University of Alberta

Culture and the Healthy Immigrant Effect: A Multiethnic Study of Canadian Immigrants' Self-Perceived Health.

by

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Dedication

To my family, Janet, Sujeet, and Shomesh: the embodiment of Canadian multiculturalism.

Abstract

I present a qualitative study investigating the self-perceived health of recently arrived Canadian immigrants. The study develops health promotion's understanding of culture as a social determinant of health, and conceptually locates it within a broader context of psychosocial factors. The study involves semi-structured individual interviews focusing on self-perceived health and well-being. The sample group consists of recently arrived (within the last 10 years) adult immigrants between 23 and 46 years of age, from a variety of cultural backgrounds, who participate with the YMCA Cross Cultural & Community Services' Host program in Kitchener-Waterloo, Ontario. I also interview two YMCA settlement program supervisors who discuss health care issues facing Canadian newcomers. Newcomer self-expression contributes to a better understanding of the social and cultural determinants of the Healthy Immigrant Effect. This study represents a theoretically and empirically informed personal examination of Canadian multiculturalism from a public health research perspective.

Acknowledgement

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Canadian Multiculturalism

The announcement of Canada's 'policy of multiculturalism' by Pierre Elliott Trudeau in the House of Commons on October 8th, 1971, struck an aberrant note in the history of nationalism. This political move towards a policy of pluralism was in glaring contrast to the long held belief that societal homogeneity was necessary for national cohesion. This uncommon pluralistic identity now lives deep in the heart of the relatively young social experiment that is Canada.

It was Trudeau, being one of Canada's most controversially enigmatic Prime Ministers, who oversaw a period of social reinvention within Canadian society that would change the ethnic and cultural character of the nation. What caused this relatively swift change in official policy towards racial and cultural diversity, and thereby the nature of Canadian identity, is a matter of some debate. Intuitively one can crudely assume that governments are rarely trendsetters or trailblazers and that the social foundations for this change must have already existed, at least in some form, to make official policies possible. Traditionally Canadian immigration laws were hardly subtle in their racism, as Reitz (1988) notes: "Historically in Canada, cultural and racial preferences were regarded as legitimated bases of immigration selection" (p. 128). Mackenzie-King's infamous assertion towards a preference for 'desirable' peoples in 1947 reflected the political and social context of a time that feared any assault on the 'British' nature of the country from Asian and other non-white populations. In a Prairie Metropolis Centre lecture in Edmonton on January 20, 2010 Robert Vineberg

argued that despite the overt official discrimination and racism of the time, Mackenzie-King's emphasis on economic needs, family reunification, and acknowledgement of a moral obligation towards refugees in immigration policy actually laid out the beginnings for future change. The eventual emergence of modern Canadian multiculturalism stemmed, therefore, from a gradual progression of change within Canadian society that eventually saw, beginning in the 1960s, a perfect storm of global context, existing political frameworks, and a charismatic leader. Ultimately, whatever the social, political, and historical roots for change, what was hereunto a largely European identity, marked with English-French tensions and the ever present (sadly to this day) marginalization of Aboriginal peoples, was to meet and be forever changed by the rest of the world.

This encounter was formally introduced by Trudeau's 1971 multicultural policy that aimed to:

> "support the cultural development of ethnocultural groups; to help members of ethnocultural groups overcome barriers to full participation in Canadian society; to promote creative encounters and interchanges among all ethnocultural groups; and to assist new Canadians in acquiring at least one of Canada's official languages." (Kymlicka 1998, p. 15)

Rather than emphasizing cultural assimilation and homogeneity these policies and their attendant programs were intended to "assist in the adjustment and well being of immigrants into the overall Canadian society...these programs are intended to familiarize the newcomers with new surroundings, furthering the settlement process" (McKone-Chaudhuri 1999, p. 34). In 1988 the overhaul of

Canada's official identity was formally capped by the enacting of the *Canadian Multiculturalism Act* which, among other things, recognizes that "multiculturalism is a fundamental characteristic of the Canadian heritage and identity and that it provides an invaluable resource in the shaping of Canada's future" (*Canadian Multiculturalism Act* 1988).

