compared to Canadian-born women (Hudon, 2015). Additionally, a larger portion of immigrant women than Canadian-born were underemployed in jobs that did not match their educational qualifications (Galarneau & Morissette, 2008). They were also more likely to earn less, on average, than immigrant men or Canadian-born women (Hudon, 2015). Consequently, 17.5 % of immigrant women, and 28.3 % of recent immigrant women reported an income level below the poverty line as compared to 14.6 % of Canadian-born women (Hudon, 2015).

Demographics: Visible Minority Women

The 2011 National Household Survey revealed that women made up 51 % of the total visible minority population, accounting for 19.3 % of the total female population in Canada (Hudon, 2016). This proportion is projected to increase to over 30 % by 2031 (Hudon, 2016; Malenfant, Lebel, & Martel, 2010). Reflecting the immigration patterns, the largest three groups of visible minority women in Canada were South Asian, Chinese, and Black. Of the visible minority women population in 2011, 68 % were immigrants (Hudon, 2016). In 2011, over fifty-two percent (52.7%) of visible minority women in Canada lived in Ontario, 41.9 % lived in Toronto, and 3.8 % lived in Ottawa. Additionally, visible minority women were relatively younger and more likely to be married than those who were not visible minority women.

Even though a higher percentage of visible minority women, aged 25 to 54, had a university degree than women in the same age group who did not self-identify as belonging to a visible minority, visible minority women lagged slightly behind in their employment rate--55.2 % compared to 57.4 % (Hudon, 2016). Unfortunately, the gap widens even further for immigrant, visible minority women (54.8 % versus 59 %). Additionally, 21.9 % of immigrant, visible minority women were below the poverty income level as compared to 14.3 % of women who were not visible minority (Hudon, 2016).

In addition to employment and income differences, 21 % of visible minority women also reported incidences of discrimination and unfair treatment on the basis of their sex, ethnicity, race, and language. These incidences took place in the job market, in service industries, or out in public (Chui & Maheux, 2011).

Healthcare System in Canada

Canadian permanent residents and citizens are provided with a universal health care insurance plan that covers all essential health care services (Health Canada, 2012). The system is built on the principles of social justice and the value of health as a right. The Canada Health Act governs the health care system in Canada by ensuring the portability, universality, accessibility, comprehensiveness, and public administration of health care services (Health Canada, 2012). The healthcare system is partly funded by federal payments collected through taxation. However, Provincial and Territorial governments are responsible for the delivery of health services to their residents and for governing who and what is covered under the provincial health insurance plan.

Within the province of Ontario, the Ontario Health Insurance Plan (OHIP) is administered by the Ontario Ministry of Health and Long-Term Care (Ontario Ministry of Health and Long-Term Care [MoHLTC], 2016). Even though Ontario residents are eligible for health insurance, some exceptions apply. The MoHLTC has established a waiting period of three months from the date when residence in Ontario begins before an Ontario resident becomes eligible for health insurance. This waiting period applies to all immigrants. Additionally, OHIP covers essential medical services that include hospitalization, physician and specialist visits, and dental surgery if done in the hospital. It does not, however, cover medications (outside of hospitalization), eye and dental care, nursing homes, or alternative and complementary therapies (MoHLTC, 2016).

The “Healthy Immigrant Effect”

Those interested in immigrating to Canada are required to complete an application process to demonstrate their eligibility to become citizens. In addition to the six-point system--English and/or French language proficiency, education, experience, age, arranged employment in Canada, and adaptability--that CIC uses, applicants are also required to undergo a medical assessment by an independent practitioner identified by CIC in the applicant’s country of origin (CIC, 2013). This process ensures that the majority of applicants are healthy, educated, skilled, young, and proficient in one of the two official languages.

The majority of empirical studies about the health and social integration of immigrants into Canadian society had utilized national survey data collected by Statistics Canada (De Maio, 2010). The surveys included: (a) the Census which is conducted every 5 years with the latest cycle being 2011; (b) the National Population Health Survey (NPHS) that had a longitudinal component that followed the same respondents every two years for nine cycles between 1994 and 2011; (c) the Canadian Community Health Survey (CCHS) that has collects cross-sectional data from a sample of 65000 participants annually since 2007; and (d) the Longitudinal Survey of Immigrants to Canada (LSIC) that was designed to capture information from a sample of immigrants who arrived in Canada between October 1, 2000, and September 30, 2001, and follow their integration journey over a four year period (Statistics Canada, 2016). Data for the LSIC were collected in three waves. The first wave was six months after landing in Canada, while the second and the third waves were at two and four years post-immigration, respectively. The LSIC is now inactive with the last wave of data having been collected in 2004-2005.

The high number of immigrants, the changing demographic profile and diversity of the population, and the desire to ensure the sustainability of Canada's national health care system, have propelled much of the research into the settlement, integration, and health of new Canadians. Utilizing data from the surveys above and others, researchers have established the health advantage that immigrants to Canada have over the Canadian-born population when they first arrive in the country. This advantage is now known as the

Healthy Immigrant Effect (HIE) and has been reported utilizing different measures including: self-rated health status (Kobayashi, Prus, & Lin, 2008; Kobayashi & Prus, 2012; Ng et al., 2005; Rotermann, 2011; Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2012;); mortality rates (Ng, 2011; Trovato & Odynak, 2011); mental health (Setia et al., 2012); Body Mass Index (BMI) as a measure of obesity (Setia, Quesnel-Vallee, Abrahamowicz, Tousignant, & Lynch, 2009); hospitalization rate (Newbold, 2009); and prevalence of chronic diseases such as diabetes, arthritis, and cardiovascular disease (Chiu, Austin, Manuel, & Tu, 2012; Rotermann, 2011).

The HIE advantage, however, varied within the recent immigrant population based on ethnicity, sex, age, and socioeconomic status. For instance, after analyzing the cross-sectional data from the 2001 CCHS, Kobayashi et al. (2008) reported that even though Black and French immigrants reported better health status than Canadian-born persons of the same ethnocultural group, this was not true for the Chinese and South Asian immigrants who were generally less healthy than the Canadian-born Chinese and South Asians. Setia et al. (2011) related a significant difference in reported unmet health care needs between visible minority women and Canadian-born White women, with the visible minority women reporting fewer unmet needs. Age was found to be a factor in self-rated health as older non-White immigrant women reported better health status than recent immigrant middle-aged women (Kobayashi & Prus, 2008). Additionally, immigrants within the lower socioeconomic brackets were more likely to report poor health and psychological distress than immigrants in higher brackets (Setia et al., 2012).

Health Disparities

While the overall health of immigrants was found to be better than that of the Canadian-born population when they first arrived in the country (Ali, McDermott, & Gravel, 2004), this advantage was found to be dependent on the sex, age, and ethnicity of the immigrant and disappeared over a short period of time (Fuller-Thompson et al., 2011; Kim et al., 2013; Kobayashi & Prus, 2012). The decline in self-rated health status is evident within the first two years of arriving in Canada (Kim et al., 2013). This decline has been associated with the following:

- age (Fuller-Thompson et al., 2011; Kim et al., 2013; Kobayashi & Prus, 2012; Newbold & Danforth, 2003; Ng et al., 2011),
- gender (Fuller-Thompson et al., 2011; Kim et al., 2013; Kobayashi & Prus, 2012; Newbold & Danforth, 2003; Ng et al., 2011; Setia et al., 2012),
- socioeconomic status (Newbold & Danforth, 2003; Setia et al., 2012),
- education (Ng et al., 2011),
- language proficiency (Fuller-Thompson et al., 2011; Ng et al., 2011; Wang & Kwak, 2015),
- ethnicity or region of origin (Fuller-Thompson et al., 2011; Kobayashi & Prus, 2012; Ng et al., 2005; Ng et al., 2011; Rotterman, 2011; Setia et al., 2012),
- experiences of discrimination (De Maio & Kemp, 2010; Fuller-Thompson et al., 2011; Kim et al., 2013; Ng et al., 2011; Wang & Kwak, 2015),

- access to healthcare services (Fuller-Thompson et al., 2011; Ng et al., 2005; Wang & Kwak, 2015),
- healthy behaviours (Ng et al., 2005),
- time since arrival (Newbold & Danforth, 2003; Rotterman, 2011),
- social capital (Ng et al., 2011; Wang & Kwak, 2015),
- immigration class (Ng et al., 2011), and
- place of settlement (Ng et al., 2011).

In addition to differences in self-rated health status across the categories above, the disparities in health between immigrants to Canada and the Canadian-born population differed in regards to access to health care services, chronic health conditions, mental health, and mortality. Newbold (2009) utilized data from the first four cycles of the NPHS (1994/95, 1996/97, 1998/99, and 2000/01) to examine the number of general practitioner (GP) consultations that immigrants make as well as the number of hospitalized days. He found that, even though there is an increase in the number of consultations with GP as length of stay in Canada increases, there is no corresponding increase in hospitalization. Considering the declining health status of immigrants and the fact that GPs are the point of access to the health system, this finding is concerning and points to the need for further in-depth research into the experiences of immigrants with the encounters with the healthcare system.

In their investigation of the extent of racial disparities in the universal healthcare system of Canada, Siddiqi et al. (Siddiqi, Wang, Quinn, Nguyen & Christy, 2016) also considered having a regular physician as a measure of access to health care. The researchers utilized secondary data from the five cycles of the CCHS that provided responses from 581,989 individuals. They found that visible minorities, other than South Asians, Chinese, and Filipinos, were less likely than Whites to have a regular physician. This was especially true for the Latin American and Aboriginal population. The researchers called for further research to determine additional measures to reduce existing disparities.

Subedi and Rosenberg (2014) utilized the same data from the 2000-2001 and 2010 cycles of the CCHS to compare the responses of immigrants to Canada with those of the Canadian-born respondents and how these differed over the 10 year period. They supported the findings by Newbold (2009) and Siddiqi et al. (2016) and added an association between the decline in health--and the corresponding increase in GP consultations--and lifestyle changes of immigrants over time in terms of increased body weight, decreased physical activity, and increased potential for drinking alcohol. Interestingly, even though the increased BMI with length of stay in Canada was found to be the case across all immigrant groups, the rate remained below that of the Canadian-born population with the exception of immigrant White males whose increased BMI was comparable to Canadian-born men (Setia et al., 2009).

Immigrants also reported a higher incidence of chronic conditions, such as diabetes, heart disease, and arthritis, than the Canadian-born population (Newbold & Danforth, 2003). Again, this incidence varied across immigrant groups and length of stay in Canada. Long-term immigrants (more than 10 years in Canada) from South Asia, the

Caribbean, Central and South America, and Sub-Saharan Africa were more likely to report having diabetes than the Canadian-born population (Creatore et al., 2010; Rotermann, 2011). The incidence of arthritis, however, was much more prevalent among long-term immigrants from Europe than among other immigrants or the Canadian-born population (Rotermann, 2011). Interestingly, the incidence of chronic conditions was found to have an inverse relationship with improved socioeconomic status, social networks, access to healthcare services, and the cultural competence of providers (Creatore et al., 2010; Newbold & Danforth, 2003).

The mental health status of recent and long-term immigrants was also compared to that of the Canadian-born population. In their analysis of the data from the three waves of the LSIC (2001-2004/05), Robert and Gilkinson (2012) found variation among the immigrant group itself with higher incidences of mental distress and emotional problems being reported by immigrants four years after they arrive than when they first land in Canada; by women more than men; by older women more than younger women; and by women from South and Central America, Africa and the Middle East more than by women from Western Europe, the United Kingdom, and the United States. When compared to the Canadian-born population, and despite the increase in reported emotional distress within the first four years in Canada, immigrants, especially non-European immigrants, were still less likely to report psychological distress than the Canadian-born population, even twelve years later (Setia et al., 2012). This trend, however, is reversed in regards to postpartum depression, with higher incidences being reported with immigrant women from non-European countries, regardless of generation and length of stay in Canada (Urquia, O'Campo, & Heaman, 2012).

In general, immigrants to Canada have lower mortality rates--or higher life expectancy--than the Canadian-born population despite the decline in health over the years (Ng, 2011). When broken down by sex and country or region of origin, the data differs slightly, with women from the United States and Sub-Saharan Africa having similar mortality rate as Canadian-born women (Ng, 2011) and women of South Asian origins having higher mortality rates due to heart disease than Canadian-born women (Omariba, 2015). Trovato and Odynak (2011) found that the lower mortality rate among immigrants could be attributed to overall fewer deaths from heart disease and cancer.

The Health of Immigrant Women in Canada

The decline in health was found to be more dramatic for women than for men, and more so for women from non-European origins (Fuller-Thompson et al., 2011; Kim et al., 2013; Kobayashi & Prus, 2012; Newbold & Danforth, 2003; Ng et al., 2011; Setia et al., 2012). Studies comparing the health of immigrant women to that of Canadian-born women found that immigrant women, though they had the same access to maternity care, were less likely to receive adequate information to support their emotional and physical wellbeing, leading to a higher number of C-sections and assisted births (Mumtaz, O'Brien, & Higginbottom, 2014). These studies also confirmed that a visible minority status is a reliable predictor of decline in self-rated health (De Maio & Kemp, 2010; Kobayashi & Prus, 2012; Setia et al., 2011; Ng et al., 2011; Subedi & Rosenberg, 2014). Women immigrating from countries other than Europe, the United States, and the United

Kingdom, were more likely to report a decline in their physical and mental health status (Setia et al., 2012); were at a higher risk for chronic illness (Chiu et al., 2012; Creatore et al., 2010); were more likely to face barriers to access to care (Dean & Wilson, 2010; Fuller-Thompson et al., 2011); had a higher risk of preterm delivery, ill-health during pregnancy, and postpartum depression (Urquia et al., 2012); and were more likely to feel isolated and lonely due to loss of social capital upon immigration (Hynie et al., 2011). In addition to an association with sex, gender, and ethnicity, the decline in health was also associated with socioeconomic factors, language proficiency, and discrimination (Kim et al., 2013).

Qualitative studies of the experiences of immigrant women with the healthcare system helped shed light on some of these associations. One such contribution was a better understanding of the barriers immigrants face when accessing health care services that expanded to include sociocultural, linguistic, geographic, and socioeconomic barriers, as well as provider cultural incompetence (Asanin & Wilson, 2008; Dastjardi et al., 2012; Wood & Newbold, 2012). Another contribution was the understanding of how immigrant women viewed health as much more than physical wellbeing and rather as the result of the interaction between the social, spiritual, mental, and environmental dimensions (Guruge & Humphreys, 2009; Guruge et al., 2010; Weerasinghe & Mitchell, 2007). This view might be at odds with a biomedical understanding of health. And, lastly, these studies highlighted the perceptions of discrimination, disrespect, and lack of cultural sensitivity that immigrant women experienced when they accessed the healthcare system (Reitmanova & Gustafson, 2008; Weerasinghe, 2012; Weerasinghe & Mitchell, 2007). However, many of the studies that investigated female immigrant health concentrated on provider perspective of the issue (Ng & Newbold, 2011; Teng, Blackmore, & Stewart, 2007), or on a particular risk or disease presentation. These presentations included breast and cancer screening (Donnelly & McKellin, 2007; Guruge, Maheu, Zanchetta, Fernandez, & Baku, 2011; Redwood-Campbell, Fowler, Laryea, Howard, & Kaczorowski, 2011), mental health (Donnelly et al., 2011), reproductive health (Gannan, Sword, Black, & Carpio, 2012; Guruge et al., 2010; Higginbottom et al., 2013; Mumtaz et al., 2014; Ng & Newbold; 2011; O'Mahony, Donnelly, Bouchal, & Este, 2013; Reitmanova & Gustafson, 2008; Urquia et al., 2012; Wilson-Mitchell, 2014), or partner abuse (Ahmad, Driver, McNally, & Stewart, 2009; Guruge & Humphreys, 2009).

Synthesis of the Literature

As mentioned earlier, the findings from many of the studies investigating the health of immigrants and immigrant women reported the results of analysis of secondary data sets from the Canadian Census, the Canadian Community Health Survey (CCHS), the National Population Health Survey (NPHS), and the Longitudinal Survey of Immigrants to Canada (LSIC). The Census and the CCHS provide cross-sectional data that allow comparisons between the immigrant population and the Canadian-born population, but do not offer an opportunity to examine changes over time (Statistics Canada, 2016). The LSIC had an ideal design for following the same participants over time and provided invaluable information. The design, however, did not allow comparison with the Canadian-born population and the four-year duration was too short for it to provide an opportunity to examine the impacts of resettlement and integration. The NPHS design was that of a true longitudinal study with the same 17,276 individuals followed over 12 years (1994/1995-2006/2007) with nine cycles of data collection (Statistics Canada, 2016). Attrition resulted in a final sample of 3081 males and 4187 females (Setia et al., 2011). When this sample is broken down further by Canadian-born versus immigrant, the numbers become very small--6,399 Canadian-born, 643 White immigrants, and 226 non-White immigrants (112 men and 114 women) (Setia et al., 2011). The small numbers beg the question of how representative of the immigrant population this sample truly is.

The definition of *recent immigrant* also differed among the studies. Some studies, those utilizing the LSIC and some of the studies utilizing the NPHS, did not define it and followed the four years or twelve years life-span of the longitudinal studies, respectively (De Maio & Kemp, 2010; Fuller-Thompson et al., 2011; Ng et al., 2011; Setia et al., 2009; Setia et al., 2011; Setia et al., 2012). Other studies utilizing data from the NPHS and the CCHS varied by either identifying a range of years (Kobayashi et al., 2008) or considering ten years (Kobayashi & Prus, 2012; Ng et al., 2005; Rotermann, 2011; Subedi & Rosenberg, 2014) or fifteen (Chiu et al., 2012) as the cutoff limit.

Statistical analyses of survey data establish associations between factors but do not determine the nature of that relationship. For instance, even though we know that there is an association between ethnicity and self-reported health status with length of stay in Canada, we cannot make any conclusions about the nature of the association. There is a need for qualitative approaches to explore the transition and integration process that immigrants to Canada follow and the impact of this process on their lives and health as it intersects with additional individual, systemic, and environmental factors (Dean & Wilson, 2010; Wang & Kwak, 2015).

The studies pointed to the need for qualitative methodologies to hear the narratives of lived experiences that cannot be provided by numbers in a national survey (Adhikari & Sanou, 2012; Asanin & Wilson, 2008). They also stressed the need to study the intersection of risk factors and determinants of health with structural and systemic determinants rather than utilizing a linear or single-factor approach to studying the issue (Dastjerdi et al., 2012; Levy, Ansara, & Stover, 2013).

The next section will present the social determinants of health from the Canadian perspective. It will help narrow the focus on the determinants of health of the immigrant population, and more specifically, immigrant women who are members of visible minorities.

The Social Determinants of Health: Multiple Jeopardies

The Public Health Agency of Canada (PHAC) identified twelve key determinants of health that are the focus of the population health program approach for the federal agency. These are: “1) income and social status, 2) social support networks, 3) education and literacy, 4) employment or working conditions, 5) social environments, 6) physical environments, 7) personal health practices and coping skills, 8) healthy child development, 9) biology and genetic endowment, 10) health services, 11) gender, and 12) culture” (PHAC, 2011). Of note, the agency included in the list both individual characteristics (e.g. biology and genetic endowment, gender, and culture) as well as social determinants (e.g. income and social status). Mikkonen and Raphael (2010) expanded the list into 14 social determinants that include: (a) Aboriginal status, (b) disability, (c) early life, (d) education, (e) employment and working conditions, (f) food insecurity, (g) health services, (h) gender, (i) housing, (j) income and income distribution, (k) race, (l) social exclusion, (m) social safety network, and (n) unemployment and job security.

Immigrants who are members of visible minority groups in Canada have many of these determinants intersecting in their lives, which prompted the call to include immigration (De Maio, 2010) and racism (Hyman, 2009) as additional determinants of health. Immigrant women who self-identify as a visible minority have the additional factors of gender, economic dependence on a spouse (Oxman-Martinez et al., 2005); income inequality, higher levels of under- and unemployment, and lack of acceptance of their education (Hudon, 2016; Dean & Wilson, 2009; Suto, 2009); incidences of discrimination and racism (Reitmanova & Gustafson, 2008; Weerasinghe, 2012; Weerasinghe & Mitchell, 2007); loss of a social network upon immigration (Hynie et al., 2011); poverty (Hudon, 2016); and barriers to access to healthcare service (Dean & Wilson, 2010; Fuller-Thompson et al., 2011); to name a few. To date, researchers have examined the impact of one or more of these factors in the lives of immigrant, visible minority women. However, research approaches have neglected, to a large extent, the multiplicative--rather than additive--intersection of those factors and their impact on the lives of immigrant women (Hancock, 2007).

> “Health researchers are in a unique position to best support this process by devising methodologies which not only enable a more systematic integration of complex social identifiers (e.g. sex, gender, ethnicity, and migration), but they also describe how such findings can be concretely integrated into existing health policies” (Vissandjee, Hyman, Spitzer, Apale, & Kamrun, 2007, p. 41).

Theoretical / Conceptual Framework

I utilized the feminist intersectionality framework as the theoretical lens to conceptualize this research study. Feminist intersectionality had its beginnings in Black feminism in the United States and the name was first coined by the critical race scholar Kimberle Crenshaw in 1989 (Crenshaw, 1989; Hankivsky, Cormier, & de Merich, 2009). The concept was first introduced to point to the need to include the experiences of Black women in feminist and antiracism discourses as the first centered on the experiences of White women and the second on those of Black men (Crenshaw, 1989; McGibbon & McPherson, 2011). Intersectionality points to the intersection of sexism and racism as a double jeopardy in the reality of Black women’s lives and the need to include that intersection in research paradigms from which it had been absent (McGibbon & McPherson, 2011, p. 60). Intersectionality provides a unique perspective on how points of oppression--that include sex, gender, and ethnicity--intersect with other social and structural dynamics, such as racism and discrimination, to shape the reality of individuals’ experiences and their health (Hankivsky, 2012; Hankivsky, 2014).

Feminist intersectionality is grounded in principles of social justice and has four foundational tenets (Rogers & Kelly, 2011). First, intersectionality focuses on identifying and eliminating social injustices. In order to do so, the researcher is required to be subjective in order to gain knowledge about health and social disparities. Second, dimensions of difference, such as gender and ethnicity, are socially constructed in time and space. They are not linear and cannot be treated as independent variables. Third, "Power relationships exist at the macro level of social systems and institutions and the micro level of interpersonal relationships" (Rogers and Kelly, 2011, p. 399). Fourth, the intersection of points of oppression, such as racism, sexism, and classism, generates a multiplicative rather than an additive effect that produces and sustains disparity and exclusion (McGibbon & McPherson, 2011; Rogers & Kelly, 2011).

McGibbon and McPherson (2011) have conceptualized Feminist Intersectionality within Complex Theory and have proposed the intersection of three contexts of oppression in determining the health outcomes of immigrant women experiencing the Healthy Immigrant Effect. The first context is that of the intersection of the fourteen social determinants of health as offered by Mikkonen and Raphael (2010) and presented in a previous section. The second context is that of the intersections of social identity and includes age, culture, (dis)ability, ethnicity, gender, immigration status, race, sexual orientation, social class, spirituality, and so forth. This context also represents the "isms" where sexism, racism, classism, and so forth result in a decline in the health of immigrant women after immigration. The third context is that of the geographic determinant of health where location would impact access and environmental patterns.