A key component of the drive towards Canadian diversification from the 1970s onwards was a marked emphasis on economic development over cultural assimilation. This is a crucial approach to immigration and multiculturalism that has perhaps saved Canada from the stronger racial tensions experienced in other immigrant receiving nations. As Reitz (1988) points out:

> "The more positive Canadian response to increased non-white immigration was reflected in the mid-1970s debate on immigration legislation; race was a minor aspect. The immigration Green Paper (Canada 1974) stressed economic aspects of immigration, not race" (p. 118-119)

By advocating an official pluralism, downplaying differential associations between race and national identity, and emphasizing economic integration in society, Canada has over the last fifty years developed a rather unique multiculturalism. This is not to say that forms of systematic racism such as employment discrimination and marginalization are absent from Canadian society, they continue to be enacted in varying forms, but rather that there is purposeful acknowledgement of their existence in official multiculturalism policy

which constitutes an immensely important first step, and a relatively unique occurrence from a global perspective, to support positive social change.

The unique nature of Canadian multiculturalism and immigration, moreover, has become a decisive factor in the makeup of today's Canadian identity. Gwynne Dyer (2001) takes note of the truly remarkable proportions of Canadian diversification:

> "Canada takes in about twice as many people, in proportion to its population, as does the United States and four times as many as the United Kingdom. As a result, the proportion of foreign-born among our people is more than 20 percent...What is truly remarkable is the ethnic profile of the immigrants to Canada, which is unique in how closely it matches the global distribution of the human population...Nobody else has this kind of spread...Canada, more than anywhere else, is truly becoming the world in one country."

Approximately a quarter million new permanent residents are registered each year in Canada (Asanin & Wilson 2008). In 2008 alone, for example, 247 243 individuals received permanent resident status (*Citizenship and Immigration Canada* 2009). To put this number in perspective one need only consider that the number of births in Canada for the 2008/2009 annual period was 377 703 (*Statistics Canada* 2008). The culturally diverse contribution of immigration, therefore, is close in magnitude to domestic births in shaping Canadian demographics. The 2006 Canadian census indicated over 200 ethnic origins (the greatest reported diversity in Canadian history), an increase in self-reported multiethnic ancestries, a growing amount of reported mixed unions, and over 5

million visible minorities representing a growing non-European diaspora (*Statistics Canada* 2008). The increasing self-definition of ethnicity in the popular space, such as Greek-Canadian for example, represents the growing evolution of a positive multicultural ideology in Canada.

From a public health standpoint, moreover, this growing and constantly changing Canadian population represents an array of challenges in providing high quality health care to a diversity of health perspectives and experiences. It is of no surprise, therefore, that the health of Canadian immigrants presents itself today as one of the most pressing and important topics facing Canadian public health and health promotion.

The Healthy Immigrant Effect

The idea of immigrants coming to the New World evokes black and white images of the poor and dispossessed disembarking at Pier 21 and Ellis Island. These images are accompanied by the lyrical "Give me your tired, your poor, your huddled masses yearning to breathe free" from Emma Lazarus' iconic poem. The immigrant is socially constructed as a bedraggled survivor escaping the ravages of the old world to find salvation in the salubrious new one. This new land is a place where the sick and poor come to better their condition.

This social perception of the immigrant, however, has not kept up with the changing nature of 21st century Canadian immigration. Yes, the emotional sentiments of Lazarus' poem still ring true but the state in which the immigrant arrives on these shores is not the disease-ridden misfortune we might believe. Nor does an immigrant's health in Canada, the proverbial land of milk and honey, necessarily improve as we might assume. Ng *et al.* (2005), for example, point out that newcomers today are subject to both formal medical screening but also, to a degree, self-health screening to undergo the physically and mentally demanding process of immigration. In fact, contrary to what we might assume, a deterioration of health status with residency time in Canada has been observed. This observation has been termed the 'Healthy Immigrant Effect'.