Intersectionality, as a framework, is not prescriptive of the methodology to be employed in conducting intersectionality research and, as a result, has been perceived as failing to achieve its potential (Choo & Ferree, 2010). The following section, however, will provide three examples of research studies that utilized the intersectionality framework to guide the analysis.

In the first study, Lee and Sum (2011) employed a participatory action research methodology to explore the perceptions of a group of young racialized women of their health and identity. The researchers conceptualized the study through the lens of transnational and postcolonial feminist theories and utilized the feminist intersectionality framework for the analysis. The participants were eight young women who had experiences of racialization and were willing to share their time and experiences through Photovoice, a participatory action research methodology. Data was collected by asking the young women to engage in creative photography and self-reflexive journaling. The researchers utilized an intersectionality analysis around the concepts of identity, health, and wellbeing. The findings included the following themes: "1) self-understandings of health; 2) mobility, identity, and health; 3) living between worlds; and 4) finding balance" (Lee & Sum, 2011, p. 153).

In the second study, Kobayashi and Prus (2011) adopted an intersectionality perspective to consider the Healthy Immigrant Effect in mid- to later life. The researchers utilized a quantitative methodology to examine the impact of gender, age, and ethnicity on the health of immigrants. Using secondary data from the 2005 cycle of the CCHS, the researchers examined the impact of the intersection of gender, age, and ethnicity on self-rated health status, the presence of chronic conditions, and the presence of activity restrictions. The findings from the study were consistent with the conclusions shared earlier in this chapter around the healthy immigrant effect. The researchers did, however, acknowledge the limitations of utilizing a quantitative methodology solely for this study and recommended a mixed method approach for future studies.

The third study was conducted by Hulko (2011) who utilized the intersectionality perspective to explore the later life experiences of dementia with eight participants and their families. The researcher conceptualized the phenomenon with intersections of privilege rather than oppressions as the participants were White, middle class, and provided with multiple supports. The researcher conducted a qualitative study and collected data through interviews, observations, photography, and photo elicitation. A grounded theory approach was used for the data analysis and resulted in a theory of dementia and intersectionality.

The dramatic decline in health status of immigrants, and especially immigrant women, shortly after their arrival in Canada suggests postimmigration dynamics of inequity that impact health and acculturation (Kim et al., 2013). There were variations in the patterns and severity of health deterioration among the immigrant populations prompting the need to examine the impact of the intersections of social and structural determinants of health with the social identity of the immigrants. Considering the intersection of sex, gender, ethnicity, and migration in the lives of the visible minority immigrant women in Canada, a feminist intersectionality framework is the most appropriate to study the intersection of these points of oppression and their impact on the health of the women. The majority of the studies reviewed point to the need for an integrated approach to the research with the immigrant women population where health is viewed as the outcome at the intersection of social location (social determinants of health), structural and social processes (structural determinants of health), and geographical location (McGibbon & McPherson, 2011).

Summary and Conclusions

In this chapter, I provided a brief overview of the HIE phenomenon and situated it within the context of immigration policies and the health care system in Canada. To provide more detail to the context, I also gave an overview of the demographics of the Canadian population and the increasing numbers of immigrants to Canada. What causes alarm is the dramatic postimmigration decline in the health of immigrants, especially visible minority immigrant women, which is the outcome of the intersection of multiple social and structural points of oppression in their lives.

Researchers studying this phenomenon had examined the health of immigrants and immigrant women as impacted by one or two factors at a time. Researchers had stressed the association between health outcomes on one hand and the social determinants of health on the other. Research studies on the experiences of immigrants with the healthcare system had been limited to either a specific population or a specific etiology. They had not been expanded to explore those experiences at the intersection of social identity with structural social determinants of health especially at the point of encounter with the healthcare system. No studies were found that examined the experiences of visible minority immigrant women in particular with encounters with the healthcare system at the intersection of their social identity with structural points of oppression. The current study did so in a diverse city in Canada, where no such study had been done before.

In the next chapter I will explore a particular methodology for conducting the study utilizing feminist intersectionality as a theoretical framework. Considering the intersection of political and structural determinants of health with the social identity of the participants, I undertook a qualitative approach using an interpretative phenomenological methodology for this study.

Chapter 3: Research Method

This interpretative phenomenological study was designed to explore the lived experiences of immigrant women who self-identify as belonging to a visible minority with encounters with the healthcare system in Ottawa, Canada. The narratives of the experiences extended to the three periods prior to, during, and after the encounters with the health system. This approach allowed me the opportunity to listen to the perspective of the participants regarding their understanding of health and access to health care services. I explored with them the barriers that might have had an impact on them accessing healthcare services, experiencing healthcare services, and following the recommended follow-ups, interventions, and treatments.

In this chapter, I describe the methodology for the study. I begin by restating the research questions, reintroducing the central phenomenon being studied, and identifying and justifying the research tradition that was utilized. In the second section, I describe the role I played as the researcher in collecting and interpreting the data. A description of the data collection and data analysis procedures follows in section three. I conclude with a section on how I addressed issues of trustworthiness and ethical concerns.

Research Design and Rationale

This study addressed the following research question: What is the perspective of immigrant women in Ottawa, Canada, of their lived experiences with encounters with the healthcare system when there is an intersection of the factors of sex, gender, ethnicity, and immigration in their lives?

Additional subquestions included:

- What meanings do immigrant women in Ottawa, Canada, attribute to health, healthcare services, and access to health services?
- How do they describe the impact of the immigration experience on their experiences with healthcare services?
- How do they describe the impact of their ethnicity on their experiences with healthcare services?
- How do they describe the impact of their gender roles on their experiences with healthcare services?
- How do they describe barriers to access to healthcare services that they might have encountered prior to, during, and following the encounter with the healthcare system?

As such, the central phenomenon being studied was the lived experiences of immigrant women who self-identify as belonging to a visible minority with encounters with the health care system. The narratives extended to the three contexts of prior to, during, and following the encounter. Immigrant women from visible minority populations in Canada have reported the most health disadvantage following immigration. Literature proposes that their experiences are impacted by the intersection of multiple determinants of health in their lives. Our understanding of their experiences will help guide future research, policy, and services.

Though longitudinal studies designed to allow researchers to follow the immigration and acculturation process of immigrants to Canada are ideal, the cost and potential rate of attrition would make them less feasible. This study aimed to capture a portion of this lived experience, especially encounters with the healthcare system, through an interpretative phenomenological analysis (IPA) approach. “IPA is concerned with the detailed examination of personal lived experience, the meaning of experience to participants, and how participants make sense of that experience” (Smith, 2011, p. 9).

An IPA approach combines the three traditions of phenomenology, hermeneutics, and idiography in order to understand the particular essence and meaning of a lived experience from the perspective of a particular group of people who have lived it in a particular context (Smith, 2011; Smith et al., 2009/2013). A phenomenological approach is best suited for the study of lived experiences (Patton, 2002) as it aims to retrospectively gain “a deeper understanding of the nature of meaning of our everyday experiences” (van Manen, 1990, p. 9). Hermeneutics is concerned with the interpretation of a text and had its foundation in the traditions of interpreting myths, legends, and biblical texts (Patton, 2002; Smith et al., 2009/2013). Idiography, on the other hand, is more concerned with the particular details of an experienced phenomenon (Smith et al., 2009/2013). Combining the three traditions of phenomenology, hermeneutics, and idiography in IPA allowed me the opportunity to make sense (interpretation: hermeneutics) of the lived experiences (lived experience: phenomenology) of immigrant women with encounters with the health care system in Ottawa, Canada (particular: idiography) when they are experiencing the intersection of sex, gender, ethnicity and immigration in their lives.

Role of the Researcher

As a research instrument in qualitative approaches, the researcher is engaged in the study during every aspect of data collection and data analysis (Maxwell, 2013, Miles et al., 2014). In this study, I conducted the interviews personally in order to “enter into the [participants’] perspectives and gather their stories” (Patton, 2002, p. 341). Additionally, after the audio recordings of the interviews were professionally transcribed verbatim, I verified the transcription by reading and rereading the transcripts while listening to the audio recording. This allowed me to immerse myself in the data as a beginning step towards the data analysis and interpretation phase.

I do not have any professional or personal relationship with any of the participants from OCISO, the originally proposed site for recruitment. This organization provides resettlement services and day programs to a large number of immigrants to Ottawa (OCISO, 2016). I had previously collaborated with this organization on a separate research project that recruited participants from OCISO and had, thus, established a collaborative relationship with the staff and leadership. Building on this relationship, I approached the leadership of the organization to raise awareness of the study and to request access to the premises to place the information flyers. I do not work or volunteer at OCISO and, beyond the above-mentioned collaboration, have had no other professional or personal relationship with the organization. The staff members at OCISO were not involved in the recruitment of participants. Women interested in participating were invited to contact the researcher directly through flyers placed at the organization offices, thus, avoiding any potential for coercion. Participation was voluntary, and the participants had the option to withdraw from the study up until the report-writing phase (Smith et al., 2009/2013).

As an immigrant woman from a visible minority, my experiences with encounters with the health care system in Canada might be construed as a personal bias. However, as a registered nurse who is fluent in both official languages, and who had not experienced many of the barriers to healthcare that other immigrant women experience, I did not approach the interpretation of these experiences with strong biases. My personal motivation for pursuing this topic stemmed from experiences with navigating the healthcare system on behalf of patients and family members who had experienced barriers to access because of the intersection of multiple factors in their lives. As a result, I felt the need to understand their perspective and how they had made sense of these experiences. This motivation strengthened my approach to the topic (Maxwell, 2013). However, in order to minimize any bias, I documented my experiences in a separate reflective journal in order to bracket off my preconceptions. Keeping a journal is especially important in the data collection and analysis phases of IPA (Smith et al., 2009/2013).

Methodology

Smith et al. (2009/2013) and Smith (2011) recommend semistructured, in-depth, individual interviews as the preferred method of data collection in IPA. Individual interviews allow the researcher to hear the perspectives and narratives of the participants who have lived the experience and are able to reflect upon it (Maxwell, 2013; Patton, 2002; Smith et al., 2009/2013). As such, I utilized semistructured individual interviews as the primary method of data collection. I will describe this methodology in depth in this section of the chapter.

Population

I purposively selected the participants to have experienced the phenomenon under study. The selection was purposive because the participants needed “to represent a perspective rather than a population” (Smith et al., 2009/2013, p. 49). They were immigrant women who self-identified as belonging to a visible minority in order to capture the multiplying effect of the intersection of sex, gender, ethnicity, and immigration in their lives.

I approached adult women between the ages of 18 and 64 who had been in Canada more than four years but less than 10 to participate in the study. The lower age limit was selected to avoid the ethical implications of interviewing participants who were not able to give legal consent to an interview. The higher age limit of 64 years was selected based on the evidence that immigrant visible minority women over the age of 65 had actually reported better health status than Canadian-born women of the same age bracket (Kobayashi & Prus, 2012) and, as such, did not seem to experience the same decline in health status as younger immigrant women. Additionally, the time limit of having been in Canada between four and 10 years was based on the findings in the literature that had proposed that the decline takes place within the first four years after immigration but that the health status levels off to the same level as the Canadian-born population after ten years (Lebrun, 2012; Setia et al., 2011).

The participants were selected to have had an encounter with the healthcare system in the previous year, as they needed to be able to describe and reflect upon that experience. The stories of the encounters covered the period prior to, during, and following the encounter. This allowed the participants to share their perceptions of access to, experience of, and follow-up to the healthcare encounters and how these might have been impacted by the intersectionality of the determinants of health in their lives. Finally, the participants were selected to be able to communicate in English, French, or Arabic, as these are the three languages most spoken in Ottawa (Statistics Canada, 2012) and that I can communicate in.

The study aimed to recruit the first few participants through flyers placed at the OCISO offices. The flyers were in the three languages selected and specified the inclusion criteria as well as the contact information for the researcher. The participants were invited to communicate with the researcher directly. Only those who met the inclusion criteria were invited to the interviews.

As IPA is primarily concerned with the details of the narrative of the lived experience under study, the focus is on the quality and depth of the narrative rather than the number of experiences (Smith, 2011; Smith et al., 2009/2013). As such, a small number of participants or interviews is preferred. Smith et al. (2009/2013) recommended three to six participants with no more than 10 interviews conducted with them. They posited that, with a smaller number of participants, the interviewer is able to delve more deeply into the detailed stories to explore the phenomenon and is not in danger of being overwhelmed by the amount of data generated from a large number of interviews.

Additionally, as I had planned to conduct the data analysis simultaneously with the data collection, I was able to determine when data saturation occurred. Data saturation is achieved when themes start recurring and when no new themes or findings emerge from the data analysis (Miles et al., 2014). Recruitment was concluded at that stage.

Instrumentation

I utilized three instruments to collect data during the individual interviews. The first instrument was a demographic questionnaire (Appendix B) that the participants completed at the beginning of the meeting. The questionnaire provided data on the age of the participant, length of time in Canada, country of origin, self-identified ethnic status, educational level, employment status, marital status, presence of dependents, history of and reasons for accessing the health care system, health status when she first arrived in Canada, and current health status. The purpose of the questionnaire was to determine which social, cultural, and economic factors were at play in the life of the participant.

The second instrument was the interview protocol (Appendix C). The researcher had developed the instrument in order to guide the actual interview process and provide a minimal structure to the interview itself. The questions were designed to build on each other and “were drawn directly from the research questions themselves” (Maxwell, 2013, p. 100).

The demographic questionnaire and the interview protocol were designed to capture data about each of the indicators identified in the conceptual framework and to probe for their intersectionality and impact on the participant’s encounter with the healthcare system. I had evaluated the tools in a pilot study with peers. Once they responded to both instruments, the participants in the pilot were asked to provide their feedback utilizing a particular reviewer feedback tool (Appendix E). I then incorporated their comments into the two instruments.

The third instrument was a template for the field notes that were collected during the visit with the participants and data analysis (Appendix D). I based it on the observation protocol described by Creswell (2013) and it was designed to capture descriptive, as well as reflective notes, from each interview. Descriptive field notes are the product of the process of transforming observations and interactions into words (Emerson, Fretz, & Shaw, 2011). Writing field notes “helps the researcher to understand what he has been observing in the first place and, thus, enables him to participate in new ways, to hear with greater acuteness, and to observe with a new lens” (Emerson et al., 2011, p. 19). As such, field notes reflected my sense-making of what I was observing and hearing and provided depth to the actual interview transcripts (Emerson et al., 2011). To ensure that the field notes captured accurately the interview process, I documented my impressions and thoughts in a separate column from the actual description of the interview (Creswell, 2013; Emerson et al., 2011). I utilized data from the three instruments during the data analysis phase.

Sampling and Data Collection

A not-for-profit organization in Ottawa, OCISO offers resettlement and integration services and supports to new immigrants (OCISO, 2016). The organization has two offices located in two of the most diverse neighbourhoods in the city. Recruitment was initiated in the two locations through flyers that were placed in the waiting and common areas (Appendix F, English version of the flyer). The documents were made available in English, French, and Arabic, the three languages that were used for the interviews.

I invited potential participants to contact me directly by email or by phone. During the call or through the email message, I verified that the caller met the inclusion criteria and outlined the time commitment of one hour for the interview and the specifics of subsequent participation in verifying interview transcripts and study findings. The potential participants were made aware of their right to withdraw from the study at any time up until the report was prepared, that the interview will be audio-recorded, and that their input and feedback will be needed to verify the interview transcripts and the study findings. If the potential participant was in agreement, she was asked to confirm a mutually appropriate time and location for the interview.

The interviews were held at a location chosen by each participant and were conducted in English, French, or Arabic, depending on the fluency and comfort level of the participant. I asked the participants to complete the demographic questionnaire (Appendix B) at the beginning of the interview. I had designed the interview to be approximately one hour long to allow the participant to share her story at length.

The interviews were audio-recorded using a mobile phone application and were transcribed verbatim as soon as possible after the interview. I then shared the interview transcripts with the participants to verify accuracy and to allow the participants the opportunity to add additional clarifications. The transcripts were shared by email or mail, as per participants' preferences.

I then reminded the participants that they would be contacted a third time at the end of the study to verify with them the themes that emerged from the data analysis. Again, their preference as to the mode of consultation, in person or by email, was ascertained at that time.

At the end of each interview, I asked each participant if she knew of anyone else who met the inclusion criteria and who could be interested in participating in the study. I then asked them to share my contact information with the potential participants for them to communicate with me directly. This snowballing technique helped me recruit an appropriate number of participants from within the immigrant community.

Data Analysis Plan

In addition to the interview transcripts and demographic questionnaires mentioned in the previous section, I kept field notes for each interview. The interviews were semistructured and utilized open-ended questions allowing me the opportunity to probe for details about the lived experience for a rich narrative. The demographic questionnaire provided additional data in regards to the intersection of other cultural, economic, and social determinants of health in the lives of the participants. The field notes provided additional context for the data analysis (Rudestram & Newton, 2007). I utilized the demographic questionnaires, interview transcripts, and field notes in the data analysis.

I conducted the interviews and verified the verbatim transcription of the interviews in order to immerse myself in the stories of the participants. I also developed a spreadsheet to log data from the demographic questionnaires and linked them via a unique identifier to the interview transcripts and field notes. Because I collected data in three different languages, I utilized Atlas Ti as the data management program because of its versatility with different languages (ATLAS.ti, 2016).

Since meanings can be lost in translation and to preserve the original meaning of the narratives shared by the participants, I conducted the data analysis of each interview transcript in both the original language and the translated English version. The data analysis process followed the process outlined by Smith et al. (2009/2013) as pertaining to the interpretative phenomenological approach (IPA). I conducted a thorough line-by-line analysis of the interview transcripts and field notes and identified emerging patterns and assigned codes. As I read the data sets multiple times, significant expressions and sentences emerged from the data, which I then coded using the participants' own words (in vivo) as much as possible (Creswell, 2013; Maxwell, 2013; Miles et al., 2014). Codes, as "labels that assign symbolic meaning to the descriptive or inferential information compiled during a study", allowed me the opportunity to categorize and retrieve similar data portions across the data sets (Miles et al., 2014, p. 71).

I then compared the emerging codes within and across data sets for commonality and divergence as part of the "iterative and inductive cycle" of the IPA approach that moves from "the descriptive to the interpretative" (Smith et al., 2009/2013, p. 79). As I became more and more immersed in the data, I was able to develop a structure that illustrated the relationship between the themes through my own intrinsic psychological knowledge and interpretation of the narratives (Smith et al., 2009/2013). As coherence between the themes was established, a narrative emerged from the data that described the full story via a representation of the themes and the relationship between them (Smith et al., 2009/2013).

Issues of Trustworthiness

Maxwell (2013) posited that validity of the data cannot be fully guaranteed in qualitative research. This section will outline how I ensured, as much as possible, the credibility, transferability, dependability, and confirmability of the data and the findings.

Credibility

The credibility or internal validity of a study refers to whether the findings of the study are clear and make sense (Miles et al., 2014). I established the credibility of the conclusions in the current study through member checks (Miles et al., 2014). As themes emerged from the data analysis, I interpreted them and the relationship between them. I then shared them with the participants to ensure that they are congruent with their life experiences and stories. Additionally, as I conducted the data analysis simultaneously with the data collection, I was able to establish when data saturation took place as themes started repeating. Data saturation is another measure of credibility (Miles et al., 2014).

Transferability

Secondly, external validity of the research refers to transferability to other settings and contexts (Miles et al., 2014). Miles et al. (2014) emphasized the importance of transferability versus generalizability of findings when addressing external validity in qualitative research. I will provide detailed descriptions of the procedures I followed and participants I interviewed in the following chapter to allow for their application in other settings (Miles et al., 2014; Rudestram & Newton, 2007).

Dependability

Thirdly, dependability of a qualitative study refers to the care by which it was conducted that will allow its replication under similar circumstances and that ensures the accuracy of the data collected (Rudestram & Newton, 2007). To ensure dependability, I will provide a detailed description of the coding scheme in the following chapter. I also ensured that all interviews were audio-recorded and transcribed verbatim and that the field notes were used appropriately to provide context for the transcripts of the digital recordings. Symbols were used within the transcripts to describe nonverbal communication, such as laughing, crying, or pauses.

Confirmability

Lastly, confirmability refers to the qualitative counterpart of objectivity in quantitative research (Miles et al., 2014). To address the issue of confirmability, and in addition to the detailed description of all processes, procedures, and methods, I bracketed my personal bias (Miles et al., 2014) as an immigrant woman from a visible minority. I documented my experience in a reflective journal that I kept throughout the data collection and data analysis phase to help me mitigate my bias. Additionally, the transcripts of the interviews and a codebook were retained on file and can be made available for others to analyze and confirm findings (Miles et al., 2014).

Criteria Specific to IPA

Smith et al. (2009/2013) posited that IPA can best meet the criteria for validity by conforming to the four characteristics identified by Lucy Yardley (2000) for the field of psychology. These included (a) sensitivity to context, (b) commitment and rigour, (c) transparency and coherence, and (d) impact and importance (Yardley, 2000, p. 219).

Sensitivity to context refers to the ability of the researcher to show sensitivity to the context of the research study through every aspect of the process and, particularly, to the participants through attention to their environment, their stories, and the congruence of the findings to their perceptions (Smith et al., 2009/2013; Yardley, 2000). For this particular study, I demonstrated sensitivity to context by continuing to treat the participants as “experiential experts” (Smith et al., 2009/2013, p. 180) rather than as a sample. As such, the final report contains as many extracts from the interview transcripts as possible to support the interpretations and to give the participants voice (Yardley, 2000). Their sociocultural background was respected, and their stories were elicited with empathy and respect. The participants were consulted as to the accuracy of interpretations made from the data and, once verified, these interpretations were also related to relevant literature (Smith et al., 2009/2013; Yardley, 2000).

The characteristic of commitment and rigour refers to the degree of care taken in the data collection, data analysis, and reporting (Smith et al., 2009/2013). I ensured that the participants were selected to match the criteria of the study and that their stories were attended to through in-depth, thorough interviews (Smith et al., 2009/2013). I also ensured that the data analysis respected the meaning that the participants attach to the experience and reported the meaning of the experiences rather than their superficial description (Smith et al., 2009/2013). I supported themes that emerged from the data by multiple quotations from the participants to ensure rigour (Smith et al., 2009/2013).

The third principle or characteristic that Smith et al. advocated for in IPA is that of transparency and coherence (Smith et al., 2009). The principle of transparency refers to the clarity by which the researcher communicates the research process in the final report (Yardley, 2000). In IPA, the researcher can demonstrate that through a thorough description of the methods of participant selection, data collection, interviewing, and data analysis and interpretation (Smith et al., 2009/2013). To that end, I have presented this information in high detail in the following chapter to ensure transparency. Additionally, Yardley (2000) advised that the principle of coherence lies in the researcher's ability to present a coherent argument for the selection of an approach. For readers to be convinced that the research indeed follows the principles of IPA, they "should be aware that they are positioned as attempting to make sense of the researcher trying to make sense of the participants' experience" (Smith et al., 2009/2013, p. 182).