The Healthy Immigrant Effect is formally described as a phenomenon wherein recently arrived immigrants initially demonstrate better health, relative to the general Canadian-born population, that gradually diminishes with residency

time in Canada. McDonald & Kennedy (2004) observe via the 1996 National Population Health Survey and the 2000-01 Canadian Community Health Survey that:

> "there is compelling evidence of a healthy immigrant effect for recent immigrant arrivals, with both immigrant men and women significantly less likely to have been diagnosed with a chronic condition than otherwise comparable native-born Canadians. Immigrants also continue to be relatively less likely to have a chronic condition, even after many years in Canada. However, there is also evidence that the gap in health status between recent immigrants and native-born Canadians narrows significantly (albeit slowly) with years in Canada." (p.1623-1624)

Newbold & Danforth (2003) similarly observe from their study of 1998/9 National Population Health Survey data that:

> "Overall, immigrants report poorer health status than their non immigrant counterparts. Controlling for period of arrival, however, revealed that the most recent arrivals conformed to the 'healthy immigrant', while those who had arrived earlier (resident 10 years or longer) were less healthy than non-immigrants." (p.1992)

The Healthy Immigrant Effect, therefore, represents a population level health occurrence that affects a certain segment of the Canadian public. But does it really demonstrate an objectively observed population health pattern? Newbold (2005) acknowledges that the observance of the Healthy Immigrant Effect relies heavily on self-report studies and notes that "the rapid decline in health status suggests changes in *perceived* health rather than *real* health, as health is re-evaluated relative to peers within Canada as opposed to the country of origin, as

optimism declines and the reality of immigrant life in the host country sets in" (p. 1368).

Ng *et al.* (2005), in contrast, reference their analysis of National Population Health Survey data from 1994/95 to 2002/3:

> "Is the decline in self-perceived health among recent non-European immigrants the result of changes in expectations as they integrate into Canadian society, or is it a real phenomenon? The results of the analysis of longitudinal data suggest the latter. Recent non-European immigrants' higher risk of reporting a deterioration in their health is mirrored in increasingly frequent doctor contacts." (p. 4)

Several potential confounders have also been suggested when contemplating the extent of statistically observed immigrant health outcomes. Lassetter & Callister (2009) point out a possible 'salmon bias' effect that involves a certain element of migrants with poor health and/or settlement experiences potentially returning to their previous homes and thus artificially decreasing incident rates. Beiser (2005), furthermore, suggest that relying on cross-sectional studies combined with a scarcity of longitudinal work may "run the very real risk of confounding time with cohort effects" (p. S33). This could lead us to erroneously compare younger and older generations of immigrants who may have significantly different contextual settlement experiences.

The need for longitudinal analysis in Canada, therefore, can perhaps rely on Statistics Canada's Longitudinal Survey of Immigrants to Canada (LSIC) which collected, starting in 2000/2001, self-health perceptions for a cohort of

Canadian newcomers in three waves (six-months, two years, and four years post arrival). Of further importance was the LSIC's differentiation between economic migrants, family reunifications, and refugees as opposed to the many cross-sectional surveys that have treated all foreign-born individuals as a homogenous mass. In his analysis of LSIC data Newbold (2009) found that all immigrant categories yielded significant declines in self-reported health over the three waves measured in accordance with Healthy Immigrant Effect expectations. Newbold (2009) also report important differences between immigrant categorizations:

> "Economic arrivals generally report better health than either refugees or family class immigrants. Moreover, these health differentials by immigrant class are reinforced by the logistic and survival analyses, which suggests that both family class and refugees are more likely to transition to poor health as compared to economic arrivals. In particular, refugees were nearly two times as likely to experience poor health within four years of arrival as compared to economic arrivals." (p. 330-331)

LSIC data provides the longitudinal support Beiser (2005) calls for whilst also demonstrating the applicability of the Healthy Immigrant Effect to all Canadian immigrant classifications.

A fair criticism of the LSIC, however, is its reliance on self-report data. Conceptually even if the Healthy Immigrant Effect were to be largely the product of changing self-perceptions does that make it any less important to public health and health promotion? In my opinion the answer is simply no. Whatever the case, we can agree that the experiences of recent immigrants to Canada, for whatever reason, lead them to report poorer health than that in which they arrived. The

fluidity, or lack thereof, between perceived and ‘objective’ health is an ontological question that I will shortly address. What I stress now, however, is that the Healthy Immigrant Effect whether imagined, ‘real’, or both, is of massive significance to public health considering the aforementioned magnitude of Canadian immigration.

Immigration and Acculturation

Historical Considerations and Linear/Unidimensional Frameworks

A popular explanation of the Healthy Immigrant Effect in public health research has been the conceptualization that newly arrived immigrants possess certain protective 'cultural factors' relative to the native born population. Over time these protective factors are thought to be lost as immigrants adopt the host society's practices and norms, at the expense of their traditional ones, thus explaining the waning health of the 'healthy immigrant'. This process has been termed a unidimensional 'Westernization' or 'acculturation' of immigrants in Canada. Linda Hunt (2003) summarizes the application of the term 'acculturation' in public health when saying:

> "In efforts to objectively model cultural influences on health, ethnic culture is commonly operationalized as level of 'acculturation,' which is measured using acculturation scales designed to quantify the extent to which individuals embrace 'mainstream' versus ethnic culture. These figures are then correlated with measures of the health outcomes of interest." (p. 974)

Acculturation, by definition, places an immigrant's native culture in dichotomous and completely discrete juxtaposition to an implied mainstream Canadian culture that is sufficiently homogenous to be quantifiably measured. The question of what 'mainstream' society really constitutes is left unchallenged and intuitively considered as a static 'Canadian' backdrop culture. As Hunt *et al.* (2004) advocate, the concept of acculturation as a linear change towards the

‘mainstream’ echoes colonial attitudes that encourage the assimilation of the other. The concept of acculturation inherently carries an approach to cultural difference that connotes a ‘normal’ in relation to which others assume varying degrees of aberrance. As Gutmann (1999) mentions “even the most sympathetic discussion in academic and applied circles regarding ‘cultural differences’ is frequently based on an implicit standard of differences when compared with the normal” (p. 176).

To make the assumptions inherent in this view of acculturation more clear we can look at the history of its conceptualization. Samuel (2009) traces the term as far back as investigations of Native American languages in the 1880s. Both Samuel (2009) and van de Vijver & Phalet (2004) agree, however, that the first purposeful definition of the actual term ‘acculturation’ was delivered by the anthropologists Redfield, Linton, and Herskovits (1936) who asserted that “Acculturation comprehends those phenomena, which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups” (p. 149). From the 1930s to 1950s the term was mainly restricted to debate within academic circles of American anthropology. As Gutmann (1999) elaborates:

> “Whereas researchers in Britain were at the time describing changes resulting from British colonialism in Africa as ‘culture contact’, in the Americas the preference was for ‘acculturation’ to describe U.S. economic, political, military, and cultural penetration of Latin America.

> When they developed the concept of acculturation several decades ago anthropologists were correcting earlier notions of static ('unmodified') cultures and the idea that change and time were not centrally relevant to the study of societies and cultures." (p. 175-176)

It is fairly ironic then that anthropologists developed the term acculturation in an effort to dispel conceptualizations of static and 'fixed' cultures only for public health to later adopt its unidimensional interpretation. Abraido-Lanza *et al.* (2006) recognize this selective adoption of an anthropological concept by public health when saying "Despite the evolution of more elaborate paradigms in the social and behavioral sciences, these linear assimilation models were adopted by much of the public health research on acculturation" (p. 1342). Abraido-Lanza *et al.* (2006) furthermore attribute early descriptions of this unidimensional model to the sociologist Robert Park in 1928 whom they describe as advocating "a linear and directional process by which loss of the original culture occurs through greater acculturation" (p. 1342). One of the most popular unidimensional conceptualizations is now attributed to Gordon (1964) whom van de Vijver & Phalet (2004) describe as arguing "that acculturation is a process of change in the direction of the mainstream culture. Migrants may differ in the speed of the process, but the outcome invariably is adaptation to the mainstream culture" (p. 216-217).

In contrast to unidimensional acculturation models I argue, as does Gutmann (1999), that ethnic identities may intensify and/or change in unanticipated ways. Cultural groups, rather than being homogenous, are dynamic,

with porous boundaries (Bailey & Peoples 2002). Culture, therefore, is notoriously difficult to assess in surveys and indices of measurement. An oversimplified categorization of individuals to a discrete culture, as often done by surveys, precludes the human capacity for multicultural subjectivities. The assumed dichotomy in the term ‘acculturation’ implies a linear identity shift. Individuals and groups, however, have the capacity to experience and enact multiple cultural identities depending on the given context. An individual can perceive very different cultural identities, for example, within a multicultural Canadian workplace as compared to their culturally specific place of worship. The linear acculturation framework assumes, however, that an immigrant would experience one form of cultural subjectivity that only changes over time spent ‘acculturating’.