The fourth and final principle is that of impact and importance (Yardley, 2000). In IPA, that principle is attained when the researcher aspires to conduct and disseminate research that is useful and interesting (Smith et al., 2009/2013). This will be further demonstrated in the final chapter.

Ethical Procedures

I received ethical approval from Walden University Institutional Review Board (IRB) once the proposal was approved by the dissertation committee and defended successfully. No organizations were approached or participants recruited before full IRB approval was received from the University. The original site for recruitment, OCISO, was not involved in the recruitment beyond the housing of the recruitment flyers in the waiting and common areas of the two office complexes. As such, no IRB approval was required from OCISO. I did, however, contact the executive director of the organization to discuss the research and obtain permission to place the flyers on site. To that end, I also executed a letter of cooperation with the leadership that was submitted as part of the ethical approval process with Walden University.

I placed a number of flyers about the study in the waiting and common areas at OCISO offices (Appendix F, English version). The flyers posted were in three languages, English, French & Arabic. The documents invited the potential participants to contact the researcher. No coercion or incentives were used in the recruitment. Participation was voluntary, and the participants were made aware of their right to withdraw from the study at any time up until the report-writing phase. Participants who were recruited through a snowballing technique were also made aware that their participation was voluntary. I shared an information letter (Appendix G) with the participants as a method of obtaining informed consent. The letter outlined the purpose of the research, the rights of the participants, the assurance of confidentiality, the potential benefits and risks of the study, and the extent of the demand on the participants' time. Participants were free to participate in or withdraw from the study should they so wish. They were also given the option of skipping any question that could elicit distress or emotional discomfort. Even though the participants did not receive payments or incentives, I offered each participant a $20.00 gift certificate for their generosity in sharing their time and stories.

To ensure confidentiality, I assigned a unique identifier and a pseudonym to each participant. The unique identifier appeared on every data record. The actual names only appeared on the consent forms, which I kept in a locked cabinet in my home office. I am the only person with access to the consent forms and data sets. A list of participant names, contact information, and corresponding pseudonyms and unique identifiers was kept with the consent forms, separate from the interview transcripts, demographic questionnaires, and field notes.

When writing the final report, I did not use any of the names of the participants and used the pseudonyms instead. This practice will also extend to any presentations or publications that will follow. I will destroy the datasets five years after the study is completed and the final report defended. Paper copies of the datasets will be shredded and recycled. Digital records of interviews and data sets will be kept on a separate encrypted drive that will be formatted and overwritten after five years.

Summary

In this chapter, I presented the methodology by which I conducted the study. I opened with a restatement of the purpose of the research as well as a reiteration of the research question. I then moved towards proposing interpretative phenomenological analysis as the most appropriate research approach and justifying the choice as well as revealing the role of the researcher as the research instrument in the study.

The second section of the chapter outlined the recruitment and participant selection strategy as well as the instruments that I utilized for data collection. The procedures for data collection and data analysis followed. The chapter concluded with two sections around how I addressed issues of validity and ethical concerns.

In the next chapter, I will present a thorough description of the study procedures, setting, and participants. I will outline the data collection and data analysis processes and will provide a thematic description of the findings from the data analysis.

Chapter 4: Results

Introduction

The purpose of this qualitative interpretative phenomenological study was to explore the lived experiences of immigrant women who self-identify as belonging to a visible minority with encounters with the healthcare system in Canada. It helped describe their lived experiences with the healthcare system when they were also experiencing the intersectionality of gender, immigration, and visible minority status. The narratives extended to three contexts of prior to, during, and after the encounter. This has allowed me the opportunity to listen to the perspectives of the participants regarding their understanding of health and access to health care services. I was also able to explore the barriers that had an impact on them accessing healthcare services, experiencing healthcare services, and following the recommended follow-ups, interventions, and treatments.

The primary research question of this study was: What is the perspective of immigrant women in Ottawa, Canada, of their lived experiences with encounters with the healthcare system when there is an intersection of the factors of sex, gender, ethnicity, and immigration in their lives?

Additional subquestions included:

- What meanings do immigrant women in Ottawa, Canada, attribute to health, healthcare services, and access to health services?
- How do they describe the impact of the immigration experience on their experiences with healthcare services?

- How do they describe the impact of their ethnicity on their experiences with healthcare services?
- How do they describe the impact of their gender roles on their experiences with healthcare services?
- How do they describe barriers to access to healthcare services that they might have experienced prior to, during, and following the encounter with the healthcare system?

This chapter describes how data was collected and analyzed. It also presents evidence of trustworthiness and the findings that were gleaned from the analysis.

Setting

The study was designed to recruit participants who had experienced the phenomenon under study and who were willing to share their stories. To that end, I met with the executive director of OCISO, an Ottawa-based nonprofit organization that offers integration services to immigrants, to discuss the study and to propose the strategy for recruitment. The executive director was welcoming and signed a letter of cooperation for the purposes of the research ethics.

The text of the recruitment flyer (Appendix F) was translated from English to French and Arabic and several colourful flyers in the three languages were posted in the waiting areas in the two sites of OCISO in Ottawa. The flyers outlined the inclusion criteria and invited those interested in sharing their stories to contact me directly. My contact information was included in the flyer.

During the initial contact, I ascertained whether the potential participants actually met the inclusion criteria prior to arranging for a convenient time and location for the interview. I also outlined at that time the time commitment and specifics of the study.

Each interview took place at a location indicated by the participant. The majority took place in the participants' homes. One took place at the house of a participant's relative. And another took place in a coffee shop close to a participant's home. None of the interviews took place in the OCISO offices or my home or office. Verification of transcripts and emerging themes was done by email or mail as per participants' preferences.

Demographics

I asked the participants to complete a demographic questionnaire (Appendix B) at the beginning of the interview. The questionnaire took approximately five minutes to complete. It provided data on the participant's age, length of time in Canada, country of origin, self-identified ethnic background, educational level, employment status, marital status, presence of dependents, health status when she first arrived in Canada and current health status, as well as the last time the participant accessed the healthcare system and whether it was for herself or for a dependent. The purpose of the questionnaire was to determine which social, cultural, and economic factors are at play in the life of the participant.

Eight women participated in the study. Of the eight participants, two were originally from Lebanon, two from Colombia, two from Cameroon, one from Curacao, and one from Honduras. Average length of time in Canada at the time of the interview was five and a half years. Of interest, four participants arrived in Canada from a country other than their country of birth or citizenship. Though all of the participants self-identified as belonging to a visible minority, the entries they used for the ethnic background included ethnicity, country of birth, mother tongue, skin color, and tribal affiliation.

Of the eight participants, six had university degrees, three of which were at a graduate level. The two other participants had received college diplomas. Two of the participants with graduate level education had completed two Master's Degrees each and one was currently pursuing a PhD level education. Three of the participants had full-time employment outside the home, one worked full-time from her home, one was employed part-time, and three were unemployed. In addition to their mother tongue, three participants spoke English and French fluently, two participants spoke English fluently, two participants spoke French fluently, and one participant spoke English and Spanish fluently.

The ages of the participants ranged from 37 to 52 years of age, for an average age of 44 years. Six participants were married, one was widowed, and one was single. With the exception of the single participant, all the participants had children. The number of children varied from one to five. The ages of the children stretched from four months to 30 years. Of interest, one of the participants, in addition to her children, identified her parents, brothers, and sisters, as dependents. Additionally, three participants identified their adult children as dependents.

When asked to rate their health status when they first arrived in Canada, two participants indicated it was excellent, two indicated it was very good, and four indicated it was good. Only one participant continued to rate her health as excellent at the time of the interview. Four rated their health status as good, one indicated it was fair, and two participants indicated that their health is now poor.

All eight participants indicated that they had accessed a healthcare service within the previous two months for themselves. Two participants had also accessed it for their children.

Table 1

Participant Demographic Information

Pseudonym	Age	Country of birth	Country came from	Employment	Education level	Fluent in…	Ethnic background	Marital status	Number of children
Zahra	52	Lebanon	UAE	Part-time	Bachelor	Arabic English French	Visible minority	Married	3
Sophia	46	Curacao	Dominican Republic	Unemployed	Diploma / trade	Dutch English Spanish	Dutch-Caribbean	Married	2
Melissa	42	Honduras	Honduras	Unemployed	Master's	Spanish English	Spanish	Married	2
Najwa	37	Lebanon	Saudi Arabia	Full-time	Master's x 2 (PhD Student)	Arabic English French	Arab	Married	3
Miranda	42	Colombia	Colombia	Full-time	Bachelor	Spanish French	Colombian	Widow	1
Esther	44	Colombia	Colombia	Full-time	Bachelor	Spanish French	Colombian	Single	0
Bethsaida	41	Cameroon	USA	Full-time	Master's x 2	English French	Black	Married	3
Mariam	50	Cameroon	Cameroon	Unemployed	Diploma	Bakweri English	Bakweri	Married	5

Table 1 highlights the demographic information collected. I have also indicated the pseudonyms chosen for each participant. Pseudonym will be used in the results section to maintain confidentiality.

Data Collection

Eight women participated in the study. Six of the participants contacted me directly and I approached two to participate. Two additional women, who did not meet the inclusion criteria, contacted me but did not participate in the research. Both women had received my contact information from other participants.

Of interest, only one of the participants had been a client of OCISO. The six participants who contacted me directly had been referred by a participant in the study or by a friend who had heard about it. The two participants whom I approached were women from my sphere who met the inclusion criteria and who had previously indicated their desire to participate.

Five of the initial communications were conducted through email and three were conducted by phone. During the initial contact, I determined eligibility to participate and gave preliminary information about the study and the time commitment of the participant. I also determined a time and location of the participant’s choice for the visit. I then sent the information letter and consent form to the participants who shared their email addresses to peruse prior to the actual visit.

Six participants chose to be interviewed in their own homes. One participant asked to be interviewed in her sister’s home where she was visiting, and one participant asked to be interviewed in a coffee shop close to her home.

All the participants read the information letter and signed the consent form (Appendix G) prior to completing the demographic questionnaire and interview. The duration of the visit with each participant varied from 45 to 90 minutes. The demographic questionnaire took approximately five minutes to complete. The length of the recorded interview portion of the visit varied from 15 to 77 minutes for an average of 38 minutes. Three of the interviews were less than 30 minutes in length. The interviews were semistructured and utilized probing questions to allow the researcher to delve into the narratives of the participants. Six interviews were conducted in English, two of which had a few words and phrases of Arabic included. And two interviews were conducted in French. Though I am functionally fluent in French, I enlisted the help of a fully bilingual interpreter to facilitate the two interviews conducted in French and ensure no meanings were lost during the dialogue. The interviews were all audio-recorded using a mobile phone application. The audio files were then saved into a secure drive for transcription.

During the data collection phase, I received a small grant towards my study from the organization where I work. The funds were used to hire a professional transcription service to complete the verbatim transcription of the interviews. I then verified the transcriptions by listening to the audio files of the interviews several times while comparing them to the transcript documents. Once verified, I sent each transcript to the respective participant for verification. Only one participant chose to elaborate on a few phrases within the transcript.

As I received each transcript back from the transcriptionist, and once verified with the audio file and with the participant, I started by conducting the initial coding. This helped guide some of the probes with consequent interviews. Themes and codes started repeating with interviews five and six. As I coded interview seven, I was assured that no new major themes emerged from the literature and that I had reached data saturation. Around that time, I received the request to participate from Mariam, the eighth participant. Mariam had a phone plan that allowed her to call out but could not receive any calls back. Unfortunately, it took her a few calls to be able to reach me. During the initial call I was able to determine that Mariam meets all of the inclusion criteria except for length of time in Canada. She had been in Canada three years only. When I told her that she did not meet the inclusion criteria, she was very disappointed and insisted on sharing her personal story. To that end, I made the decision to conduct the interview with her and include her perspective, but as a discrepant case. I will elaborate further on her story in a following section of this chapter.

In addition to the interview transcripts and demographic questionnaires mentioned in the previous section, I kept field notes for each interview. The interviews were semistructured and utilized open-ended questions allowing me the opportunity to probe for details about the lived experience for a rich narrative. The demographic questionnaire provided additional data in regards to the intersection of other cultural, economic, and social determinants of health in the lives of the participants. The field notes provided additional context for the data analysis (Rudestram & Newton, 2007).

Data Analysis

I conducted the interviews and verified the verbatim transcriptions of the interviews in order to immerse myself in the stories of the participants. I also developed a spreadsheet to log data from the demographic questionnaires and linked them via unique identifiers and pseudonyms to the interview transcripts and field notes. Because the text of the transcripts contained words in three different languages, I utilized Atlas Ti as the data management program because of its versatility with multiple languages (ATLAS.ti, 2016).

To allow consistency with the language, I translated the transcripts of the French interviews to English and added these, in addition to the original French version of the transcripts to the files for analysis, bringing the number of files to be coded to ten--six original English transcripts, two French transcripts, and two translations of the French transcripts. Any coded quotes were matched between the original French and translated English transcripts to ensure that no meaning was lost in the translation. Additionally, both the original quotes as well as their translations are included in the findings section of this report.

I conducted the data analysis following the process outlined by Smith et al. (2009/2013) for IPA. I began by reading and rereading the transcripts in order to immerse myself in the stories of the participants. I also listened to the audio recordings several times while reading the transcripts. While listening to the recordings I kept a separate journal to jot down expressions and connections.

In the second stage, I started highlighting different portions of the text that were of interest. I added notes and codes in the margins as I read through each transcript. As per IPA (Smith et al, 2009/2013) three types of comments were included in the margins: (a) descriptive comments that described what the participant was expressing, such as when the participants defined what health meant to them; (b) linguistic comments that pulled out words and phrases that the participants used in order to explore them further; and (c) conceptual comments that delved into the concepts emerging from what the participants were experiencing and sharing.

At this stage, I entered all of the interviews into the data management program, Atlas Ti. I then coded all the highlighted quotes with the notes that were jotted in the margins and, where possible, utilized the participants' own words for the coding (Creswell, 2013; Maxwell, 2013; Miles et al., 2014). In total, the program indicated that there were 127 codes used for 626 quotes in the ten documents. Table 2 outlines the number of coded quotes and codes per interview transcript.

Table 2

Number of Quotes and Codes per Interview Transcript

	Number of Quotes	Number of Codes	Number of Code Groups
IWH01	125	36	13
IWH02	21	11	7
IWH03	71	31	11
IWH04	141	64	13
IWH05-English	36	20	9
IWH05-French	36	20	9
IWH06-English	24	16	7
IWH06-French	24	16	7
IWH07	132	56	12
IWH08	16	10	4

Thirdly, I scanned the different codes to identify the relationships and patterns between them. I compared the emerging codes within and across data sets for commonality and divergence as part of the "iterative and inductive cycle" of the IPA approach that moves from "the descriptive to the interpretative" (Smith et al., 2009/2013, p. 79). To help with the mapping, I used self-adhesive notes, each with a theme, on a large board. The notes were moved around and rearranged as part of the sense-making process until they could be grouped into distinctive groups of codes. This exercise resulted in 16 code groups or themes. These are listed in Table 3. The themes that emerged reflected "not only the participants' original words and thoughts, but also the analyst's interpretation" (Smith et al, 2009/2013, p. 92). Those code groups were arranged accordingly in the data management program.

Table 3

List of Code Groups and Number of Quotes Associated With Them

Code Groups or Themes	Number of coded quotes
Definition of health	25
Access	237 (includes subgroups)
Knowledge of healthcare system	19
Gatekeeping practices	53
Perceptions of client-provider interactions	64
Integration	15
Personal attributes	17
Immigration experience	70
Social capital	41
Gender role	23
Sex	4
Discrimination and racism	72
Advocating for self or family member	59
Recommendations	37
Desired relationship with healthcare providers	42
Continuity of care and integrated services	7

In the fourth step, as I became more and more immersed in the data, I was able to develop a structure that illustrates the relationship between the themes through my own intrinsic knowledge and interpretation of the narratives (Smith et al., 2009/2013). Three specific strategies, as described by Smith et al. (2009/2013) were used to determine the connections between the 16 code groups or themes. The first strategy was abstraction, which is a process by which like codes are grouped together into a "super-ordinate theme" (p. 96). For example, the two code groups, *desired relationship with healthcare providers* and *continuity of care and integrated services* were grouped together under *recommendations* as the superordinate theme.

The second strategy was subsumption where one theme was used as the one under which others can be brought together and related. *Access*, in this case became the theme under which I grouped *sex*, *gender*, *knowledge of the system*, *gatekeeping practices, individual and systemic barriers to access,* and *"I was a number": Experiences of interactions with health care providers*. As a result, I then regrouped the 16 code groups into six themes and several subthemes. I will discuss these further in the results section.

The third strategy was contextualization where the field notes and journal helped set the context through which the codes helped determine the story being told by the participants. As I established coherence between the themes, a narrative emerged from the data that described the full story via a representation of the themes and the relationship between them (Smith et al., 2009/2013). The narrative that emerged is described at length in the interpretation section of Chapter 5.

Evidence of Trustworthiness

Following the strategies outlined in the previous chapter, I will share in this section how I ensured, as much as possible, the credibility, transferability, dependability, and confirmability of the data and the findings. I will also outline the IPA-specific strategies that I employed.

Credibility

The credibility or internal validity of a study refers to whether the findings of the study are clear and make sense (Miles et al., 2014). To that end, I sought feedback about the emerging themes from the participants in the study to establish credibility. Additionally, as I conducted the data analysis simultaneously with the data collection, I was able to establish when data saturation took place as themes started repeating. Data saturation is another measure of credibility (Miles et al., 2014).

Transferability

Secondly, to ensure transferability to other settings, I described in earlier sections of this chapter the exact procedures I followed for the data collection and analysis. I also included detailed descriptions of the participants in the demographics section.

Dependability

Thirdly, dependability of a qualitative study refers to the care by which it was conducted that will allow its replication under similar circumstances and that ensures the accuracy of the data collected (Rudestram & Newton, 2007). To ensure dependability, I provided a detailed description of the coding scheme in the previous section. I had also ensured that the interviews were audio-recorded and then transcribed verbatim by a professional transcriptionist. Additionally, I had kept field notes throughout the interview process that helped provide context during data analysis.

Confirmability

Lastly, confirmability refers to the qualitative counterpart of objectivity in quantitative research (Miles et al., 2014). To address the issue of confirmability, and in addition to the detailed description of all processes, procedures, and methods, I documented a journal entry outlining my own personal bias as an immigrant woman who self-identifies as a visible minority. I have also kept a reflective journal throughout the data collection and data analysis phases. Additionally, I will retain the transcripts and codebook on file for five years and will make them available for others to confirm findings.

Criteria Specific to IPA

Smith et al. (2009/2013) posited that IPA can best meet the criteria for validity by conforming to the four characteristics identified by Lucy Yardley (2000) for the field of psychology. These included (a) sensitivity to context, (b) commitment and rigour, (c) transparency and coherence, and (d) impact and importance (Yardley, 2000, p. 219). I had presented a description of each of these characteristics in Chapter 3. In this section, I will outline the strategies I used to address them.

Sensitivity to context. I demonstrated sensitivity to context by continuing to treat the participants as "experiential experts" (Smith et al., 2009/2013, p. 180) rather than as a sample. To that end, I am including as many extracts from the interview transcripts as possible to support the interpretations and to give the participants voice (Yardley, 2000). Their sociocultural background was respected, and their stories were elicited with empathy and respect. I consulted the participants as to the accuracy of both the interview transcripts and the interpretations made from the data. Additionally, I will be relating these interpretations to relevant literature in the following chapter (Smith et al., 2009/2013; Yardley, 2000).

Commitment and rigour. To meet this criterion, I ensured that the participants were selected to match the criteria of the study and that their stories were attended to through in-depth, thorough interviews (Smith et al., 2009/2013). I also ensured that the data analysis respected the meaning that the participants attached to the experience and is reporting the meaning of the experiences rather than their superficial description (Smith et al., 2009/2013). Furthermore, I supported themes that emerged from the data with multiple quotations from the participants to ensure rigour (Smith et al., 2009/2013).

Transparency and coherence. The principle of transparency refers to the clarity by which the researcher communicates the research process in the final report (Yardley, 2000). To meet the criterion of transparency, I gave a thorough description of the processes of participant selection, data collection, interviewing, and data analysis and interpretation (Smith et al., 2009/2013). Additionally, and in order to meet the criterion of coherence, I am presenting the research findings in the next section in a manner that allows the readers to "be aware that they are positioned as attempting to make sense of the researcher trying to make sense of the participants' experience" (Smith et al., 2009/2013, p. 182).

Impact and importance. This characteristic will be demonstrated further in Chapter 5 as I discuss the interpretations and findings in light of existing literature and make recommendation for future research and policy.

Results

This section will describe the themes and subthemes that emerged from the data analysis and provide quotes to support each. I have used the participants' words in quotations to support the different themes that emerged. Where quotations from the French interviews were used, I also included the English translation in brackets. In Chapter 5, I will present an interpretation of the findings in light of the research questions I sought to answer.

Thematic Presentation

The 16 code groups presented in Table 3 were remapped to describe the connections and relationships between them. As a result, six final themes emerged from the data analysis, (a) definition of health; (b) access to healthcare; (c) "Integration is like a puzzle": Integrating into Canadian life; (d) navigating the healthcare system; (e) "Being a visible minority, it's a pain not only in healthcare, even at Walmart": Discrimination and racism; and (f) recommendations. Those themes are presented in table 4.

Of note, even though in the original coding the theme of *discrimination and racism* was embedded in the two themes of *access* and *integration experience*, the stories being told compelled me to separate this theme and give it its own significance. Additionally, the subthemes of *continuity of care and integrated services* and *desired relationship with healthcare providers*, were renamed *system-level recommendations* and *provider-level recommendations*, respectively.

Table 4

Themes and Subthemes

Theme	Subthemes
a) Definition of health	
b) Access to healthcare	• Sex and gender role • Knowledge of the healthcare system • Gatekeeping practices within the system • System-level and individual-level barriers to access • "I was a number": Experiences of interactions with healthcare providers
c) "Integration is like a puzzle": Integrating into Canadian life	• Immigration experience • Social capital • Individual characteristics • "Women feel it more than men": Gender role
d) Navigating the healthcare system	
e) "Being a visible minority, it's a pain not only in healthcare, even at Walmart": Discrimination and racism	• Subtle discrimination • Overt racism • "I don't know what to do": Reaction to racism
f) Recommendations	• System Level: Continuity of care and integrated services • Provider Level: Desired relationship with healthcare providers

Theme 1: Definition of Health. All the participants viewed health holistically and proposed definitions that went beyond physical wellbeing. They even pushed the definition towards the functional level. They agreed that health encompasses the physical, emotional, and mental levels. Najwa, the only licensed healthcare professional in the group, defined health as "physical, mental, and psychological wellbeing." Mariam, who

is currently studying to be a personal support worker, concurred and defined health as encompassing the physical, emotional, social, and spiritual dimensions. Zahra, who was recovering from a health crisis when we met, defined health as "feeling well mentally, physically, and emotionally." She also noted that she would consider herself healthy if she did not need (emphasis on *need*) to see a physician for any kind of ailment, was not taking medication, and did not require assistance with basic care. She expressed it this way,

> I think I am okay with the basic things, basic life assistance, I'll be fine and this is healthy for me now. Not being, not seeing a doctor, not taking medication, that's being healthy. When you feel the need to see a doctor, that's not being healthy. Health stops here.