This linear explanation of the Healthy Immigrant Effect also relies on the ability to measure acculturation in relation to health outcomes. This assumes that researchers are confident in knowing what the construct ‘acculturation’ is and that they can accurately measure it. The main measurements of acculturation have often been birth, language proficiency, and residency time. Salant & Lauderdale (2003) explain that current acculturation measurement techniques such as scales, language proficiency, time in country, percentage of life in country, and age at arrival have been inadequate in accounting for health determinants such as socioeconomic status, gender, type of immigrant, and ethnic community in the

new country. Koneru *et al.* (2006) elaborate this point in reference to their literature search regarding acculturation and mental health:

> "...several studies employ single variables (e.g., language, nativity status) to represent acculturation. These variables can be conceived as proxy variables of acculturation and are more reflective of grouping or population categories. More importantly, they do not measure specific values, beliefs, expectations, roles, norms, or cultural practices that define cultural adaptation." (p. 77)

These measures rely on objective characteristics to describe an individualized culture status. Culture, however, is a shared system of subjective meanings. One's cultural subjectivity, therefore, is not based on objective indicators such as residency time, but rather on one's own perception, construction, interaction with, and understanding of the physical and social environment. Social epidemiology, however, often unquestioningly applies the aforementioned indicators without debating their validity. This assumption demonstrates a tendency to perceive culture in epidemiology and public health as an individualized and intrinsic quality no different to, for example, blood pressure.

Abraido-Lanza *et al.* (2006) therefore explain that multi-dimensional and reciprocal acculturation theories need development in order to challenge the linear theory of immigrant acculturation. Theories that employ a reference 'mainstream' host culture imply that cultural change is specific only to immigrants during the social action of immigration. This negates the capacity of dialectic cultural interaction. It would be difficult to argue that the Canadian

experience and landscape of shared social meanings has not been influenced in the last fifty years despite large waves of immigration from all over the world. Cultural interaction is inherently dialectic. Framing the Healthy Immigrant Effect as the result of Westernization/acculturation assumes that 'Western/mainstream' culture is somehow impervious to change. It borders, though implicitly, on ethnocentrism to consider the capacity for culture change to be specific to the other while one's self is somehow natural and fixed. It also implies a fixed 'Canadianess' for immigrants to adopt rather than contribute to. Multi-faceted theoretical interpretations of acculturation, however, consider immigrants as active members in a lived environment with dynamic interactions occurring within multiple social settings (Abraido-Lanza *et al.* 2006). This idea of dynamic acculturation takes into account multiple factors such as migrant and personal experience, age, income, and socioeconomic status.

To address the need for a multi-dimensional understanding of acculturation there has been a focus towards immigrant subjectivities themselves. Dossa (2002), in reference to her study of Canadian-Iranian immigrant women, relates that participants, via their stories, create a space of meaning in which they communicate their past experiences and current/future concerns. Immigrant women, rather than sharing the marginalized categories of population health research (i.e. they don't speak English and are not qualified) instead create their own social space/perceptions as told by narrative. Thurston & Vissandjee (2005) further support this by saying an ecological perspective can be helpful in

understanding the barriers faced by immigrant women to maintain their health. A conceptual framework of the experiences and influences, as related by the immigrant, incorporates micro, meso, and macro levels of consideration. Simich *et al.* (2007) advocate that consideration be given to participants' personal experiences and perceptions of health throughout the phases of pre-migration, migration itself, and life in Canada. Meadows *et al.* (2001), furthermore, point out that female immigrants' perceptions of health, dependent on varying cultural constructions surrounding gender norms, are often structured in relation to other family members rather than the self. This projection of one's definition of self-health to family members suggests a different cultural understanding of health from that of the individual-centred model in Western biomedicine. The newcomer patient-Canadian health professional relationship can therefore be affected if each party is entering the interaction with different assumptions and considerations of what constitutes health. As a result, the interaction of multicultural constructions of health can be significant to the Healthy Immigrant Effect and the provision of health care to immigrants.