The participants also spoke of health in terms of ability to function in life, use all of one's senses, maintain a social life, and exercise and be fit. Sophia shared that health for her is "that I can use my senses and enjoy life with all my senses and in the right way. I don't have pain. I feel good and vital and energy and happy." Bethsaida saw health as her ability "to get up and do what I have to do." Miranda also saw health as her body meeting the need for her to work and perform daily activities, "la santé c'est important pour moi parce que c'est la façon, je puisse savoir que mon corps répond à mes besoins pour travailler, mes besoins pour réaliser les journées quotidiennes [Health is important to me because that is how I could know that my body meets my needs to work, my need to perform everyday activity]." Esther's definition agreed with Miranda's and took it one step further by defining it as "my life". She explained her rationale as follows,

> Pour moi la santé c'est très en forme, avoir beaucoup d'énergie et avoir une qualité de vie parce que si tu n'as pas la santé, tu ne peux pas travailler. Donc c'est pour ça j'ai dit que c'est ma vie.
>
> [For me health is to be very fit, have lots of energy and have a quality of life because if you do not have health, you cannot work. So that's why I said that it is my life]

Of interest, Melissa was the only one who explicitly connected her ill-health to her immigration experience. When asked to define health, she expressed that she currently does not have any health, but that emotional health is a big part of her health. She went on to say, "my energy level is pretty low, my immune system is pretty low, and when I came here I was healthy. I don't know if that is due to lack of sun or different environment."

Two of the participants also connected the social determinants of health to their definition of health. Melissa, who was unemployed at the time of the interview partly due to health issues, explained that "employment status has an impact on your economic status, which has an impact on your social status, and then, of course, on your health." Bethsaida's definition agreed with Melissa's. She explained, "I don't think that you can dissociate the economic from the health, because everything, everything turn around that economic thing. Even your health."

Theme 2: Access to healthcare. As part of the interview protocol, I asked all the participants what access to healthcare meant to them. Invariably, the participants started their definition with having access to a family physician. As family physicians are the entry point to healthcare in Canada, their definition is not surprising. Esther explained, “vraiment depuis que j’ai rencontré le médecin de famille c’est plus agréable que quand on n’a pas de médecin de famille, c’est plus difficile. [Really after I met the family doctor it is better than when you do not have a family doctor, it was more difficult].”

As I probed more into their experiences of access, their responses became broader and more encompassing of other healthcare services and providers. Esther described it as the opportunity to get treatment or help for all that ails her, “C’est l’opportunité pour me faire soigner de toutes le maladies que j’ai. [It is the opportunity to get treatment for all the ailments that I have].” Zahra spoke of access to urgent care clinics, emergency rooms, specialists, and hospitals. Bethsaida also broadened her definition of healthcare providers and health services. She said, “I think a nurse would be a good provider. A pharmacist can be one. A physiotherapist, chiropractor.” Bethsaida also spoke of the ability to choose one’s own family physician as an issue of access. She said,

> I would like to be able to have access to a healthcare provider, to a healthcare facility. Or if I don’t think this provider was the right one for me, I want to be able to choose the one that I think might be.

When asked to describe barriers to access and their experiences of access, the participants spoke of barriers that encompassed the periods prior to encounters with the healthcare system, during the encounter, and following the encounter. Their responses are grouped into five categories: (a) sex and gender role, (b) knowledge of the healthcare system, (c) gatekeeping practices within the system, (d) system-level and individual-level barriers to access, and (e) “I was a number”: Experiences of interactions with healthcare providers. Each will be elaborated on and supported by the participants' own words in the following sections.

Sex and gender role. The participants felt that, as women, they needed to access health care more than men because of the nature of female health needs throughout the life span. Zahra said,

> Being a woman, it's different. Like you need to see too many doctors throughout your life… Physically, I think, a woman is different from a man… Let's talk about menopause, or childbirth, or reaching a certain age, and then you have to start to do a mammogram and two three other things. So a woman sees much more doctors in different fields, much more than men.

Najwa agreed with this perspective stating, "So for my husband it's easier maybe." Bethsaida also agreed with this perspective and hypothesized that it could be because women do not take care of their own needs like men do. She said about her husband, "He is very into taking care of himself, more than I do. I guess maybe that woman thing too, I don't know."

Additionally, women as part of their role as wives, mothers, and daughters, tended to access the healthcare system on behalf of their family members. Zahra, describing her role before her immigration to Canada,

> We're used to a different system where usually moms, wives, take care of all these things, right? So taking an appointment, even if you don't have little kids, right, even when they are grown up or when they are sick or whatever, I used to take appointments for everyone.

Similarly, Sophia negotiated access to a family physician for her adult children. She said, “Then I ask her if my children could come too and she said it was not a problem and so my sons met her too and started to journey there as well.” Bethsaida, who also makes the medical appointments for her husband and children, said, “I’m the one making sure that if the medication are prescribed, they take them. When they take them at the right time, whatever is needed, with food or not.”

Melissa also shared that her need to continue on with her role as mother and wife, has impacted her decision-making in regards to treatments. She felt that she needed to accept whatever options she was given in order to be able to take care of her family. She explained, “I was desperate when I got in this treatment, because I needed to be fine, to look after [my daughter], to take care of my baby.”

Knowledge of the healthcare system. The participants indicated that they were not familiar with the healthcare system in Canada when they first arrived. They were not aware of the need for a family physician as the point of access for health services or of the process of finding a family physician. Zahra explained, “So knowing that I have to have the family doctor was a new thing. That’s one. So again, access was, like, oh, so I have to have a family doctor, I can’t go to a specialist directly.” Miranda echoed that statement and her lack of understanding of how to navigate the system, “Nous on a, on ne savait pas quoi faire si on avait, comment il faut aller chercher, on avait vraiment de la peine et de pouvoir comprendre. [We did not know what to do if we had, how to find help, we really had difficulty in understanding].” Similarly, Najwa stated, “I wasn’t sure about how the system works. So it was my lack of knowledge, I didn’t know that I have to have a GP." Zahra explained that she "didn't know that there is no health insurance that everything and that it's divided, like it's different plans."

In addition to the lack of knowledge of the healthcare system, two of the participants felt that they did not know what their personal rights are within the system. Bethsaida, who was not initially happy with the therapeutic relationship that she had with her physician, mentioned to a friend that she was hoping to look for another. Her friend cautioned her not to and said that in Canada, you cannot just switch doctors when you have already found one. Bethsaida expressed her confusion about this issue as she still does not know whether switching family physicians is within her rights or not. Najwa expressed the same doubts when she said, "And the other thing is, I don't know my rights. I was kind of really frustrated many times that, like, should I change my GP?"

Gatekeeping practices within the system. Even after finding a family physician, participants spoke of gatekeeping practices within the system that presented barriers to access. The availability of the family physician was a barrier that was recognized by all the participants. Wait times to see the physician were sometimes three months long, depending on the nature of the issue. Zahra told of the time when they needed to see the family physician because her daughter had a concussion. She said, "We wanted to see our doctor, the family doctor, and she had no availabilities. Maybe the first available appointment was after three months. So we both start crying in the clinic." Mariam also shared that when she calls for an appointment, "Maybe the appointment maybe last one month, two months, other, you know, they give you an appointment for maybe two weeks." Similarly, Miranda, said that she usually has a wait of three weeks to see her family physician, “Mais il faut attendre toujours les trois semaines pour que le médecin puisse me voir. [But I always have to wait three weeks for the physician to be able to see me].” This was also the experience of Melissa and Najwa, both of whom shared that they were not able to see their family physicians at times because of their lack of availability.

Participants shared that they can only bring one complaint at a time to the attention of their family physician, which is rather frustrating for them since they believe some of their symptoms are connected. Esther shared her frustration of how she was allowed only three questions and for anything else she needed to take another appointment,

> Je voulais une personne qui me traite bien parce que c’était 15 minutes seulement vous avez le droit à trois questions. Avant, j’ai dit, ‘okay, mais j’ai beaucoup de choses.’ ‘Non, mais demande un autre rendez-vous. On n’a pas le, c’est seulement trois questions.’ Donc c’était, c’est comme la frustration au début.
> [I wanted someone who treats me well because you only had 15 minutes, you are entitled to three questions. Before, I said, ‘Okay, but I have a lot of things.’ ‘No, but you can request another appointment. We have time for only three questions.’ So it was, like, frustrating in the beginning].

This experience was echoed by Miranda as well who shared, “et en plus ils vont devoir dans leur sans rendez-vous ils vous dissent, ‘je peux vous traiter juste une chose et c’est tout.’ Donc c’est difficile. [Plus they will tell you in the appointment, ‘I can deal with only one thing and that’s it.’ So it’s hard].” Bethsaida also shared a similar experience. When she went in for her annual physical exam, she was told to make another appointment if she wished to talk about a particular issue as that will not be discussed during that specific appointment.

Participants shared their experiences with receptionists as gatekeepers as well. Mariam put it simply, “they receive the call, they listen to you, and they ask about what you want. So you explain. Then they check their schedule and then they place you with an appointment to see the doctor.” Unfortunately, not all experiences were positive. Melissa shared what she witnessed at her doctor’s clinic,

> The secretary, she’s the meanest person I ever know, because people get there with pain. Oh, I feel so bad about them, and this secretary treat them like, she is not wasting time writing down their appointments because she is too busy. I feel so bad about that. Yeah. She’s so mean and the doctor is not better than her.

Melissa also spoke of the time she called her doctor in an urgent situation and told the receptionist that it was an emergency. Melissa continued, “And she told me, ‘No, he’s booked. He doesn’t have any space in his schedule’.” Similarly, Zahra shared how at times she would drop in or call to make an appointment and “the receptionist will look at me and said maybe” or would respond with “yes, the physician is here but she cannot see you. She’s busy with other patients.”

These gatekeeping practices also extended to specialist. In this case, the family physicians themselves acted as gatekeepers. Najwa shared that she “couldn’t get referral to a specialist without GP.” She cautioned as well “there should be a very strong reason for the GP to refer you to a consultant. So it’s like she needs a strong evidence. And that’s kind of frustrating.” Zahra and Melissa shared similar experiences. In Melissa’s case, however, her family physician went above the call of duty to arrange for a referral for her. She shared that when her family physician felt that a referral to a rheumatologist was going to take a while, "he went to his house and asked him to take me."

Additionally, participants shared that family physicians act as gatekeepers by limiting the number of options that are offered to them. Melissa commented that even though she had received a treatment in Honduras that was successful in addressing her chronic condition, her physician here did not want to consider it. She said, "I went to a second opinion, to another rheumatologist here, and he told me that the treatment that I had in Honduras, they do it here in Canada. But my doctor doesn't want to put me on that treatment." This has forced her to continue to take a treatment for the past five years that she finds is impacting her quality of life. Similarly, Najwa, in describing a dialogue she had with her family physician, said,

> Because the lab tells there is something wrong. It keeps being bad, bad, bad, bad, and there's no improvement. And I'm trying to tell you what I've done in the past before coming to Canada, and this is the way it works, and you're not convinced for some reason.

Najwa went on to try to justify why they might be hesitating to tailor treatments. She felt that "it seems like they have to do lots of justification in order to prescribe or refer or do anything." She speculated that they limit options because they are required to follow specific guidelines and the system does not allow them the freedom to tailor treatments.

System-level and individual-level barriers to access. The participants expressed their frustration with the complexity of the healthcare system. Najwa felt that “the slowness in the system and the coolness they are treating the patient with is not good. It’s frustrating.”

The long waits to access services were the source of most frustrations. In addition to the long wait at the very beginning to be assigned a family physician, there were long waits to access urgent clinics, specialists, diagnostics, and emergency services. Some of the participants had to wait more than a year to have a family physician accept their files. Miranda explained that you had to be actively involved in finding a family physician; and that, despite that, it took two to three years for her to find a clinic that will accept her file. She shared,

> Ici il faut chercher, il faut s’impliquer pour aller chercher la clinique et le médecin… ici il faut que nous on trouve une clinique qui accepte d’ouvrir le dossier en premier pour qu’on puisse avoir le service et après ça nous a pris deux à trois ans pour pouvoir trouver le médecin de famille.
>
> [Here it is necessary to search, it is necessary to be involved and go find the clinic and the physician… here it is necessary to find a clinic that will accept to open new files first so we can have the service and then it took us two to three years to find a family physician].

Bethsaida also had to wait over a year for access to a family physician. She and her family had initially immigrated to Canada from the United States of America in 2011. She had, however, to continue to travel between Canada and the United States because of work and finally settled permanently in Canada in 2012. She was able to have access a year later only because she and her husband became students at the university and they were assigned a physician through student services. She said,

> I came in 2012 and the first time I met a healthcare provider was in 2013 because we couldn't have a family physician. So 2013 when we became students, through that we were able to get a provider at Ottawa U.

Zahra, on the other hand was able to access a family physician for herself and her family shortly after arriving due to her brother's intervention. Her brother and his family were leaving Canada on a work assignment for three years and he asked his family physician if she would be open to taking his sister's family on her docket to replace his family. The family physician agreed and Zahra had access. This is how she described it, "My brother was there and they were leaving, so it's four files and we were five, so we were accepted because of availability, not because I chose her as a doctor." She recognizes that this is unusual and felt that she was "lucky" to be able to have that immediate access. "I have to have a family doctor. And I'm lucky that I found a family doctor within four weeks or five weeks after our arrival."

When unable to access a family physician, whether due to lack of knowledge of the system or the physician's availability, participants had to resort to the walk-in clinics or urgent care clinics. Miranda shared that, due to their own lack of knowledge, they had to utilize a walk-in clinic, "on ne savait pas comment fonctionnait le système de santé et on a trouve juste des cliniques sans rendez-vous. [We did not know how to function in the healthcare system and found only the walk-in clinics]." To access the walk-in clinics, however, you needed to go at a very early hour to take a number and stand in line to be given an appointment. Esther explained, “il faut que tu ailles de bonne heure, tu prennes une fiche, ils vont te donner une heure spécifique et dans la clinique d’urgence. [It is necessary that you go early, you take a number, they will give you a specific time for the urgent care clinic].” Zahra shared similar experience with her family physician’s clinic,

> I have to be in front of the clinic I think before 7:30 to be at least number one or two. So when the door opens, half open, to the entrance, we take numbers and then when the second door opens, we run to get in line for them to take our information. And this is from, I would say, 7:30 ‘till 8:15. And if not, I have another chance they said if I call at 10:00, imagine how many phone calls. They said at 10:00, five minutes, all the afternoon will be booked.

These instances were discouraging, as Miranda experienced,

> Donc on ne savait pas si on aurait la place ou pas. Par contre, on était très tôt le matin et déjà il avait des files de personne pour faire la même demande de service. Donc on était décourageait souvent.
>
> [So we did not know if we would have a turn or not. By contrast, it was very early in the morning and already there were queues of people waiting for the same request for service. So we were often discouraged].

Miranda explained that even when you were there very early and standing in line, you were not guaranteed a spot on the schedule to be seen since they were limited in the number of patients they could see.

> Il y avait des moments où on ne savait pas, deux à trois fois on aller très tôt et tout d'un coup ils ont dit « aujourd'hui on va juste recevoir juste sept patients ». L'autre journée il a dit « aujourd'hui on va dire 15 patients ». Donc on ne savait pas jamais.
>
> [There were times when we did not know, two to three times we went early and suddenly they would say, "Today we will receive only seven patients." The other day, he said, "Today we will see 15 patients." So we do not ever know].

Yet, if you are not in line very early in the morning, you run the risk of not being seen at all, as was experienced by Najwa, "We went to all those walk-in clinics and none of them accepted us because they either can't, are overwhelmed, or are going to close in half an hour. They can't accept us."

In addition to the frustrations of accessing services through walk-in clinics, the service itself was fragmented and presented its own challenges. The participants shared that when accessing multiple providers in walk-in clinics, no one owns your file and, thus, no one will follow-up on plans of care and test results. Miranda explained, "Et en plus ce médecin de famille tu peux avoir le résultat de l'examen. Mais ils ne font pas le suivi parce que c'est juste le médecin de famille qui peut faire le suivi. [Plus, with the family physician you can have the results of your tests. They do not follow up because it is only the family doctor who can monitor]." In that case, the participant had to still make the appointment and request that the physician seeing her in the clinic actually look at the results and let her know if there is anything that needs to be addressed.

> On l’a vécu et si tu n’as pas un médecin de famille, il faut faire le rendez-vous, il faut aller chercher encore le rendez-vous pour que le médecin pour lui dire, « s.v.p. lisez le résultat des examens », parce que sinon ils ne vont pas vous dire quoi faire dans la prochaine étape.
>
> [If you do not have a family physician, it is necessary to make the appointment, you still have to make the appointment and tell the physician, “Please read the results of the examinations”, because, otherwise, they will not tell you what to do next].

This fragmentation was also experienced across transitions of care between family physicians and specialists. Records or requisitions were not always transmitted appropriately leading to gaps and frustrations. Zahra shared that when she was referred to a specialist and she went in to see her, the doctor did not have her file or results, “My file and whatever, all the details, she did not have them.” She then questioned how the transfer of accountability between the physicians takes place, “So these papers, these emails, who access them? Who does this job? Is it the doctor? Is it the nurse? Is it one of the staff in the unit?” There remain gaps in the system that prevent the transmission of data from one provider to another, despite advances in technology. “Although the system now is much easier, I think, and they can access, but still at a certain level, I don’t know why she could not access my file.”

On a positive note, the participants shared that having electronic records and test results helped improve the speed and efficiency of access. Esther described the efficient access to records that her family physician had and the convenience that provided, “Et mon médecin de famille a sa Clinique, c'est tout sur ordinateur. Ils sont super bien organises et tout de suite ils le mettent dans l'ordinateur et tout sort, la prescription ca sort par. C'est spécial. C'est rapide. [And my family physician at the clinic, it's all on the computer. They are super well organized and they immediately enter it in the computer and everything prints out, the prescriptions print out. It's special. It's fast]."

When unable to access walk-in clinics, participants would then resort to emergency rooms, which presented another level of frustration because of wait times and fragmentation in care. Melissa shared the experience they had when her husband had to access the emergency room due to a torn Achilles tendon,

> He went by ambulance to [hospital], and he wait there for seven hours and after that he passed to another room. He was seen by another doctor. He wait there for another two hours and then he was seen by the doctor.

Esther shared similar experiences that she had with emergency services where she actually would wait 12 or 18 hours to be treated. She said, "Quand je n'avais pas de médecin que c'était, il fallait attendre 12 ou 18 heures à l'urgence. [When I did not have a physician, I had to wait 12 to 18 hours in the emergency department]." Najwa also related the time when her husband had to take their son to the paediatric emergency department and had to wait six hours to be seen, "So he waited six hours in the emergency room to see the physician."

Of note, as immigrants, the participants had access to the provincial Ontario Health Insurance Plan (OHIP), which provides full coverage for basic health services, urgent care, hospitals, and medications while hospitalized. However, unless they have additional health insurance and benefits, they would have to pay out of pocket for medications, dentists, eye care, and other supplementary services such as, physiotherapists, and psychoanalysts. Mariam explained that, “You are not covered for dentist, you are not covered for eye, you have to pay from your pockets.” Bethsaida felt that this is definitely a barrier, “Accessibility in terms of financial accessibility is even…is a barrier for me, because I’m thinking it is going to cost me.” She went on to say that, now that she has a job that offers supplemental insurance benefits,

> I can pay for my child dental. I can, they can go to see a physiotherapist. That is a dream. That is for me is a huge dream come true. Like, years back, forget it. You can’t talk about it. But it’s giving me access to health.

The supplemental health insurance coverage is usually a benefit of full-time employment. It is offered to employees and their families. Zahra, Sophia, Miranda, and Mariam did not have any supplemental health coverage. Melissa had coverage through her husband’s work. And Najwa, Esther, and Bethsaida had coverage through theirs. Zahra had attempted to purchase private insurance but was denied due to her chronic health conditions.

Additionally, because of the regulations for medications in Canada, very few can be purchased over the counter. Access to medications is through a prescription. The participants felt that this added an additional layer to accessing treatment since they have to wait to see a physician and by the time they do so, their symptoms would have worsened. Najwa expressed it this way,

> And the problem is that you cannot do self-medication on everything so you have to go through [physicians]. Like I can't go and buy antibiotics let's say, not that I'm a fan of antibiotics, but I am just giving an example. Or I can't go and buy steroids for him because I know that's the thing [that would help him]. So it's very challenging, except Tempra and some decongestant drug you can buy. So you have to go through the physicians and every time you go through physician, there are barriers.

Bethsaida felt strongly that good work with sufficient income and good benefits opens doors for you that poverty would prevent you from accessing. She felt that "the poorer you are, I think, the less care you have, or the less respect you get. You are treated with less dignity." She stressed that it went beyond benefits and that a good profession or job changed your social standing, "You are a Tim Horton server, then what?! You know. Then there are some conversations you are not part of. Then there are some people you cannot meet. Then there are some health insurance you can't access."

Even though work provides access to benefits and supplemental health services, the nature of the work might not allow flexibility to access those services during the hours they are offered. Bethsaida shared that when she was working shifts, she was not able to take time off work to go to medical appointments. She said, "I used to work shift work and it was horrible, I couldn't take time off. It was just sometimes impossible to get time off to take the kids."

All the participants were fluent in either one or both of the official languages. As such they did not experience any language barriers to healthcare. They did feel, however, that had they not spoken the language, they would have faced additional difficulties in accessing care. Zahra felt, that despite her fluency in both official languages, she has had to make accommodations because of her accent. She explained, “I’m sure my English is not the English they’re used to, so I repeat myself and I speak slowly.” Najwa felt strongly that language could be a big barrier as she had witnessed instances where it was an issue. While waiting to see the doctor, she witnessed a family trying to explain to the receptionist why they needed an appointment with the physician. Najwa said that as she watched them struggle she thought, “How are they going to describe their sickness in sign?”

“I was a number”: Experiences of interactions with healthcare providers. The participants were disappointed with what they described as cold and impersonal interactions with the healthcare system, especially with the physicians. Melissa felt truly that she was simply a number, not only where the specialist was concerned, but also with the obstetrician when she had her baby, “The obstetrician, I was just another number coming to his office.” They spoke of how they were often told that the physician was too busy and did not have time to either see them, or hear all of their concerns. Zahra shared about her own experience saying, “They’re overbooked. My doctor, more than once, like told me clearly, ‘I can’t see you more than five minutes. This has to wait till the physical’.” She also shared that she once told her clearly, “I have only five minutes, so what is it?” Bethsaida had a similar experience where her physician said to her, “You know what? I don’t have time for that. You have to make another appointment for that because this is not why you are here.” Melissa, trying to understand why she was hurried, mused, “Maybe they’re too busy. Maybe they don’t have the time to take with each patient. I don’t know. Maybe it’s what we spoke about earlier, about personality.”