As Patil *et al.* (2009) summarize, acculturation is a contentious issue in anthropology but has only recently been widely critiqued in public health. This is probably because the concept of acculturation, to anyone who is not an anthropologist, being defined as a 'sub-group' adopting the patterns of a dominant group may, at first glance, makes sense intuitively. Patil *et al.* acknowledge the importance, demonstrated by epidemiological studies, of time and language as

‘exposures to Western practices’. The problem, however, of relying on these two proxies, despite the potentially overlooked fact that ‘exposure to Western practices’ quite often begins before immigration, is that they do not explain how residency time and language influence health, only that it does. This approach also risks ignoring geopolitical, historical, and social processes that influence language skills and access to resources. Local context such as varying community and neighbourhood characteristics may have large and variable influences on health. Ultimately, the literature suggests that public health could benefit from further inquiry into multi-faceted considerations and alternatives to linear/unidimensional acculturation models.

Conceptualizing Alternatives to Linear Acculturation

When trying to consolidate important health-related factors facing recent Canadian newcomers with linear models of acculturation I found myself with a problem. I had been trying to understand the ‘immigrant experience’ as a continuous social process where analyzing discrete factors, in isolation, was extremely problematic. Linear models of acculturation involved extracting individual factors, such as an essentialized ‘culture’, in a conceptual isolation that meant, at least to me, stripping their context to the point of incomprehensibility. In an attempt to deal with this problem I decided to conceptually challenge myself to identify important ‘factors’ which formed integral aspects of a potential ‘acculturation process’. The factors I settled on, rather than being discretely individual, formed the continuous and interrelated relationship between: 1) the

self-perception, expectation, and idealization a newcomer has of life in Canada when arriving; 2) the characteristics of the host society and how it socially locates migrants; and 3) the reflexive processes of the migrant to experiences of social location. I emphasize that these three 'factors' do not constitute discrete entities but rather act in concert to exert significant influence on the varied and intensely context specific manifestations of migration, acculturation, and health.

The first conceptual factor I consider important to the relationship between acculturation and health is the self-perception, expectation, and idealization that newcomers have when initially arriving in Canada. This consideration emphasizes the role of agency in determining the 'acculturative' process. Such an approach, therefore, drew me to the well-known Berry (1997) theory of bi-cultural acculturation strategies. It should be noted that Berry, in his theoretical approach, enacts a universalist perspective advocating the existence of common social and psychological human processes that are interpreted and manifested in culturally varied ways. As Berry (2009) himself states:

> "The universalist perspective asserts that all human societies exhibit commonalities ('cultural universals'), and that all individual human beings possess basic psychological processes ('psychological universals'). These psychological processes are shared, species-common characteristics of all human beings on which cultures play infinite variations during the course of development and daily activity." (p. 364)

Berry's theory of acculturation involves a universally shared human capacity to consciously strategize their acculturative process when migrating to a new country/society. This is not to say that individuals and groups are completely

free to choose their adaptive identities, for much depends on the characteristics of the receiving society as I will discuss shortly, but rather that specific strategies are employed by immigrant groups and individuals. Berry (1997) points out four possible strategies consisting of *assimilation, separation, integration, and marginalization*. These strategies differ from each other by their respective emphases on retaining traditional cultural identities relative to the cultural norms and value systems of the host country. As van de Vijver & Phalet (2004) mention "A migrant is supposed to have to deal with two questions. First, do I want to establish good relationships with the host culture?" and "Do I want to maintain good relations with my native culture?" (p. 217). Assimilation involves the complete loss of former cultural identities and adoption of a dominant host country subjectivity. Separation, conversely, involves an avoidance of interaction with groups outside one's traditional culture and an exclusive maintenance of 'old-country' identities. Integration possesses the capacity for bi-cultural identities that are fluid depending on the social context. This involves the maintenance of traditional cultural subjectivities in particular settings whilst also allowing for host country roles and value systems to be assumed when interacting with others in larger society. Marginalization represents a liminal position one is more likely thrust into, rather than explicitly choosing, where traditional cultural meanings are lost, or likely stripped, whilst adoption and interaction with host society norms and culture is structurally restricted or impeded.