Most of the participants also described the impersonal and cold attitude of the physician during the healthcare encounters. Zahra expressed her frustration about the “very technical, very practical, and very cold” attitude and blamed it on the fact that they are too busy to be personal. She said,

> I know you are a doctor. I know maybe you might be overbooked because of the running late expression--I learn it very very early on. So, oh, she’s running late. We accepted that. So she does not have the time to change and make it a bit personal.

Sophia had similar experiences with her own family physician. She described it as “very unpersonal. I felt like it was like a machine. It was nothing personal.” Zahra wished they would just look at you when you are in their office. She said,

> I’m the kind of people that I like eye contact and being in front of the laptop doesn’t help much, because like I’ll do [She leans forward as if trying to catch someone’s attention]. Please look at me. I have these two minutes or five minutes. Let’s have them, it is important to give eye contact.

Melissa described her experience with the specialist as a “terrible experience.” She elaborated,

> He doesn’t look at your face. He just write down. He doesn’t. If I go there and tell him I have a pain here, ‘oh, that’s not about the rheumatoid arthritis. That’s…’ He

> doesn’t care if my pain is not due to the RA. He doesn’t take care about that. And he’s a pretty cold person.

Esther who shared her own experience when she went to the physician with a private health concern also expressed experiencing this dismissive attitude. She felt that something that is so big and private for her was treated as if it was nothing by them. “Je lui ai donné la question de ça. Elle a dit, ‘C’est normal ici, il faut seulement prendre ses médicaments’. Okay, je me sentais blesse parce que c’est quelque chose privée et pour eux c’est rien. [I asked her the question. She said, ‘It is normal here, you just take your medication’. Okay, I felt hurt because it’s a private thing and for them it’s nothing].”

The dismissive attitude extended to previous medical history, and where Sophia was concerned, might be explained by it. She shared,

> If they ask for history of the papers of the past, you know, from your doctor, if a doctor begins like that with you, then they already have the background of you, and they can start with a more personal, you know. But if you don’t have that, you don’t know nothing about the person, you know.

Zahra had a lot of difficulty with the fact that all her previous medical history was summarily dismissed when she first arrived in Canada. “I have no history”, she said, several times through the interview. She had brought electronic and hard copy files of her medical files with her and the doctor dismissed them as less than optimal because the Canadian medical “system is different” and the doctor “would rather not look at the old papers.” Zahra thought that was a mistake because she felt that, had they considered that history, it might have prevented her from having two major health crisis that were life-threatening. Here is how she expressed it,

> I think that was a huge mistake. If I have the chance to tell her, for example, that, "No, I had previously this issue. I had high blood pressure." I felt I needed someone to talk to, someone to tell, not having a chance to look into the papers, I don't know if she didn't trust the system. I don't care if she doesn't trust the system, but all I care about is that to tell her that if you look at this, if you look at these numbers, they don't look good, and we have to start from here. Why start from scratch?...When I look back at this, I think we could have prevented something. But, unfortunately, we didn't.

This was the case as well for Najwa. She had a chronic condition that was diagnosed prior to arriving in Canada and for which she was receiving treatment. She was frustrated that the physician would not consider her history and continue with the treatment that she had been on. She relayed a dialogue she had with her family physician, "I'm trying to tell you what I've done in the past before coming to Canada, and this is the way it works, and you're not convinced for some reason."

The participants felt that this dismissive attitude led them, at times, to expect very little from their physicians. Zahra confided, "I will see my family doctor now in two weeks and I will tell her. But I know. I will tell her not expecting that she can do anything about it."

Theme 3: "Integration is like a puzzle": Integrating into Canadian life. As I met with each of the participants and heard their stories, it became obvious that each had integrated to a different level into life in Canada. That level depended to a large extent on length of time she had been in Canada as well as a number of other factors, including previous immigration experience and her social capital. Bethsaida put it this way,

> If an immigrant is integrated as the other, it's like a puzzle to me. It's a puzzle where the pieces have to come together and I think when the people that do puzzles, they usually start somewhere. Like that's the starting point, and then they add other pieces, and to me the first piece will be different for everybody. But to me, it's really finding that place that will allow you to start your connections.

Similarly, each of the participants told a story that is unique and yet portrays where her starting point was. Each starting point and, in many cases, the level of completion of the integration puzzle to date was different for each participant. The stories highlighted that social integration was impacted by the immigration experience, social capital, individual attributes, sex, and gender role of the immigrant woman.

Immigration experience. The participants shared that, in general, Canadians are welcoming of immigrants and that once you integrate, Canada starts to feel like home. Najwa shared, "When I came to Canada initially, I was so surprised by the kindness of people. I was so happy to come back and live here." Bethsaida shared a similar experience of when she went to the immigration office to complete paperwork, "And the lady came to us and said, 'Welcome to Canada'. And I thought what a difference. Are there people like that still. Anyway, it was just a totally different experience." Bethsaida also shared that you know you have integrated when Canada starts to feel like home. She felt that her children are also settled now, "My son started working at McDonald's. He's excited about that. My daughter made friends. So they are okay.” Because her family is settled, she felt that Ottawa is now her home, “For me, this is home now.”

Working and earning a wage eased the social integration experience and enabled the participants to access networks, potential opportunities, and supplemental health services. Bethsaida explained, “I think the immigrant experience itself is a factor in getting better healthcare. The better you integrate the better services you actually get. The first integration is to find a job.” This was echoed by Miranda who said, “Donc c’était difficile pour nous comprendre. Parce que la Colombie, l’accès c’est plus facile. Quand on est une personne qui travaille on a l’accès tout de suite. [So it was hard for us to understand. Because in Columbia access is easier. When we have a person who is working we have immediate access].” Once you have a job, Bethsaida shared, it gives you “access to health insurance, to people, to connection.” If you do not have that job “then there are some conversation you are not part of. Then there are some people you can’t meet. Then there are some health insurance you can’t access.”

The participants felt that the immigration experience itself had an impact on their physical health. Zahra said,

> Coming here, trying to adjust, and all the stress, that you might encounter at the beginning when you come, especially as a family, that was a change to my body and it needed time so my blood pressure was higher than usual for a long time… it’s two completely different systems and adaptation is not as easy, and they impact health, definitely.

Melissa echoed this experience and shared,

> Everything started from there. Everything started from there. Yes, because it was hard to get into the culture when I got here. I felt like a fish out of water. So that makes me feel depressed, makes me feel that I do not belong here, you know. So I would say that the emotional part, it's the base of how I'm feeling right now.

Each participant told a story of immigration that, despite its uniqueness, had both positive and negative aspects to it. What they also agreed on is that starting over is difficult and that they have had to make necessary sacrifices in terms of socioeconomic status in order to invest in a future for themselves and their children. They have had to take a step back professionally in some instances, and have had to pursue further education in others as they started over again. Each participant had a unique story to share about those first few months and years. The details of each story will be shared next.

Zahra, who immigrated from the Middle East with her husband and three adult children, came with a stable economic status and was able to establish a household almost immediately. Her husband, when he could not find employment in Canada, had to return to the Middle East and find employment there to continue to support the household. Zahra is a school teacher and had a hard time finding employment. She had to settle for a part time job teaching English as a second language simply to add Canadian experience to her resume. She explained,

> So I started. I said at least I put something on my CV. I didn't think about, I didn't care at the time about having any benefits. I just wanted to add a company name, someone's name on that CV.

Sophia applied for immigrant status after marrying her Canadian husband. She shared that she is completely dependent on him financially and was not able to apply for a job until she received her immigration papers the previous year. Because she arrived with two older children, the financial burden on the household was multiplied and they are still struggling to make ends meet.

Melissa had a similar experience as well. At this stage, her husband remains the primary wage earner in the family as her qualifications were not accepted. She explained,

> Sometimes I work some part-time jobs. I do it from home or wherever I can do it. But I don’t go out even though I have a university preparation, but the times that I went to look for a job, they ask me Canadian experience. I don’t have Canadian experience. And how can I get it if they don’t give me the opportunity. So that makes me feel like I’m not prepared enough professionally.

Najwa was in a better financial position than the other participants because of the nature of her educational preparation and that of her husband, which gave her an advantage. Both she and her husband were registered nurses who had worked in Western settings and who had graduated from a Western educational system. They also had the financial stability from their work in the Middle East. As a result, they were able to find employment that is congruent with their qualifications soon after arriving in Canada and acquiring their licensure to practice nursing. At the time of her immigration, Najwa was completing a second graduate degree at a Western university and has since enrolled in a PhD program at a local university.

Miranda and Esther had arrived into Canada as part of the Live-in Caregiver program. They struggled in the beginning to make ends meet and to learn the language as they spoke neither of the two official languages. Miranda was widowed soon after and had to struggle with raising a child on her own. She compromised by operating a home-based childcare service from her own home. Esther shared that she is still struggling financially. She is currently working in a child care centre on contract work that is not as stable as she would have liked but that gives her supplemental health insurance benefits. She is, however, continuing to struggle with housing instability.

Bethsaida's story is closer to Najwa's in that both she and her husband had originally immigrated to a country other than Canada where they received additional education and employment opportunities which helped ease the integration journey. Even though at the beginning and for a few months, Bethsaida continued to work in the United States and travel to Canada until her family was more settled, this helped ease some of the financial burden and helped them find a place to live until her husband found employment. Despite this advantage, they had a hard time starting over again as she put it,

> So I went to the States. It was the whole experience of, you know, starting over, being treated like a second-class citizen sometime, even a third-class citizen, you know and trying to find a way, someway up but knowing who you are, but always trying to prove yourself, you know, and working harder than everybody else sometime to reach a place where you can be seen. Then you come to Canada and you start all over.

Bethsaida shared that despite their graduate level education that they acquired in the United States, they had a hard time finding employment, “I send out I don’t know how many job applications when I came in and I couldn’t get anything.” Her husband ended up working as a clerk in a grocery store for several months and is currently employed as a bus driver while he completes his second PhD. She explained that underemployment is a reality for immigrants “because you got the job that you can get to feed your family and your spouse is doing the same thing on his side.” She went on to say, “a lot of people don’t even work in their field, but to give you a sense of belonging somewhere and that’s first thing to me.” Bethsaida is currently employed full-time and truly enjoys her work.

Mariam had emigrated from Africa as well. Unlike Bethsaida’s experience, Mariam and her husband are still struggling to make ends meet for themselves and their five children. Her husband works in a menial job as a wage earner and she is currently unemployed and has gone back to school to complete a personal support worker program. They do not own their current home and are renting in an area that offers lower rental rates because of distance from downtown. They do not have supplemental health insurance and, as such, have to pay out of pocket for medications and treatments.

Participants also shared that access to certain culturally-specific foods is not easy due to availability and expense. Mariam and Bethsaida mentioned that there is only one place in Ottawa that sells African foods and that it is usually too expensive to buy except on special occasions. Bethsaida shared,

> Here in Ottawa, I only know one market that will sell African stuff. Like Christmas is coming, everybody's just going to go there to find something from their country. But because it is coming all the way from Africa, it is expensive, so this is a treat. You cannot buy that every day.

Similarly, Sophia shared that there is only one Dutch store in Ottawa and that she only shops there occasionally due to the cost. She also missed some of the Caribbean foods that she had gotten used to such as plantain and yucca and shared that she never cooks it in Ottawa and waits until she visits the islands to eat it.

Bethsaida also felt that the compromised economic status of immigrants will force their nutritional choices. Because healthier diets are more expensive, immigrants might have no choice but to opt for the less healthy diet because of cost.

> Food is expensive. And when you add to that the kids, and you want to eat healthy, it's expensive. Trying to find equivalency here or when you can't find it, now adjust to whatever you have with the income you have. If fast food is cheaper, that's what they're going to get.

The participants shared that their integration experiences were influenced by their economic and educational status, not only because of the impact on nutritional choices, but also because of the impact on access to health services and social networks. Zahra explained, "If I don't work, I don't get paid and I do not pay for my drugs and there are many. Going back to work, I know it's important financially, but in my case now, it is very important emotionally." Bethsaida shared, "If you have a good job with insurance on top of your regular Ontario insurance, you can access already some things. So for me, that gives you some security." The security of an economic status extended towards social position and social standing. Bethsaida felt that because they did not come directly from Africa, they were able to attain a better social position faster. She explained,

> I don't know if it would have been easy if we were coming directly from Cameroon. I don't know if it would have made a difference for example in the neighbourhood we will have landed in. I think maybe because I see some people where they live when they start. They are stuck in some places with other immigrants, what people in the States call projects.

She went on to say that it was her paystub from California that helped them get a good place to live, "My paystub from California played a role in the person accepting to give these people [meaning her family] a place to stay." She also felt that the educational and economic advantage that she had helped widen her social network. She said, "If you are a Tim Horton's server, then what? You know. There are some conversations you are not part of, then there are some people you can't meet." She cautioned, however, that you would need to make some sacrifices in order to attain your goals of a more stable socioeconomic status,

> And so for me that's important. But it's hard. In order to reach that point where you have that job, you have to think. You have a family. If you have little kids, can I go back to school? How is that going to affect all of us? It's just, to me, that's a huge, it's just difficult.

Social capital. As part of the integration puzzle, each of the participants told a story of how members of their social network helped them navigate through the first few steps of integration into establishing roots in their new home. This included postimmigration paperwork, applying for health insurance, finding a family physician, finding housing and work, and providing emotional and financial support when needed.

Coming to Ottawa was the obvious choice for Zahra as she already had a sister and a brother who lived here, as well as a brother who lived in Toronto. They were her starting point to the integration puzzle as they helped her and her children integrate into Canadian life while her husband continued to travel between Ottawa and the Middle East. She shared how her brother helped her find a family physician,

> If my brother did not open the subject and say, "[Zahra], you need a family doctor and I went to our clinic today and we're withdrawing." Because he was travelling, right? "So I told them and they said yes. They will accept a family of five." If I have no family here, who would have told me about this, that this is the most important thing?

Zahra's sister also helped her find her first home and has since helped her move from the house to an apartment. While she was recuperating from her last health crisis, she was able to stay with her sister until she regained her strength. Even after that, her sister and daughter provided much of the physical and emotional support, "[Daughter] is, like, driving me everywhere."

Sophia's story is similar in that she had the support of a family member to start the social integration journey. Her husband is Canadian and he sponsored her and her sons to become permanent residents. He also helped them navigate through those first few months in Canada until their residency papers came through. Sophia spoke of how he helped them find a school for the younger son and had the older son work with him in his own business. She shared that he bought them a car and helped them get their driver's licences. He also connected her to a small community of faith and a group of Spanish-speaking women who have given her much support and within which she is very active.

Melissa's husband had come to Canada originally as a student and was very familiar with life in Canada. When they first arrived, and until they found a place of their own, they lived with his mother who had emigrated following a work experience in Ottawa. Because her husband spoke English fluently, while Melissa spoke none when she first arrived, he became her voice and her advocate. She explained that he continues to be a wonderful help to her in navigating through healthcare and other services, "My husband always went with me. So he, anything that I couldn't communicate to my obstetrician, my husband was there. If he wasn't there, I won't feel confident being there by myself." A friend of hers had connected them to a Spanish-speaking family physician with whom she has a great therapeutic relationship, "He's a wonderful physician. He's so caring. He'll listen to you. He cares about you. He calls you when you're sick. And that was a blessing."

Despite the support that Melissa has received in integrating into Canadian life she still struggles with life here and feels that she misses her family back in Honduras. She felt it most intensely when she had her baby five years ago,

> I was attended by the nurses, they were wonderful. They were pretty caring and I don't have any complaint about that. But my family was not there. I know, I

> understand. They are back in Honduras, but I felt so alone. Only my husband was there.

Esther came to Canada as a live-in caregiver into a physician's household. They became her link to integrating into Canadian life and accessing the healthcare system. She explains that the physician and his wife managed a family care clinic and they helped her navigate the healthcare system by referring her to one of the family physicians within their clinic. Esther explains,

> La personne qui m'a servi c'est un docteur et, parce que j'ai eu la bénédiction que j'ai travaillé dans le 2008 avec, j'étais nanny dans une maison de docteur. C'est pour ça que j'ai eu le médecin de famille… Quand ils ont ouvert la deuxième clinique, ils m'ont donné une madame pour mon médecin de famille.
> [The person who helped me is a doctor whom I was blessed to have worked with in 2008, I was a nanny in a doctor's house. That is why I have a family physician… When they opened the second clinic, they gave me a woman to be my family physician].

By doing so, Esther was also able to refer her sister and her family to the same family health clinic, "Quand j'ai connu eux, toute ma famille a eu des médecins de famille. [When I met them, my whole family had family physicians]."

Najwa emigrated to Canada with her husband and two sons from the Middle East. They had been working for a few years in Saudi Arabia before coming to Canada. Najwa shared that her brother-in-law and his family live in Ottawa and that influenced their decision to come here as well as the decision of which area in Ottawa to live in.

When Bethsaida and her family first arrived in Canada, her brother-in-law helped them navigate through the postimmigration paperwork. She clarified,

> So if you don't have somebody to navigate you through that system when you come, to say okay, drive you. Because my brother-in-law had to drive us places. Because he went through the system himself. This is where you do your social insurance number. This is where you go. This is where you do that. Then start the process of connecting.

It is their church family, however, that helped them find a place to live and connected them with potential employment opportunities. She explained,

> The thing with housing here it worked out well, because, again, friend to friend. We call ahead of time. We're looking for something in Ottawa. My pay stub from California played a role in the person accepting to give these people a place to stay, but they still asked for somebody to co-sign for us that had a job in Canada. So they did that.

Bethsaida's church family also connected them to potential job opportunities. She shared,

> So when I came, we started going to a community church that was a good thing. That's actually how I met somebody. They said, oh, maybe you can apply to [organization]. It made a difference for me and for my husband because I have a person at church who referred him to somebody. He worked for a whole summer at grocery store as a clerk and everything.

She also shared that they helped them get a bit of a start by giving them a financial gift, "I guess some people came together and they give me an envelope. I remember $500. I was like wow. That was a blessing, you know, welcome thing."

In addition to being a source of positive support, a social network could also be a source of negative stress. Zahra shared that her father is a widower and is advanced in age. After trying to live in Canada for a couple of years he found it very hard because he does not speak any of the official languages and does not drive. He then decided that he would rather live in his own home in the Middle East. This, however, placed a strain on the whole family as they take turns every year to go back and spend time with him. They have also pooled their resources to ensure that he has live-in help and that his financial needs are taken care of. In addition to her father, Zahra worries about her adult children and their welfare. In terms of healthcare, she struggles with not being able to make the appointments for her children and advocating for them. "There are restrictions and till now, I struggle to think of it as positive. You know, like they value the privacy and the personal stuff." She felt that she feels helpless which makes it very stressful for her. "I feel kind of helpless because I can't take an appointment and tell them here you go. Even this portion I cannot do, and to me, that's also stressful, that's very stressful."

Najwa shared that she has had to hide some of her experiences of discrimination and racism from her family back home so as not to worry them or influence their opinion negatively about Canada. Speaking of her experience when her sister came to visit, she explained,

> I didn’t tell her anything because I didn’t want her also to hate the country or I don’t want her to go with a negative feeling back about how I’m living here, because she’s the only person who visited me so far. When someone visits, you want them to get the best impression about your life because they’re going to take this impression and submit it. I don’t want my family to be anxious about me. Like she’s suffering or she’s not happy.

Bethsaida is helping her siblings in Africa support the needs of her aging father. Because Cameroon does not have a universal healthcare system, they are constantly worried about her father’s health expenses. She explained,

> My father who used to be a civil servant who is now retired, we have to pay cash for his health needs. I’m thinking I have to make sure that there is money in an account in Cameroon that is there in case he needs help, that they’re going to take him to hospital.

Individual characteristics. The participants shared that their integration experience was also influenced by individual characteristics that included a past history of migration, being a “qualified immigrant”, fluency in one or both of the official languages, and being driven to succeed.

Of interest, participants who had a previous history of migrating felt that their immigration and integration experiences were not as difficult. Bethsaida had immigrated to Canada from the United States of America to which she had emigrated a few years earlier from Cameroon. She explained that it was easier for her to adjust than it was for her husband, because of her history of migrating,

> From all our family members I'm the one that adjusted better to change. Maybe because of my background to my dad, he used to be a civil servant in Cameroon, so we move all around the country. My husband grew up in one place and then he moved just few places.

She felt that because they came from the United States instead of directly from Cameroon, they were able to settle faster, despite the change fatigue that she described they were all feeling. She felt that Ottawa is now her home, "For me, this is home now."

Sophia, who was born in Curacao, had lived in England and Spain prior to settling in the Dominican Republic. She married a Canadian gentleman and moved to Canada with her two sons. She too, felt that the immigration experience was not as hard because she was used to starting over in different parts of the world. This experience was echoed by Najwa and Zahra who had lived in Saudi Arabia and the United Arab Emirates, respectively, prior to immigrating to Canada. By contrast, Melissa had a hard time integrating when she first arrived. She had arrived directly from Honduras and had no history of migration prior. She explained,

> I felt so lonely, so out of the culture. It has been difficult for me to realize, to embrace this culture as mine now, that I am part of this culture. Now, I'm getting there, but it has been difficult for me.

Bethsaida called herself a "qualified immigrant" because the process of screening and immigration ensures that the person who immigrates can and should be able to integrate faster. She explained, "I came here as a qualified immigrant… You have to prove that you are healthy, prove your education, your health. Everything is checked."

She also added that “qualified immigrants, they will already have a contact here, a family member or a close friend that will navigate them through the system.”

At the time of the interviews, all the participants were fluent in one or both of the official languages. The participants, who were fluent in English or French when they first arrived in Canada, had an easier time integrating. When asked if language was a barrier for her, Zahra explained,

> I speak English. I speak French. So it’s not a big deal. And I do have the courage to ask for repetition if I don’t get the things, especially at the beginning because maybe their accent was different, maybe the way they say things was different.

Similarly, Najwa responded to the same question with, “I didn’t go through that because I can speak three languages.” Bethsaida concurred and added that because she was bilingual, with French as a second language, she was accepted into a French graduate program at the local university, “What helped me was also that I was bilingual French. I was able to go back to Ottawa U in French only program and that helped.” Bethsaida also shared that when she first arrived in the United States from Cameroon, she did not speak any English and had to learn it there. Language was not a barrier for Sophia either as she spoke English fluently.

In addition to a history of migration and language fluency, the participants felt that, as women, they needed to persevere through the challenges of the immigration experience. They also needed to continue to strive to improve their circumstances to counter the disadvantages experienced as immigrant, visible minority women. Bethsaida said, “Women, we can take anything. We will start anywhere.” She then described her experience once she decided to go back to school for graduate studies. In describing the first Master’s degree that she completed in the United States she said,

> I did my other Master’s part-time in four years because my kids were little and I was working full-time nights because we couldn’t afford babysitting. So my husband could be a student full-time. He would be the babysitter at night when I go to work.

She went on to explain her decision to go back to school for a second graduate degree, she said,

> I thought I was done with school and then I went few months in [Organization]. I thought, I don’t think so. I don’t think this is what I want to do for the rest of my life. You know, I need to go back to school.

Melissa took advantage of the free educational programs offered to immigrants to improve her English and French proficiency. She also shared that, by persevering through those first few years, she is finally starting to feel more at home here. She said, “I’m getting there. I’m feeling more comfortable here in the culture, I have more friends, I involve in a lot of activities, at church, the community, and my children’s school.”

Both Miranda and Esther pursued French as a second language when they first arrived in Canada and are currently learning English. Miranda has opened a small daycare in her own home and has had to qualify for it by taking additional training and education. Similarly, Ester pursued additional courses and is currently working full-time in a daycare centre. Of the participants, Miranda and Ester have been in Canada the longest and are well settled.

Najwa, who is pursuing a PhD with three children at home, including a newborn, described some of the challenges that she is facing at school and work. Her response to these challenges can be depicted with the two phrases she used, “I passed the challenge” and “I didn’t give up yet.” Even though she already has a professional degree and two Master’s degrees, she has decided to go back and pursue a doctoral level education in order to improve her opportunities for advancement.

Of interest, the participants did not describe the same level of perseverance and drive from their husbands that they had themselves. Zahra’s husband, for instance, chose to continue to travel between the two countries rather than try to integrate fully into Canadian life. Najwa’s husband has no intention at this stage to pursue further education beyond his professional degree despite Najwa’s three additional advanced degrees. Bethsaida felt that this is due to the fact that men have a harder time adjusting to starting over again. She explained,

> I think men have a hard time starting over to the bottom when they have had some sense of worth, what they consider that, and to sometime go through the lack of recognition, of respect, it’s hard. Some of them are going back. Some of them divorce are happening. It’s a tough road for men. Women, we can take anything. We will start anywhere.

“Women feel it more than men”: Gender role. Some of the participants shared that, as women, their roles as mothers and wives made it harder for them to integrate.

Even as their roles changed, this was more a stressor than a facilitator. Zahra explained that because her children are older, she experienced a sudden shift in her role as a mother when she came to Canada. She explained how this has caused her a level of stress and anxiety,

> I feel I have more knowledge than them in this matter, but again, practically, they care less about it because they're healthy. Even after my two incidents, I keep saying please. One of my sons smokes. "Please stop smoking. You go with me. We're allowed one member, family member, to go to the rehab to these sessions. Why don't you go for me, with me?" And of course the usually the response is very negative all the time. So, health-wise, it does affect, and I consider this, in my situation, a stressor.

Bethsaida shared that she continues to try keeping her family healthy even as she works full-time outside the home. She had to do so even when she was studying part-time and working nights. She said,

> I'm still cooking my own food. I make sure I cook every day. But it can take a toll, you know. It can become a burden to cook for your family at one point given that you are trying to make a living.

Melissa shared that she has chosen to take on part-time work when it is available to do from home as she has to take care of her family. She explained that she considers her family her ministry right now, but that this has prevented her from seeking employment outside the house despite her university-level educational preparation. She said,

> I’m not working right now because my big ministries are my children, so I want to be here for them. Sometimes I work some part-time jobs. I do it from home or wherever I can do it. But I do not go out even though I have a university preparation.

She went on to say that this has impacted her integration--and consequently, her health--negatively. She explained,

> Everything started from there. Everything started from there. Yes, because it was hard to get into the culture when I got here. I felt like a fish out of water. I was more independent back in my country. Now I have to depend on my husband and in all of the matters, not only he helps me communicate sometimes with other people, he helps me in the economic part… so that makes me feel like I’m not prepared enough professionally. So that makes me feel that I don’t belong here, you know? So I would say that the emotional part, it’s the base of how I/m feeling right now.

At the same time, some of the participants shared that, as their roles changed, so did their husbands’. Sophia explained how before her marriage, she and her sons were extremely close and she was both father and mother to them. After her marriage, her husband has taken on some of the duties of preparing her sons for life here in Canada and for leaving the home as mature adults. Even though she feels they should not leave the house until they are married, she is resigned to the fact that, in Canada, that might not be possible and that cultural norms are different.

Najwa’s role shifted as well when she was bed-ridden during her pregnancy and her husband had to take their sick son to the emergency room. Her frustration at not being there to advocate was evident in her retelling of the story. She shared,

> He wasn’t able to breathe, and then I was really panicking and I was pregnant and it was the time where I was supposed to be bedridden. And then I needed to go to emergency room. We went to all those walk-in clinic and none of them accepted us because they either they can’t, they’re overwhelmed, they’re going to close in half an hour. They can’t accept us. So we went to [local hospital] and my husband went there because I wasn’t able to also go with him.

Bethsaida also shared that, because her husband works shift work, this has allowed him more time during the day to take on the role of healthcare navigator. She said, “I used to be the one navigating the health care system. My husband is now more at home because his schedule is more flexible.”

Theme 4: Navigating the healthcare system. All of the participants had arrived in Canada from countries where the healthcare system was not universal. As such, they were used to accessing the services when they were able to pay for them or through employment health insurance. Their lack of knowledge of the Canadian healthcare system impacted their ability to navigate it for themselves and on behalf of their family members. They had to learn how to advocate for themselves and their loved ones as well as how to use workarounds when they experienced barriers to access.

Miranda spoke of how she had to actually find a family health clinic and advocate on behalf of her family before they accepted to open a file for her. “Nous on a trouvé la clinique, jusqu'à ce que finalement ils ont acceptés à ouvrir un dossier pour nous, pour moi spécifiquement. [We found the clinic, until finally they accepted to open a file for us, for me specifically]." She explained that, in Canada, you have to be involved in searching for your own family physician, "Ici il faut chercher, il faut s'impliquer pour aller chercher la clinique et le médecin. [You have to search here, it is necessary to get involved in finding the clinic and the physician]."

During the visit with the physician, participants had to advocate for treatments, diagnostics, or referrals. Najwa shared that she always has to remind her family physician of the need to request a specific blood test to be repeated every six months, "I always have to remind her. 'No, we can do it next year.' I'm like 'No, I have to do it at least every six months'." She also described how hard she had to advocate for a change in treatment for herself,

> It took me one year and a half to convince her to go to 10,000IU and she's not very happy about it. My vitamin D is extremely low and during pregnancy I need vitamin D more and more…I negotiate with her because I have the background and I can tell her.

Najwa felt that, even though the physician has the healthcare knowledge, they do not have the same insight you would have about your own health. As such, you need to be able to advocate for yourself. She said,

> [The physician] is going to do what she thinks is right. And I'm like, what is right is what I also think is right. I am not going to take your role as a physician, but I have the right to advocate for myself.

Najwa also told of experiences when she had to advocate for her children's healthcare needs as well. She described her experience of having to advocate, even beg, for diagnostic imaging for her newborn child who was born with a mouth lesion that is getting worse as time passes.

> I have a problem with my daughter right now, and I don't know. It could be a tumour. I don't know if it's benign or not. And she doesn't think it's something serious until I went to her as a walk-in. I told her, "I'm really scared. I can't sleep. Look at this thing in her mouth and please refer me," and this is the only time she referred me… I don't need to live in the darkness. It's been many months now. I went to her, I said, "Look, I can't sleep. Look at her mouth. It's blue now. If it's going to become necrotic, even if it's benign, it won't be something nice. If it's necrotic it's a big issue." I told her I'm not leaving before referring me to a specialist. Stop telling me it's fine. It's not fine. It's growing and now it's blue. It's very blue. It mean there is no oxygen. So this is really unacceptable.

Najwa described an experience they had when they had to take her son to the emergency department because of a constricted airway. Her husband had to advocate for treatment when the physician did not take the condition as seriously as they felt it was.

> He was telling her, "I'm a nurse. I'm a critical care nurse and I know wheezes. We know the history of our son. I'm not ignorant. I know what's going on with my son. So please believe me and give him something. I don't want to come

> back because I know that I will come back and wait another like six, seven hours."

Zahra shared similar experiences in regards to her own family physician and felt that she could not truly trust physicians because they had missed or ignored warning signs in the past. She said, "I asked her to check my blood pressure. She looked at me and said, 'Oh really? You want me…' I said, 'Yeah, I think it's high, because I feel the headaches'. Which I did and it was high." She also shared an experience with a specialist that impacted her trust in the healthcare professionals.

> In 2013, when the nephrologist saw me, she saw that the adrenaline glands were not the correct size, but again, she didn't say anything. She did not recommend anything. She was a specialist. So to be honest, I do not trust any of them. No one.

Zahra, as a result, felt that patients ought to have access to their own records in order to better advocate for themselves.

> If I had this in paper and I read it, I would take it and go to my doctor, "There is something here. I have a question. I'm concerned about this. Does this mean anything?" And then she'll explain and then I'll trust.

The lack of access and lack of trust, has led some of the participants to self-medicate or to stop treatments without informing the physician. Melissa, who was having severe side effects from the treatment she had been on for her rheumatoid arthritis, chose to simply stop taking her medication, "I stopped the medication about two and a half months ago." When I asked her if her physician was aware, she responded with, "I don't know and I don't care. I don't care what he says." She then went on to relate how when she relayed a concern about the side effects in the past, he offered her an alternate treatment that would cause her even more severe side effects. She was so disappointed with the care, that she requested a second opinion and went to see another rheumatologist, “I went to a second opinion, to another rheumatologist here.”

Najwa shared that her husband actually gave antibiotics to their son who had had fever for 72 hours, as they were waiting to be seen in the emergency room. “During this time, he was giving him antibiotics.” Medications that could not be accessed over the counter were sometimes purchased from the country of origin. Miranda felt it was faster to ask her family to send the medications from Colombia.

> Je ne sais pas si on peut dire ça, mais des fois c’est préférable à demander à un autre pays d’envoyer des médicaments pour qu’on puisse se soigner nous-mêmes qu’attendre que le médecin d’ici va nous donner…Dans la famille, pouvait aller le médecin et l’envoyer. Sinon on ne pouvait, c’était plus rapide que d’aller chercher le service.
>
> [I don’t know if we can say this, but sometimes it is preferable to ask another country to send the medications for us so we can heal ourselves while waiting for the doctor here to give us… In the family, they can go to the physician and he will send it. Otherwise we could not, it is faster than accessing the service].

In addition to accessing medications from other countries, participants employed workarounds to access services that included using the services of healthcare students and accessing walk-in clinics, especially when their family physician was scheduled to be in attendance. Miranda shared that she accessed the services offered for free by dental hygiene students in their educational program at a college close by. “Et avec le dentiste, c’est cher, mais il y a un service au cégep qui c’est accessible et donc on a aussi, on connait la programmation et on demande rendez-vous là-bas. [And with the dentist, it is expensive, but there is a service at the college that is accessible and so we have to know the schedule and request an appointment there].” She also shared that she sometimes made sure to access the services of the walk-in clinic when her own family physician was scheduled,

> Mais il faut attendre toujours les trois semaines pour que le médecin puisse me voir. Et c’est parce qu’elle prend à cœur vraiment ses patients. Donc on a pu aller dans une journée ou elle était médecin comme sans rendez-vous.
> [It is always necessary to wait three weeks for the physician to see me. That is because she really takes to heart her patients. So, we can go the day she is scheduled in the walk-in clinic].

The other participants followed the same strategy to access their family physicians. Najwa shared that, in order to see her physician in a timely manner for her daughter, she chose to access her as a walk-in. She said, “She doesn’t think it’s something serious until I went to her as a walk-in.” Zahra was frustrated as well with the limited access to her family physician and shared that she would usually try to schedule a time to see her physician when she is scheduled in the urgent care clinic. She said, “And if I want to see her, she’s usually, once a week she’s in charge of the urgent care in the clinic. It’s not easy.” Similarly, Esther shared that she would try to schedule an appointment in the urgent care clinic associated with her family health team when her physician was there for a more expedient access, “Je suis allée a la clinique d’urgence parce que ou est ma docteur de famille. [I go to the urgent care clinic because my family physician is there].”

Even when their own family physician was not scheduled in the walk-in clinic, the participants still chose to access it as an option for quicker access. Miriam explained, “Unless it is an emergency, you can go to urgent care.” Melissa explained that because of the difficulty of accessing her daughter’s pediatrician, she finds herself using the walk-in clinic more often than not, “I had to go to a walk-in clinic, which is what I use most of the time, even when my daughter is sick, because it is too hard to get to her pediatrician.” Both Miranda and Esther also shared that when they need to be seen and are unable to get an appointment with their family physician, they go to the walk-in clinic associated with their family health team and ask to be seen. Esther said, “Quand j’ai des urgences, je peux y aller dans sa cliniques à lui et je demande pour lui et c’est lui qui me fait le service. [When I have an emergency, I can go to his clinic and ask for him, and he will provide me the service].” Miranda shared,

> Quand c’est l’urgence il faut toujours aller à la clinique sans rendez-vous, ça veut dire qu’on doit aller dans, quand il y a un médecin d’urgence qui nous attend pour pouvoir nous soigner.
>
> [When it is an emergency, it is necessary to go to the walk-in clinic, that means we have to go in when there is an emergency physician who is waiting to care for us].

Theme 5: “Being a visible minority, it’s a pain in healthcare, or not only in healthcare, even at Wal-Mart”: Discrimination and racism. When I first started the interviews with the participants, I did not prompt with questions about their experiences with racism or discrimination. As the theme emerged with the first few interviews, I chose to include it in the overarching theme of *access to healthcare* because it depicted experiences with the health care providers and within the healthcare system. It was only as I heard the stories told by Najwa and Bethsaida and the experiences they had outside the healthcare system that I was compelled to separate the theme and give it its own heading. Their stories begged to be told separately.

The participants spoke of experiences of discrimination and racism that varied from subtle discrimination and disrespect to overt racism and assault. Invariably, they did not know how to react and questioned whether the issue lay with them rather than with the offender. This section will be divided into three subthemes, (a) subtle discrimination, (b) overt racism, and (c) reaction to racism.

Subtle discrimination. Experiences of subtle racism were felt by the participants but were hard to prove. Bethsaida explained them as instances of disrespect. She said, “Then you start over and you can see the same treatment, the same disrespect. And those are in the workplace, in the hospital. Those are difficult things to prove, it’s hard to even express those.” Najwa, on the other hand, saw these experiences as differential treatment and marginalization. She explained that she experienced those incidences everywhere she went, not just in healthcare, “That’s a huge challenge and I found it everywhere, in healthcare, wherever I go.” She gave an example of when she went for diagnostics, "Let's say when I go and do blood test or when I do x-ray or any kind of procedure, I don't know. The kindness is not the same. They do not treat you the same way they treat others." She even pointed it out to her husband when they first came to Canada, "I used to say to my husband look at the way, it is funny, the way he's behaving with me."

Najwa explained that this treatment extended to her workplace and school. She shared that the workload that is assigned to her is much more than is assigned to anyone else,

> When I went on mat leave, I had four big studies that I was working on. And she gave them to four people and the four of them were complaining about each of the studies. I don't even have time to [eat]. I eat as I work. I don't have dedicated time to eat. That is how much I'm busy.

Najwa felt that because of the fiduciary relationship with her supervisor, she could not complain for fear of reprisal. She shared, "When I try to speak with my boss, [she says] if you don't like it, leave. She wouldn't even bother to know what's the problem." She explained that, despite how hard she is working, she is made to feel as if she is barely meeting her supervisor's expectations. So she works harder. "I'm barely kind of meeting her requirements. Just try to avoid any kind of [confrontation]; I don't want to give her excuse to fire me. So I work [with] no break."

Najwa went on to say that people treat her as if she is an idiot, "So people react and they assume you are an idiot. You are someone who should be treated badly. And this is how they are behaving." She shared that her accent and the way she looks could be the reason behind this behaviour. "My accent is obviously not Canadian. It's very

Lebanese. And the way I look. Yeah, the way I look, for sure. I'm not smart enough to meet their expectations."

This impression extended to her experience with the university where she is pursuing doctoral studies. She explained how the professor, who happens to be the coordinator of the program, is placing arbitrary barriers in her path and asking for extra requirements and extra work. Even though the application process asked for either academic or professional references, the professor insisted on only academic references. Najwa also shared that he belittled her second Master's degree because it was achieved through distance education. She explained,

> He said, "We don't prefer online universities." I said, "Excuse me, [Name of university] is one of the best fifty universities in the world. So if you have any problem with the university you need to tell me exactly what your concerns are so I can answer. But if you just tell me it's online, it's not acceptable, because it is not easy to graduate from this specific university."

She later found out that one of her classmates had a similar degree from the same university, yet did not experience the same barriers.

> And it happens that my colleague, he's Canadian. And he graduated Master degree from [same university] because it was recommended by his mom and lots of friends to do his Master degree. He's Canadian and he's done it online at the same university I've done it, and when I told her what this admission coordinator is saying, she said he has no right to do so. So I realized that maybe he's giving me more barrier, more excuses to reject my application.

In addition to the admission requirements, the program coordinator requested higher grades, more difficult course selection, and a rigid start date, which, again, were different from what was required from her colleagues. As a result, Najwa is starting to feel that maybe she has made a mistake. She said, "I think I did a mistake. I forgot I'm a visible minority (laughs). I'm so used to myself, till extreme I really forget. So yeah, yeah, so there is discrimination. It's not only you feel it. You live it." She is feeling that she is being pushed to leave the program and now has a decision to make about that. "Do I really need to go through this challenge? I'm going to see him for the next five, six years. So it's something. So I don't know. I need to decide."

Overt racism. Najwa felt that those experiences of discrimination and racism have gotten worse in the last couple of years and have now progressed to violence and assault. She believes that the political unrest in the Middle East has contributed to the increased levels of racism and that people are no longer trying to hide it and are openly aggressive. She explained,

> June 2013, that was the beginning of war in Middle East, specifically like in Syria and the complicated things that are becoming worse and worse every day. So I started to feel like it's not the same thing as before. I mean the way people treat you.

She felt that people are reacting because of fear, "That was like, it's not they are not happy to see you, they are scared to see you." She felt this difference at work and out in public. She explained,

> I used to go with my colleagues during lunch break. And after the parliament attack, they are avoiding me totally, the moment I pass by, they stop talking. You know what I mean? It's kind of very obvious. When we go, let's say, to heat the food, if they are coming, they go the other way. It was very obvious. Okay, don't come with us to lunch any more.

Similarly, out in public, Najwa experienced instances of discrimination that left her baffled. She said,

> Someone gave me a finger the other day. I'm like what? If I was wrong, I wouldn't even deserve that, and I wasn't even wrong. So people they react and they assume you are an idiot, you are someone who should be treated badly. And this is how they're behaving.

Those instances varied from blatant denial of service to rudeness to actual assault. Najwa explained how she was denied the same considerations as other doctoral students, "So everything he said I'm not allowed, I'm not allowed, I'm not allowed, it was given for other people." She felt that some people were extremely rude in their interaction with her, "They're so rude, so rude. I'm not saying 100 percent, but at least 50 percent of the time. So you have to suck it up all the time and that's it."

Bethsaida shared a similar perspective of when they were denied service by a clerk in an immigration office when they first arrived. She said,

> We came to the office. We were five of us. And I don't know what her job is. So I guess she was supposed to register all of us and look at our paperwork or whatever. And so we came on time. She made us wait. She said we were five

> and so we were too many people and she stressed on the too many people. So we sat there waited, waited, waited and then when it was time for somebody to see us, I was with her and I asked her a question regarding a name issue in the paper and she said you know, "It is not my job to deal with that. You just going to go and come back." I said, "Well, I'm just new. I don't know…" [She interrupted], "But you know what? I don't have time for anything like that. I told you already you got too many people. We can't do that anymore. So that's it. We can't even continue to deal this paperwork. You're going to have to go and come back another day."

Najwa also told the story of when her sister came to visit and the difference in the way her sister was treated versus how she was treated. She explained that her sister does not wear a head cover like she does. When they were out shopping, the store attendant treated her sister differently. She explained, "So the moment they see me, they change the way they treat her. That's like something. Because she looks cute, she's not veiled, you know."

Najwa felt that the discriminatory behaviors have gotten worse and are now outright threats and assault. She said, "You should see how aggressive they turn the moment they see me because I'm veiled, you know what I mean? Giving me the finger. They swear. They're really very aggressive." She told of a specific incidence of when someone tried to run her over.

> I was almost struck by a car the other day. That was something really really extremely scary. I was walking, it's my right to walk, and it's two-way things

> going to my work, just crossing the street, and it's for pedestrian. And he has to stop. There is a stop sign. So he stopped and I was walking, crossing the street, and after he stopped, he ran very fast. So I have to run back because he decided to hit me. So, yeah, it's not only the mental and psychological frustration, there is also kind of [physical] threat.

Of interest, Najwa feels that her husband is treated differently and does not experience the same level of racism as she does. She explained, "Like when I speak with my husband, he says, 'You're exaggerating'. I said, 'Maybe, but this is how I feel. And you're lucky you don't feel the same, because I'm scared for my kids'. You know."

"I don't know what to do": Reaction to racism. Participants who experienced discrimination and racism did not know how to react to it, especially if the person they are dealing with had the power to act in reprisal. Bethsaida, in reaction to the discriminatory behaviour she experienced at the immigration office, said,

> So I thought, okay. I've been through the system and through discrimination, racial, whatever, before. So I had to think. While she's doing that I'm thinking to myself, okay, what do I say? What do I say to this lady? How do I react? And you have the stereotype of the black angry woman, you know, so I didn't know what to do. To be honest, I was a little confused. So I sat there and then I said, okay. So I grabbed my papers. I didn't say anything, came out and my husband look at me and he could know that something just happened. I said, "Let's go."

Najwa felt the same way. She shared, "So it's everywhere. Everywhere I go. Yeah. So it's a big big big challenge and I'm not sure what to do." She went on to say that this is impacting her emotionally and psychologically. She is crying because of the frustration of trying to navigate the arbitrary barriers placed in her path at school. She shared, “For the school, oh yeah, yesterday I cried. One of the professors, he’s so mean to me.” Despite that, she is willing to take the extra measures to address the unreasonable demands that were made of her, “He’s expecting us to study 20 hours. I’m studying more than 50 hours a week. So I’m really doing the best of my best and I’m not meeting what I’m supposed to be.”

She has, however, reached a stage where she avoids those encounters whenever possible and relies on her husband to go out in public. She shared, “And like now every time we need anything, I told my husband, can you go, because if they see me, probably, they….” She went on to say,

> It’s becoming worse and worse, and every time something is happening, I’m telling you, I’m scared. I’m scared … Like I’m talking to you, if anything happened to France now, oh my God! If it’s in Canada, oh my! I would bury myself here. I wouldn’t leave my house even for grocery. So yeah, so I don’t know what’s the solution for this one.