What is especially important, however, are the personal expectations of one's life in the host country that are implicit with each strategy. The relationship between these expectations, and especially expectations of personal identity, with the subsequent realities of life in the host society can have important ramifications on what Berry terms 'acculturative stress'. As Beiser (2005) forewarns "when acculturation changes aspirations, and the means for achieving ambitions are slight, mental disorder is a highly likely result" (p. S38). Tannenbaum (2007) further contributes to our understanding of this dynamic when pointing out that "Berry elaborates on the consequential acculturative stress that, according to his model, is highest in strategies that lack supportive network...and lowest when they succeed in merging various aspects from both cultures" (p. 148). The expectations and idealizations newcomers bring to Canada function as the all-important backdrop used to understand and evaluate one's identity, agency, and well-being when navigating and experiencing the realities of life in Canada. The relationship between expectations and daily life in the host-country may result, if they are sufficiently at odds, in Berry's (1995) characterization of acculturative stress. But to understand the potential of acculturative stress, and its influence on immigrant health, we need to address the second issue of importance I have chosen to highlight: the structural characteristics of the host culture.

Mulgan (2009), in his *Migration Immigration Source* feature story article, perhaps shares the same universalist sense of Berry when stating:

> "Our framework for making sense of these patterns starts from the simple observation that human beings evolved to be able to read

> surrounding physical and social environments because this was essential to our prospects for survival.
>
> It is in our nature to be able to analyze whether a group still has a place for us, whether we are likely to be cared for and protected in a particular place, or ostracized and rejected."

The patterns Mulgan refers to are a society's structural and social positioning of groups and individuals along sociodemographic categorizations such as, for example, economic class, race, ethnicity, language, and gender. Particular societal manifestations of these categorizations are context specific and culturally dynamic. We all have, however, an intrinsically human ability to intuitively sense how we are positioned in any given surrounding. The characteristics of a host country, therefore, impose structural constraints on newcomers' acculturative strategies. The way a society structurally positions a newcomer, through a complex interaction of sociodemographic factors and cultural attitudes, is a crucially important issue influencing immigrant health. As Berry (1997) notes "Acculturation strategies have been shown to have substantial relationships with positive adaptation: integration is usually the most successful; marginalization is the least" (p. 24). Marginalization is unlikely to be the freely chosen course for any individual or group and is only made possible when dominant culture norms, attitudes, and policies directly or indirectly promote a differential relationship between ethnicity/culture and citizenship/access to power. In contrast, integration, being the most favorable adaptive strategy according to Berry, is more likely to occur in societies that "are accepting of cultural pluralism

resulting from immigration, taking steps to support the continuation of cultural diversity as a shared communal resource; this position represents a positive multicultural ideology" (Berry 1997, p. 17). Feelings of belonging and engagement are most likely to foster the integration strategy and thereby potentially better health outcomes. Key indicators to how a host society positions newcomers, moreover, are in the fields of economic opportunity and politics. The access, or lack thereof, to satisfying and socially valued employment is an immediate and formative experience in determining a newcomer's future subjectivity, and perhaps stress and well-being, in relation to their new society. Access to political power perhaps provides the most poignant indication of a society's characteristics as Mulgan (2009) illustrates when saying "A political system in which people who look like you and share your values fill key roles will encourage feelings of belonging. So too will leaders who give shape to a community, articulating common aspirations." We should therefore consider, in the Canadian context, policy shifts such as the *Multiculturalism Act* and the extent to which foreign-born populations are represented in our government as important factors in the field of immigrant health. The structural characteristics of a host society present themselves as significant influences on newcomer health outcomes. How these structural characteristics interact with the personal expectations of newcomers leads to my third issue of importance: reflexive processes to being socially located.