Bethsaida shared that she used to think that the problem was with her and not with the offender. She explained,

> I used to think I was the problem. All these time when something like that happened, I would say, did I say something that wasn’t the right thing to say? Did I walk in here in a way that was [confrontational]?

Najwa continues to feel that she needs to justify the behaviours of the offender and feels that she cannot really blame them. Because she is a Muslim who wears a head cover, when she walks in the street, people think she is a terrorist or what she called "human monsters". As such, she cannot blame them for discriminating against her or attacking her. She said,

> I could feel that they are unhappy to see me. And I was like okay. I don't blame you. I don't blame you. I don't blame you. I know what's going on, and I know what you see and I'm more scared and frustrated than you do, believe it or not… Now this is kind of reaction that happens anywhere if they feel that their country is invaded by stranger, by someone who's not having the same culture as they do.
>
> For him, I'm a terrorist. So he's doing a favour for the country trying to kill me.

She feels that, even though she would be targeted by the terrorists like any other Canadian, people cannot tell the difference and she cannot simply walk on the street and explain herself. As a result, she simply avoids going out. She explained,

> I personally was extremely depressed because of what's going on and because I'm Muslim. When you see someone like ISIS claiming that they are Muslim, oh, my God! I'm not them. And they can't be what I'm raised, the way I am. And they don't represent me in any way. They are my enemy as much as for any Canadian. But when you walk people don't know the difference… It's not like they're not happy to see you, they are scared to see you. I'm like oh my God! Believe it or not, I hate to walk on the street. I hate to go outside. You can't walk and explain yourself.

Theme 6: Recommendations. The participants shared a number of recommendations to improve the experiences of encounters with the healthcare system. They were clear, however, in that they believed in the universal healthcare system and are advocating for changes within the current system. The recommendations can be grouped under two subthemes, system-level and provider-level recommendations.

System-level: Continuity of care and integrated services. Zahra and Melissa felt that Citizenship and Immigration Canada (CIC) ought to collaborate with other departments, including Health Canada, to support the social integration of immigrants, especially immigrant women into life in Canada. Even though some educational sessions are offered to new immigrants about potential job opportunities and for schools for children, there is a need to also provide sessions about healthcare and how to access and navigate through healthcare services. Zahra said,

> Information sessions, whatever they call them, under different denomination, to know more the country, the system. They care much more about the education part, but not about health. So I remember if my brother didn't open the subject and say you need the family doctor who would have tell me about this, that this is the most important thing? That was the first gap I think, like to me that's a big gap. Okay, we care about our children education, about our education, but also we should care about our health, no one tells or even like say anything about the need to have a family doctor. That was not an easy access. If I were to go back, that wasn't clear to me. That was not clear in the system.

She also felt that immigrant women should also be made aware of the immigration integration services that are available in the community especially those that are geared towards women specifically. Melissa felt that this integration service should extend to helping newcomers access employment opportunities that match their qualifications. She articulated that, by finding employment, immigrants can improve their integration journey and, as such, access to health and other services. She expressed it thus, “Canada is bringing people here. We apply as professionals. We apply as permanent residents… I think if Canada is taking new people to live here, they need to open the door for jobs for people who are professionals.”

The participants also bemoaned the lack of continuity and integrated services in healthcare. They felt that because they were forced to access services through walk-in and urgent care clinics and because of the less-than-optimal communication between specialists and family physicians, their care was fractured and led to bad outcomes. Miranda spoke of the fractured care, especially during follow up appointments with the walk-in clinic. She said, “Comme je vous disais, il n’offrait pas le suivi. Donc si on était bien, tant mieux. Mais sinon il faut retourner. Mais ce n’est pas toujours le même médecin qui nous voyait parce que c’était une clinique sans rendez-vous. [As I mentioned, it did not offer follow-ups. So if we get better, that is good. Otherwise, we had to come back. It was not always the same physician who saw us because it was a walk-in clinic].” Zahra shared that her care was delayed over three weeks because of the ineffective communication processes among the physicians which led to bad outcomes.

She felt that there is a need to improve the interprofessional communication across settings and providers. She said,

> She sent to the clinic and they replied. But at that time I thought the miscommunication between them, so I don't know, is it the doctor that should see this directly or is it a staff member? So these paper, these emails, who access them? Who does this job? Is it the doctor? Is it the nurse? Is it one of the staff in the clinic? So that delayed the communication between two doctors, and it's the same between both specialists, between the first and the second one. So is this just bureaucracy? It's just lack of staff. It's just lack of time? I don't know. I don't know. But I'm sure if they communicate well, or better, I think we could have prevented something, but unfortunately we didn't.

Zahra also recommended that the health screening that is conducted prior to immigration and past medical history be communicated to the family physician and included in current medical records. This sentiment was echoed by Melissa and Najwa who felt that a medication regimen that worked in the past in their country of origin should also be considered as an option for current treatment. Melissa shared that a medication that worked for her in the past was not even considered as an option for her in Canada despite its availability and the side effects that she had been suffering of with the current treatment. She said,

> He offered me one treatment and since he saw my history, rheumatoidis, history, the treatment that I had back in Honduras and he offered me this one… the

> treatment that I had in Honduras, they do it here in Canada. But my doctor doesn't want to put me that treatment.

Najwa shared her frustration with the way her Vitamin D deficiency is managed,

> Like I need more than 1,000 a day and, before coming here, I used to take 50,000 a week just to boost it up. Here she said, "No. It's too much." I'm like, "It's too much, but it works. This is the only way it works for me." So it took me one year and a half to convince her to go to the 10,000 and she's not very happy about it, and my vitamin D is extremely low.

Najwa also felt that we need easier quicker access to healthcare services. The wait times to access physicians and treatments are simply unacceptable. "For the system, they need to work on easier and quicker access. It's not acceptable. It's not fair." She felt that sometimes waiting "means losing life or quality of life."

Lastly, Najwa expressed the need to address discrimination by following the dictates of our Multiculturalism Act. She said,

> Now the other challenge is not only healthcare centred. It's a bigger issue, which is the discrimination. I know that there is, in the Constitution, there is a Multiculturalism Act which has been since Trudeau, the father. Canada was the first country in the world to put a policy and make it an Act and obviously they were facing huge issues to go that way, but I don't think they overcame this problem. It's affecting everything, health care, employment, it's everywhere.

Provider level: Desired relationship with healthcare providers. The participants' interactions with the healthcare providers helped guide their recommendation of what needs to be addressed at this level. Participants spoke of having a therapeutic relationship with a physician who utilized a holistic patient-centred approach to care. They did not like the impersonal and cold nature of the interactions they had with healthcare providers and wanted a relationship that showed that the healthcare providers actually “cared” for them as individuals and families. Melissa articulated her hoped for relationship with her rheumatologist,

> For me, the relationship between a patient and a doctor, it has to be a relationship. It has to be back and forth… Feeling like he cares what I’m feeling, he cares, and that he has some options for me. Feeling like he’s caring, he’s concerned about my problem.

They spoke of personable and empathetic physicians whom they had in previous countries. Sophia simply said that healthcare providers “can start with being more personal” in their interactions with patients and families. Zahra echoed this sentiment when she said that her relationship with her own family physician had drastically improved because she has “lots of medical support, some kind of personal touch now.” Melissa expressed her relationship with her family physician thus, “He hears me. My family doctor I go there and I pour out all my emotions. I pour out all my feelings, my concern, and he listens to me and he gives me answers and he gives me options.” Similarly, Bethsaida described how her relationship with her family physician has changed over the course of the last two years and how it is much more personable now. She said,

> He just opened up more, trusted me with my relationship with him. So that two weeks ago when I was there, he was already that we know each other better, you know. There was a relationship there was created that wasn't there before.

She explained how he acknowledged her experience as important and that is what turned the tide of the relationship. "I felt like he was more receptive of what I was saying. He acknowledged what I was saying. He was actually asking questions to understand what was going on with me."

The participants also shared that they hoped for healthcare providers who could address their needs beyond physical health. Sophia spoke of a need to be seen in a more personal manner and not as someone without history. Zahra felt that healthcare providers ought to address "the mental, emotional, the social aspects that are affecting my health directly." She was thrilled when her family physician started probing into the psychosocial aspects of her life and exploring the financial and cultural stressors that were impacting her,

> Now, I would say, she is all mine. No laptop, nothing. She cross her hand and she says, "You tell me now. How are you feeling today? What happened this month? How did your son do that?" And she remembers. I like that she remembers. I feel like she cares. That's me in front of her… So she asked too many questions and I was glad. I was really happy, I was smiling.

Miranda spoke fondly of her own family physician who would call her personally to ask how she is doing or to relay the results of tests. She said,

> Quand on a un médecin de famille, la nôtre, la mienne est une spéciale, c'est une madame qui m'appelle et me dit, "Comme vas-tu? Ton examen est bon ou il faut que nous on va se revoir." C'est elle-même qui me donne rendez-vous des fois pour moi et on aime vraiment. Je suis reconnaissante.
>
> [When we have a family physician, ours, mine is special. It's a lady who would call me and say, "How are you? Your test is good or we need to see you again." She herself is the one who gives me the appointment, and we really like her. I am grateful].

The participants also recommended that an individual should have the ability and right to select her or his own physician based on preference and regardless of geographical location. This was important to the participants because they could then--if possible--select a physician who matches them culturally, whether by gender, ethnicity, immigrant status, or language. Zahra explained her preference for a physician from her own culture "who knows my culture, who knows where I come from. It's not only the language." Of interest, the participants felt more connected to physicians who were of a visible minority background and who could relate to their personal experiences. Both Najwa and Bethsaida recognized that they are able to relate better to their own family physicians because they belonged to visible minorities as well. Melissa also explained that because her family physician is from a Spanish speaking country and speaks her language, she is able to communicate with him better, "I was able to communicate with him in my own language." Miranda and Ester indicated that having a female physician has been a better option for them. Miranda felt that the humaneness of her female family physician made a great difference in her care. She shared, “Mon médecin de famille est génial, c’est une madame très, très humaine. [My family physician is great. She is a lady very very humane].” Ester was also very clear on her preference for a female physician, “C’est un homme, la deuxième c’est une madame. C’était plus à l’aise à lui dire à elle. [It was a man, the second was a lady. I was more comfortable saying things to her].”

Zahra recommended that physicians receive cultural competence training so they can better address their specific needs. Zahra indicated that she would select a family physician based on her or his cultural competence and awareness of the unique needs of immigrant women.

> I think if everyone somehow has the chance to choose a doctor in a different way, not only according to where do you live… I understand schools, but I didn’t understand also doctors. Right. Or maybe if the doctors are more aware. They talk about diversity and multiculturalism and all this, but if they’re in their little caucus that’s not helpful for immigrant woman. I think.

Zahra went on to explain that she is more satisfied with her relationship with her family physician now that the physician is starting to explore cultural needs with her. She said, “I feel that it gives her more idea of who I am, how I think, the way we take things, which is a bit different, of course, than the Canadian way.”

Summary

I began this chapter by highlighting the process of data collection and analysis for an interpretative phonological study that explored the lived experiences of visible minority immigrant women with encounters with the healthcare system in Canada. The eight participants were purposively selected in order to explore the intersection of sex, gender, immigration, and ethnicity in their lives and how those would have impacted the encounters with the healthcare system. I then presented the results of the data analysis of the transcribed interviews, demographic questionnaires, and field notes that were managed in an ATLAS.ti database. Six themes emerged from the data analysis: (a) definition of health, (b) access to healthcare, (c) integrating into Canadian life, (d) navigating the healthcare system, (e) discrimination and racism, and (f) recommendations to improve the experience.

In Chapter 5, I will present an interpretation of these themes in light of current literature on the healthy immigrant effect and the health of women in general and that of immigrant women in particular. The chapter will also include an overview of the limitations of the study and a recommendations section for policy, research, and academia. I will conclude the chapter with a section that outlines the implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative interpretative phenomenological study was to explore the lived experiences of immigrant women who self-identified as belonging to a visible minority with encounters with the healthcare system in Canada. It aimed to describe their lived experiences at the intersection of sex, gender, immigration, and visible minority status in their lives. The narratives extend to three contexts of prior to, during, and after the encounter. This has allowed me the opportunity to listen to the perspectives of the participants regarding their understanding of health and access to health care services. I was also able to explore the barriers that had an impact on them accessing healthcare services, experiencing healthcare services, and following the recommended follow-ups, interventions, and treatments.

Data analysis resulted in six themes and several subthemes. The themes were (a) definition of health, (b) access to healthcare, (c) integrating into Canadian life, (d) navigating the healthcare system, (e) discrimination and racism; and (f) recommendations.

In the following section of this chapter, I will interpret the results in view of research questions, current literature, and the theoretical framework utilized in this study. I will then revisit the limitations of the study and follow with recommendations for further research. The chapter will conclude with implications of the findings to social change.

Interpretation of Findings

In this section, I present the interpretation of the results of this qualitative research study in light of the research questions that guided the methodology and analysis. I will present each research question individually and compare the results from the data analysis to what was presented through the literature review in Chapter 2 and the additional reviews that I conducted following the emergence of the themes. Even though the research questions centered on the experiences of the participants with the healthcare system, their responses encompassed life in Canada in general and the healthcare system in particular. As such, the interpretation of the results will include the totality of the lived experiences of the women that they shared in the narratives, not only what they experienced in the encounters with the healthcare system.

The primary research question of this study was: What is the perspective of immigrant women in Ottawa, Canada, of their lived experiences with encounters with the healthcare system when there is an intersection of the factors of sex, gender, ethnicity, and immigration in their lives? I will address this question in the form of a narrative at the end of this section. Following the narrative, I will also outline the theoretical considerations around the framework that guided this study.

Question 1: What Meanings Do Immigrant Women in Ottawa, Canada, Attribute to Health, Healthcare Services, and Access to Health Services?

The participants defined health more holistically and confirmed what was presented in the literature, stressing the importance of viewing health in light of the interaction of social, spiritual, emotional, and environmental factors in their lives (Guruge

& Humphreys, 2009; Guruge et al., 2010; Weerasinghe & Mitchell, 2007). They also stressed the importance of the social determinants of health by explicitly connecting their health to their employment status and, consequently, their socioeconomic status. What was surprising, however, is how they viewed health in terms of their ability to function well independently, be happy, and enjoy life by using all of one's senses. Though this perspective resonates with the holistic view of health, it also provides depth and definition to the concept of health.

Similarly, the participants had a broader understanding of healthcare services that expanded beyond those offered by physicians in clinics and hospitals. Their understanding included those offered by dentists, specialists, pharmacists, and other healthcare professionals including nurses, physiotherapists, and occupational therapists, among others. Invariably, when asked about accessing healthcare services, however, the participants started their stories with their lack of knowledge of the Canadian healthcare system and of their experiences of finding or being assigned a family physician. Once able to have a family physician, participants broadened their definition of access to include timely access to the family physician; access to specialists, medications and supplemental services; and access to emergency services. They also identified language proficiency as a facilitator of access. This understanding confirms what was reported in prior studies (Fuller-Thompson et al., 2011; Kim et al., 2013; NG et al., 2011; Wang & Kwak, 2015).

The women in the study identified some of the barriers to healthcare that they had experienced or witnessed. These included availability of the physician, wait times, cost of medication and supplementary services, language, and work and personal responsibilities. These are consistent with existing literature (Campbell et al., 2014; Harrington at al., 2013). The participants voiced their frustration as well with the “one complaint at a time” rule which is in congruence with what was reported by Campbell et al. (2014). Additionally, the participants listed a number of gatekeeping practices within the system that impacted their access to services. These included the roles played by receptionists as gatekeepers to physicians and family physicians as gatekeepers to specialists, diagnostics, prescription medications, and options. This finding expands on what was previously reported in the literature.

Of interest, the women included access to their own personal health records and the ability to choose their own family physician as considerations for access. This is a new contribution to existing literature and is understandable in light of their experiences with healthcare in their original countries, their educational level, and the gender role of health navigator for family members that the participants played.

Question 2a: How Do They Describe the Impact of the Immigration Experience on Their Experiences With Healthcare Services?

The participants’ immigration and integration experiences were easier if they had the social network to provide the entry point into the integration journey and to support them through it. Consistent with what was reported in the literature (Hynie et al., 2011), the absence of a social network impacted their integration and their health. Najwa and Melissa emphasized the impact of the emotional and social elements after the birth of their daughters as they felt the loss of social networks and social supports. This confirms current evidence in the literature around postpartum depression and postimmigration deterioration in self-perceived mental health status (Chadwick & Collins, 2015; Gagnon et al., 2013; Hynie et al., 2011; Urquia et al., 2012). This finding also highlights the intersection of sex, gender, and the immigration experience.

The women's families in their countries of origin were sources of both, support and stress. The family was contacted for medications and other culturally-specific resources and was also the source of support when the woman travelled back to her country of origin for medical treatments. This finding had been previously reported in the literature (Wang & Kwak, 2015). On the other hand, the women felt compelled to contribute to the financial stability of family members in the country of origin, especially parents. They also made it a point to hide the hardships and discrimination they were experiencing in Canada for fear of worrying their family members or giving them a negative impression of their new life in Canada.

When they first accessed the healthcare system, the women were disappointed by the impersonal, and at times dismissive, attitude of the healthcare professionals. They contrasted these experiences to ones in their previous countries where they were able to establish therapeutic relationships with their family physicians. The perceived impersonal and cold attitude that the women experienced led to an erosion of their trust in the healthcare professionals and, subsequently, to a lack of adherence to treatment plan and under-reporting of health concerns. This is consistent with what was reported in the literature by Hagiwara et al. (2013).

Perhaps the most impactful factor that influenced the immigration experience that was reported by the participants is their loss of identity. They reported how they felt that they had no history and they were just a number. Their health concerns were dismissed and they felt hurried through the encounters which added to their feelings of loss. They expressed frustration at the lack of continuity and the personal cost to their health that they experienced. Though this finding had not been previously reported in regards to immigrant women, a similar finding, dubbed "diminishment of individuality", was reported by John McIntyre et al. (2011, p.178) in their study of the experiences of gender minorities with access to supportive mental health services. The researchers explained that this barrier is inherent in the medical model that views similar presentations as arising from the same cause while disregarding the unique context of the presenting individual.

Even though half of the participants came from countries other than their country of birth and citizenship, all of the participants felt the weight of having to start over again. Some were unable to find employment, yet others were underemployed in positions for which they were overqualified. Some have chosen to pursue additional education and retraining in order to improve their economic status. They reported experiencing compromised socioeconomic status and housing instability as well as a pressing need to find employment in order to improve their social and economic standing. This, too, is consistent with what was previously reported in the literature about the socioeconomic status of Canadian immigrants and its impact on their health (Labonté et al., 2015; Newbold & Danforth, 2003; Setia et al., 2012).

Question 2b: How Do They Describe the Impact of Their Ethnicity on Their Experiences With Healthcare Services?

In addition to struggling to adjust to new norms and values, participants shared stories of subtle disrespect and discrimination and stories of overt racism. Similar to what was reported by Hudon (2016), these experiences bled from everyday life in public and in the workplace, into schools and encounters with the healthcare system. What they experienced ran the gamut from dismissal of concerns and denial of service to acts of aggression and assault. The association between those experiences of discrimination and racism and the deterioration in health status had been previously reported in the literature (De Maio & Kemp, 2010; Fuller-Thompson et al., 2011; Kim et al., 2013; Wang & Kwak, 2015).

Question 2c: How Do They Describe the Impact of Their Gender Roles on Their Experiences With Healthcare Services?

As women, the participants accessed the healthcare system more often than their spouses. They made the appointments and coordinated the visits for themselves, their children, and their spouses. Their roles as mothers, however, also prevented them at times from accessing healthcare or from following recommended treatment options because of lack of access to childcare or because of the impact the side effects of certain treatments would have on them caring for their children. This is consistent with what was reported by Harrington et al. (2013) in regards to the impact of personal responsibilities on access to healthcare services. Similarly, the association between gender and health status adds to what had been previously reported in the literature (Fuller-Thompson et al., 2011; Kim et al., 2013; Kobayashi & Prus, 2012).

Question 3: How Do They Describe Barriers to Access to Healthcare Services That They Might Have Experienced Prior to, During, and Following the Encounter With the Healthcare System?

When addressing access to healthcare services, the majority of research studies explored the barriers prior to the encounter with the healthcare system. This study explored barriers that the participants experienced prior to, during, and following the encounter with the healthcare system. This section will share the perspectives of the participants regarding barriers that had an impact on them accessing healthcare services, experiencing healthcare services, and following the recommended follow-ups, interventions, and treatments.

Before. As discussed in the results section of Chapter 4 and the interpretations above, the participants in the study expressed frustration with the difficulties they had in accessing healthcare. The barriers that they experienced included, lack of knowledge of the healthcare system, not having a family physician, wait times, availability of the physician, gatekeeping practices within the system, language and geographic barriers, personal responsibilities, and hours of service that conflicted with their work hours.

During. During the encounter with the healthcare system, as was reported previously, the participants faced impersonal interactions with the physicians and a sense of loss of identity and history. They shared instances where their concerns were dismissed and where limitations were imposed on them in regards to number of complaints discussed, as well as their treatment options. They found themselves at times begging for referrals, diagnostics, and medications. Language and cultural barriers as well as experiences of discrimination and racism impacted the encounters negatively. These experiences hampered the participants' efforts in establishing therapeutic relationships with their physicians and prompted some to declare their lack of trust in the system and the healthcare professionals.

After. Costs, relationship with healthcare professionals, and fragmented care were some of the barriers cited by the participants for their lack of adherence to recommended treatments options. The participants had to pay out of pocket for drugs and supplementary services, such as physiotherapy and dental care, which are not covered by the Ontario Health Insurance Plan (OHIP). When the cost was too high for them to purchase those services, they either went without or contacted family in their country of origin to purchase and send the medications for them. Wang and Kwak (2015) reported similar findings in their study of immigrant Koreans in Toronto, Canada. Additionally, in the absence of a therapeutic relationship with the healthcare professional, the participants were unable to fully explore treatment options that were more culturally and personally congruent which impacted their trust in and adherence to the recommended treatments (Hagiwara et al., 2013). Furthermore, the participants voiced their frustration with the long waits for follow-up appointments with specialists as well as with the fragmented care that they received between and within settings.

Narrative

The overarching question that guided the study was: What is the perspective of immigrant women in Ottawa, Canada, of their lived experiences with encounters with the healthcare system when there is an intersection of the factors of sex, gender, ethnicity, and immigration in their lives? In this section, I will interpret the findings in light of this question in the form of a narrative.

Each participant arrived in Canada under unique circumstances. Though the reasons for immigrating varied among the participants, they all arrived in Canada with the hope of building a better and safer life for themselves and/or their children. Integrating into life in Canada was facilitated by existing social support networks that consisted of either family or friends. Speaking one of the official languages and having a previous history of migration helped ease the integration journey.

Access to the health care system was complicated by the lack of knowledge of the system and the need for a family physician as the point of entry. Cultural and linguistic matching with the family physician facilitated the development of a therapeutic relationship which, in turn, helped ensure cultural congruence of and adherence to treatment options. Factors that impacted the experience with the healthcare system were identified at the individual, provider, and system level. Individual level factors that impacted access included being female, level of integration, fluency in one of the official languages, social capital, education level, employment status, and gender role. Provider level factors that influenced the participants’ experience with the healthcare system included the provider’s ability to build a therapeutic relationship with the participant, cultural competence, consideration of previous social and medical history, and ability and willingness to bridge the linguistic and cultural gaps. System level factors included availability of physicians, wait times, insurance coverage of medications and other essential services, and gatekeeping practices within the system.

In addition to impacting their access to healthcare, the participants' sex, gender role, immigration experience, and visible minority status impacted their integration into life in Canada. This led to further impact on their health. Furthermore, the discriminatory and racist experiences they endured had further impact on their health and ability to pursue opportunities to secure and improve their social and health status. The participants who reported the worse health status had experienced the multiplicity of those factors in their lives to a higher extent, especially when these were compounded with a linguistic or religious minority status. For example, Melissa who represents a visible and linguistic minority, and whose gender role prevented her from seeking full-time employment outside the home, reported the worst deterioration in her health from excellent to poor since arriving in Canada. Of interest, Najwa, who is fluent in both official languages and whose socioeconomic status is stable, also reported deterioration in her health as a result of the racism and discrimination she was facing in every aspect of her life. Her visible minority status as a Muslim woman who wears the hijab has made her a target at a time of global unrest and fear. As a result, she is now afraid to even leave her house for fear of assault.

The participants confirmed that employment facilitates their integration process as it provides a means for improving social and health status. The stability of the employment status of the participants impacted the stability of their housing situations. This finding was previously reported by Labonte et al. (2015). Of interest, only two of the eight participants owned their homes. The remaining participants rented their dwellings.

Theoretical Considerations

The choice of feminist intersectionality framework was most appropriate for this study. Feminist intersectionality provides a unique perspective on how social identities intersect with structural dynamics and processes to shape the experiences of individuals and impact their health (Hankivsky, 2014). This study provided further evidence to the efficacy of the framework in the study of the lived experiences of immigrant women of visible and linguistic minority backgrounds. It affirmed the need to consider women's social identities--that include sex, gender, ethnicity, linguistic ability, and immigration experience--as they intersect with social dynamics of racism and discrimination and structural processes of immigration and health policy to shape their experiences and health outcomes.

This study also provided further support to the conceptualization of Feminist Intersectionality within Complex Theory as was proposed by McGibbon and McPherson (2011). In their conceptualization, the authors proposed three contexts of intersection, the social determinants of health as offered by Mikkonen and Raphael (2010), the intersections of social identities as presented earlier, and the geographic determinants of health as they impact access and environmental patterns (McGibbon & McPherson, 2011). Within the first context, the findings of this study highlighted the impact of a number of the social determinants of health reported by the participants--that include education, employment, health services, gender, housing, income, race, social exclusion, social safety network, and job security--on the health outcomes of the participants. The participants' culture, ethnicity, gender, immigration status, race, social class, and religious affiliations as well as their experiences of disrespect, discrimination, and racism supported the intersection with the second context of social identities. Though not all of the participants reported the impact of the third context of location on their health, two of the participants did feel that geography and the environment within which they lived had an impact on their health.

The findings from the study further supported Spritzer's (2012) conceptualization of oppression as a social determinant of health. She posited,

> Once in the country, the derogation of credentials and foreign work experience, along with shifting gendered, familial, and communal demands, constrain social mobility, particularly for foreign-born racialized women. I argue that oppressive circumstances effected through structural and gendered racism are implicated in the disparity between newcomers' dreams of a better life and their realities, the realization of which leads to chronic stress, which is manifested in a variety of ways (Spritzer, 2012, p. 114).

This was evident in the lived experiences shared by Zahra, Melissa, and Najwa who reported instances of racism and oppression and who suffered from chronic health conditions.

Limitations of the Study

This study examined the lived experiences of eight participants with encounters with the healthcare system in Canada at the intersection of sex, gender, ethnicity, and immigration in their lives. The aim of the study was not to generalize the findings to the experiences of all of the immigrant women in Canada. In congruence with the spirit of qualitative research, the purpose was to gain an understanding of those lived experiences from the perspective of a gendered and marginalized position.

As is the nature of interpretative phenomenological approaches, I presented the experiences of the participants in the form of stories and narratives rather than verified measurable facts. The stories are their perspectives and, as such are factual for them as they have lived through and been changed by them. Furthermore, as the aim was to hear and document those stories, I concentrated the data collection and analysis on documenting and interpreting those stories rather than the issues behind them.

Much of the context for the experiences of the participants was captured in the field notes that I kept as I visited with them and connected with them later to verify themes. I have shared this context in the stories I wrote about them. Though I did not capture the contexts in the audio-recorded part of the interviews, I did document them in the field notes which provided context for the thematic analysis of the interview transcripts. The field notes have been included in the datasets for each participant.

One participant, Mariam, did not meet all of the inclusion criteria as she had been in Canada less than four years at the time of the interview. I included her story out of respect for her desire to be heard. As I met with her after data saturation was established, her story simply affirmed what was already shared by the other participants.

Two opposing perspectives arose from the data analysis, language as a barrier and private versus public healthcare. Though most of the participants, with the exception of Zahra and Melissa, did not experience language as a barrier in healthcare, they did voice concerns that someone who is not able to communicate in either English or French would have a hard time communicating with the healthcare professionals. Additionally, the participants all came from countries where the healthcare system was private. They felt that within that system they had more options for accessing physicians and specialists of their own choice and that access was faster. On the other hand, they did express concerns about the cost and inequity of access within the private healthcare system. The participants felt that with a few changes, the public health care system in Canada could be made much better than what they had experienced in the past.

Finally, my role as an immigrant woman from a visible minority as well as that of a health care professional and a researcher could have caused the participants to react with bias. Potential bias was controlled by following the five strategies identified by Creswell (2013) and Maxwell (2013). First, the quality of the data collected was ensured by spending a prolonged amount of time in the field with the participants and by taking detailed and extensive field notes. Second, the interviews were planned to be one hour long, semistructured, and face-to-face. The length and structure of the interviews allowed me the opportunity to probe further for additional information and helped ensure a level of richness to the data collected. Third, the interviews were transcribed verbatim and the transcripts were verified with the participants for accuracy. Fourth, to mitigate personal bias, I bracketed and documented my experience as an immigrant woman from a visible minority in a reflective journal that I kept and updated throughout the data collection and analysis phases. Lastly, I verified the emerging themes and subthemes or findings with the participants in the study to ensure that I had, indeed, captured their stories.

Recommendations for Further Research

In addition to the recommendations made by the participants and shared as a sixth theme in the results section of Chapter 4, this section will share recommendations that arose from the interpretation of the results in light of current literature. The recommendations will address research and policy in the fields of healthcare and immigration.

Much of what we know about the Healthy Immigrant Effect was derived from the analysis of data collected as part of the LSIC (Statistics Canada, 2016). The LSIC had an ideal design for following the same participants over time and provided invaluable information. The design, however, did not allow comparison with the Canadian-born population and the four-year duration was too short for it to provide an opportunity to examine the impacts of resettlement and integration. As such, there is a need for true longitudinal studies that follow a large group of immigrants over ten to fifteen years postimmigration and that compare their health to that of the Canadian-born population.

As the health of immigrants continues to be a large focus for much of the dialogue in population health of late, there is a need to consider immigration as one of the social determinant of health (Castaneda et al, 2014). As immigrants settle into new countries, the social determinants of health play a large part in their integration and health outcomes. Unfortunately, there has been a disconnect between the two areas of immigration and social determinants of health that “has resulted in missed opportunities for research, practice, and policy work” (Castaneda et al, 2014, p. 376). Future research should consider the immigration status, the motivation for immigration, and immigration policy, and their impact on the health of immigrants within a social determinants of health framework.

Najwa’s experiences with discrimination and assault because of her religious minority status, compel me to call for the inclusion of religious minority status in future research. Similarly, Zahra’s and Melissa’s experiences with the barriers they had to overcome because of language or accent also compel the inclusion of linguistic minority status in future research into immigrant health. In the same way that a visible minority status evokes discriminatory and racist behaviour by other, inability to speak English or French or the presence of a strong accent as well as the wearing of traditional dress, especially a hijab, could provoke the same kind of behaviour (Spitzer, 2012, p. 118).

All eight participants in the study were able to communicate fluently in one, or both, official languages. This allowed them to bridge the communication gap with their healthcare professionals and share their stories for this study. There is a need, however, to explore the lived experiences of immigrant women who are not able to speak either of the official languages and who would have had to rely on an interpreter to access healthcare services.

Additionally, as world events and the way they are portrayed in the media are shaping our view of refugees and immigrants, there is a rising anti-immigrant sentiment against religious and visible minorities (Reitmanova, Gustafson, & Ahmed, 2015). As such, there is a need to examine how the current anti-immigrant sentiment is impacting the health of immigrant to Canada. Viruell-Fuentes et al. (2012), in their study of immigrant health in the United States, called for similar research with immigrants, their children, and U.S.-born individuals of similar ethnic backgrounds. As Canada is one of a few developed countries that rely on immigration as a means of population and economic growth, such studies would help shed a brighter light on the health inequities experienced by immigrants over multiple generations.

The participants were clear in their message that, even though they did not have to pay out of pocket for essential healthcare services, the inefficiencies in the system made healthcare extremely costly to their health and wellbeing. They called for reforms to the healthcare system that would allow them to choose providers and that would make access equitable and efficient. These reforms need to consider the structural, systemic, and social barriers to access--including health, immigration, and social policies--that immigrant women from visible minorities have to navigate through and the impact of those barriers on their health and social standing.

Implications for Social Change

Four of the eight participants in the study reported deterioration in their health since they arrived in Canada. All four women have been in Canada less than six years. Their stories are similar to many of the stories of other immigrant women. This study helped tell their stories and shed some light on their experiences to better understand the social and structural factors that negatively impacted their health. It also helped add to the body of knowledge around the healthy immigrant effect in Canada.

The study findings have also pointed a spotlight on the impact current health and immigration policies have on the lived experiences of immigrant women with the Canadian healthcare system. The healthcare system is built on the principles of social justice and yet fails a large portion of the population that it exists to serve. This study helps add to the evidence that calls for the inclusion of social and environmental issues in any dialogue about health.

This study utilized a feminist intersectionality framework in an IPA approach. As such, it added to the body of research utilizing this framework and supporting its use in marginalized and racialized populations. It also added to the body of evidence supporting the better fit of qualitative approaches, especially IPA, to research utilizing the feminist intersectionality framework.

Lastly, the participants’ experiences and stories pointed to the need for the cultural competence of the healthcare professionals. The women felt heard and seen when their cultural needs were addressed and when their unique perspectives were considered. There is a need, therefore, for including cultural competence training in the curricula of the health professions, especially in light of the Healthy Immigrant Effect and the increasing diversity of Canada’s population.

Conclusion

In this study I studied the encounters of eight immigrant women who self-identified as belonging to a visible minority with the healthcare system in Canada. Each of the stories pointed to the need for system-level lines of inquiry that can shed light on the ways structural discrimination and racism have had an impact on their social and health trajectory. This study is joining the call to consider immigration a social determinant of health (Castaneda et al, 2015) and immigration policy as health policy (Viruell-Fuentes et al, 2012).

> Amidst increasing anti-immigration environments, a focus on the structural factors that influence the lives of immigrants and those of subsequent generations is necessary to develop multi-level interventions that promote the successful, healthy integration of immigrants and their children in the country (Viruell-Fuentes et al, 2012, p. 2104).

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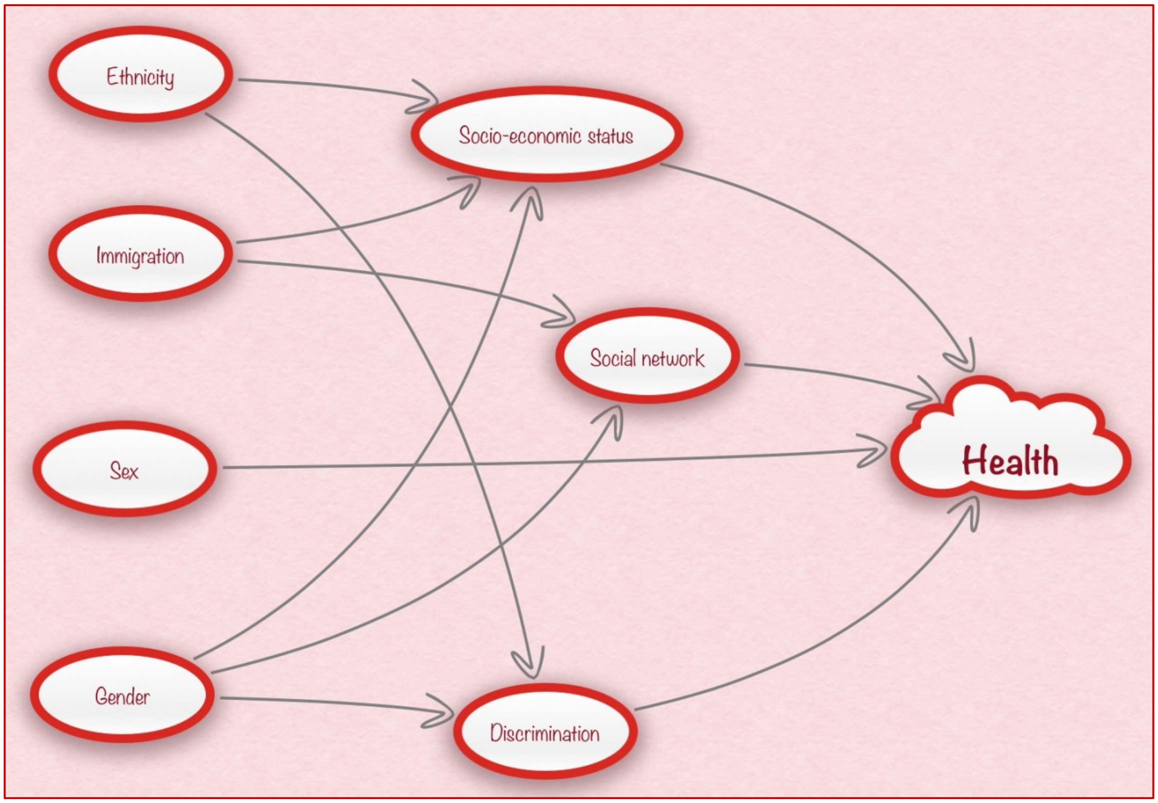
Appendix A: Conceptual Framework Guiding the Literature Review

Concept Map: *The lived experiences of immigrant women from a visible minority with healthcare when there is an intersection of sex, gender, ethnicity, and immigration in their lives.*



Appendix B: Demographic Questionnaire

Date: ____
Time: ____
Location: ____
Interviewee (Unique Identifier): ____________________________________

This interview is part of a study to explore the lived experiences of immigrant women to Canada with encounters with the healthcare system.

Please respond to the questions below to the best of your ability.

When were you born?	
What year did you arrive in Canada?	
What country did you immigrate from?	
What country were you born in?	
How would you describe your ethnic background?	
What level of education have you attained?	☐ Less that high school ☐ High school ☐ Diploma / Trade ☐ Bachelor ☐ Masters ☐ PhD ☐ Other: _____________________
Employment status	☐ Unemployed ☐ Employed part time ☐ Employed full-time ☐ Operating own business ☐ Work from home
Do you speak English or French?	☐ English fluently ☐ English slightly ☐ French Fluently ☐ French Slightly ☐ No English or French
Marital status	☐ Single ☐ Married ☐ Divorced ☐ Common law

	☐ Widowed
Number of children and their ages	☐ Number of Children: _____ ☐ Age(s) ________________
Dependents:	☐ None ☐ Children ☐ Parents ☐ In-laws ☐ Other family members ____________
What was your health like when you first arrived in Canada?	☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent
What is your health status now?	☐ Poor ☐ Fair ☐ Good ☐ Very good ☐ Excellent
When was the last time you saw a Healthcare professional?	
Was it for yourself or for a dependent?	☐ Self ☐ Dependent

Appendix C: Interview Protocol

Date: ____
Time: _____________________________________
Location: ______________________________________
Interviewee (Unique Identifier): _________________________________

This interview is part of a study to explore the lived experiences of immigrant women to Canada with encounters with the healthcare system. Your participation is absolutely voluntary and you may choose not to respond to specific questions or to withdraw at any time without providing a reason. The information you provide is strictly confidential

Questions:

1. What does “health” mean to you?
2. What does “access to healthcare services” mean to you?
3. Whom do you mostly access the healthcare system for? Self? Dependents? Parents? Others?
4. What kind of healthcare services do you access? How easy is it to access? Why?
5. Tell me about some of the encounters you have had with a healthcare professional. Tell me about the positive and not so positive aspects of these encounters. What is your perspective of these experiences and encounters?
6. Bring to mind the very last encounter you had. Tell me about it.
7. How satisfied/happy were you with the encounter with the healthcare system? Why?
8. Were you able to follow the recommendations of the healthcare professional? Why or why not?
9. Could anything have been done to make the encounter better? Explain.
10. Who else should I talk to in order to learn more?

Thank you again for taking the time to meet with me. Please rest assured that your anonymity will be protected and that your name will not be mentioned in any of the reports or presentations.

Appendix D: Field Notes Protocol

Date: ____
Time: ____
Location: ____
Interviewee (Unique identifier): _____________________________________

Descriptive Notes	Reflective Notes

Appendix E: Reviewer Feedback Form

1. From start to finish, how many minutes did it take you to complete the demographic questionnaire? _________ minutes

2. The time it took to complete the questionnaire and interview was (check one):
   ☐ Appropriate for the study purpose
   ☐ Too long
   ☐ Too short

3. As a study participant, the length of the questionnaire and the duration of the interview would be (check one):
   ☐ Feasible for me to complete
   ☐ A possible but unlikely barrier for me to participate in the study
   ☐ A likely and major barrier for me to participate on the study

4. Overall, the instructions contained in the letter of information and consent were:
   ☐ Clear ☐ Not Clear
   If not clear, what areas do we need to clarify?

5. In terms of overall content, are there any questions you feel should be added to the questionnaire for identifying factors that influence the experiences of immigrant women with the healthcare system in Canada?
   ☐ No ☐ Yes If yes describe…..

6. In terms of overall content, are there any questions that you feel should be added to elicit information about the experiences of immigrant women in Canada with the Canadian Healthcare system?
   ☐ No ☐ Yes If yes describe…..

7. In terms of overall content, are there any questions that you feel should be added to the questionnaire when describing the <u>demographics</u> (personal descriptive information) of immigrant women to Canada taking part in the study?
   ☐ No ☐ Yes If yes, describe…..

8. Are there questions you feel are unimportant, irrelevant, or redundant and could be eliminated without jeopardizing the accuracy and completeness of the study results?

   ☐ No ☐ Yes If yes, please list the questions by their number:

9. Questionnaire Format:

   a) The overall format of the questionnaire was:

   ☐ Easy to Read ☐ Difficult to Read

   If difficult to read, what aspects of the format should be changed?

   b) Overall, the questions were ordered in a logical and organized manner that was easy to follow:

   ☐ Agree ☐ Disagree

   If disagree, how can we improve this?

10. The 3 most important suggestions I have for improving the questions are:

    1. ______________________________
    2. ______________________________
    3. ______________________________

11. Other comments:

____

____

____

Many thanks for your valuable input.

Appendix F: Recruitment Flyer, English text

Immigrant Women's Health

Did you know that immigrant women are at a higher risk for ill health than Canadian-born women?

If you are an immigrant woman who…

- **… has been in Canada less than ten years, but more than four;**
- **… is between the ages of 18 and 64;**
- **… self-identifies as belonging to a visible minority;**
- **… speaks English, French, or Arabic; and**
- **… has visited a doctor, a clinic, or a hospital for yourself or a family member in the last year;**

Your experience would be of most interest to me.

If so, would you like to participate in a research study and share your story?

Please contact me to arrange for a time when we can chat.

Thank you in advance for taking the time to share your story.

Salma Debs-Ivall, RN, MScN
PhD Student

613-878-7495
salma.debs-ivall@waldenu.edu

Appendix G: Information Letter and Consent Form

Walden University
Consent to Participate in a Research Study

IRB Study No. 09-22-15-0333765
Date: ____________________

Walden University: College of Social and Behavioral Sciences, School of Public Policy and Administration
Title of Study: The Lived Experiences of Immigrant Canadian Women with the Healthcare System at the Intersection of Sex, Gender, Ethnicity, and Immigration
Principal Researcher: Salma Debs-Ivall, RN, MScN, PhD Student
Email: salma.debs-ivall@waldenu.edu
Phone: (613) 878-7495
Dissertation Committee Chair/Faculty Advisor: Dr. Joyce Haines

You are invited to take part in a research study about the experiences that immigrant women have with the healthcare system in Canada as they access it for themselves or a family member. The researcher is inviting immigrant women between the ages of 18 and 64 who have been in Canada more than four years, but less than ten; who are from a visible minority; and who have visited a doctor, clinic, or hospital in the past year for themselves or a family member to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Salma Debs-Ivall, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to understand the experiences of immigrant Canadian women with the healthcare system to determine if there are any barriers that would need to be addressed.

Procedures:

If you agree to be in this study, you will be asked to:

- Provide consent to participate in the study.
- Respond to a short demographic questionnaire that would take about five minutes to complete.
- Participate in personal interviews with the researcher at a location of your choice that would take about an hour to complete.
- Provide consent to have the interview audio-recorded.
- Provide your feedback on the interview transcripts and allow the researcher to check with you about the accuracy of the findings.

Here are some sample questions:

11. What does "health" mean to you?
12. What does "access to healthcare services" mean to you?
13. Whom do you mostly access the healthcare system for? Self? Dependents? Parents? Others?
14. What kind of healthcare services do you access? How easy is it to access? Why?
15. Tell me about some of the encounters you have had with a healthcare professional. Tell me about the positive and not so positive aspects of these encounters. What is your perspective of these experiences and encounters?
16. Bring to mind the very last encounter you had. Tell me about it.
17. How satisfied/happy were you with the encounter with the healthcare system? Why?
18. Were you able to follow the recommendations of the healthcare professional? Why or why not?
19. Could anything have been done to make the encounter better? Explain.

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Ottawa Community Immigrant Services Organization will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as becoming upset when recounting an unpleasant experience. Being in this study would not pose risk to your safety or wellbeing.

The results of the study will provide researchers and policy makers with information to help guide health policy and future research to improve access to health services for immigrant women.

Payment:
You will receive a $20.00 gift certificate for a coffee shop to thank you for taking the time to meet with the researcher.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by assigning unique identifiers to each participant and keeping all electronic records password-protected on a separate server. Any hard copy documents will only be identified with a unique identifier assigned to each participant. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher by phone or email at the coordinates identified above. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 001-612-312-1210. Walden University's approval number for this study is **09-22-15-0333765** and it expires on **September 21, 2016.**

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Participant ________________________________

Date of consent ________________________________

Participant's Signature ________________________________

Researcher’s Signature ______________________