Now we come full circle in the ongoing process of acculturation experienced by newcomers. Individuals and groups are simultaneously being socially located within their environment and reacting in turn. This reaction is diversely manifested and strongly influenced by both individual expectations and the social characteristics of the host society as previously discussed. Forms of both passive and active adaptation make up unique avenues of coping and resilience. Consciously, the actions of the immigrant may imbue direct and indirect discourses of resilience that challenge and remake social boundaries that impede their personal ambitions and expectations. Unconsciously, however, new social categorizations of what it means to be of, for example, a certain ethnicity, gender, or age within the new society will be internalized with increased personal interaction and experience of these social norms. One may intuitively begin, in some part at least, to assume the roles in which society has continuously positioned you. The extent to which this process is experienced is not uniform but, rather, intensely context specific and based on factors such as acculturation strategy, personal ambitions, traditional culture, host country, ethnicity, race, religion, age, gender, and every other psychosocial possibility one can contemplate. The combined positive and negative effects of all these mitigating factors heavily influence the experience of acculturative stress and well-being.

The understanding of reflexive processes to social positioning can be made particularly clear, for example, in the relationship between acculturation, social positioning, and the children of immigrants. This can also help

conceptualize alternatives to linear theories of acculturation and the errant belief, in my opinion, that progressive assimilation to the dominant culture is the sole course of events. Firstly as Portes (1997) notes "the long-term effects of immigration for the host society depend less on the fate of first generation immigrants than on their descendants. Patterns of adaptation of the first generation set the stage for what is to come" (p. 814). Of particular note, therefore, is the challenge that segmented assimilation theory provides to traditional linear conceptualizations. Portes & Rumbaut (2005), being principal founders of this theory, describe segmented assimilation theory as a process of many possibilities:

> "This concept...describes alternative paths of adaptation as depending on a number of factors of which four are considered decisive: 1) the history of the first generation; 2) the pace of acculturation among parents and children and its bearing on normative integration; 3) the barriers, cultural and economic, confronted by second-generation youth in their quest for successful adaptation; 4) the family and community resources for confronting these barriers." (p. 986)

The dynamic of external social positioning and concomitant reflexive processes, in segmented assimilation theory, determines adaptation and health outcomes. Segmented assimilation also suggests the concept of dissonant acculturation wherein the first and second generation acculturate at differing rates. This can cause role reversals and disruptions in traditional family authority as the second generation quickly becomes better able to navigate and interact with the dominant culture. There is significant support for this strong generational

dynamic in the literature. South Asian immigrant Atlantic Canadian women, for example, in the Samuel (2009) study revealed a source of stress to be intergenerational conflict between parents and their Canadian raised children. Participants felt that their children were embarrassed by their parents' language skills and associated more with white peers. Samuel relates that parents and children develop culturally different expectations of one another and the resulting misunderstandings can lead to conflict and stress. Eurocentric patterns in schooling may also infer a sense of inferiority and children may associate their parents' use of language with disdain. Stodolska (2008) demonstrates some of the 'many possibilities' of segmented assimilation when pointing out that Polish participants felt, due to longer working hours, they hardly saw their parents in the US (with the consequent negative effects of less parental supervision) whereas Mexican participants, lacking the large familial networks they had in Mexico, conversely felt they spent more time with their parents. Korean participants, moreover, especially related intergenerational conflict due to issues such as educational choices, friends, and potential interracial marriages. Ying and Han (2008) further mention that "In the case of immigrant parents, this diminished sociocultural competence in American settings may limit their participation in contexts that are gaining importance to their children, such as the school and their expanding extra-familial social world" (p. 114). The differing patterns of social positioning, experienced within larger society, by first and second generations are respectively internalized and may significantly alter family dynamics. Acevedo-

Garcia *et al.* (2005) point out the possible health consequences of role reversals when mentioning that “In immigrant families, role reversal may weaken parental control and thus the anti-smoking socialization process within the family, leading youth to engage in smoking and other health risk behaviors” (p. 1238). Portes (1997) also illustrates that economic discrimination may frustrate the aspirations of second generation populations with the reflexive result of “The blocked mobility experienced by these groups [becoming] translated over time into an oppositional stance toward mainstream society” (p. 815). Conversely, segmented assimilation theory also describes consonant acculturation where first and second generations acculturate in relative synchronization. Portes (1997) describes this as potentially mitigated by the presence of a significant co-ethnic community and, in some cases, may reflect Berry’s segregation acculturation strategy. Consonant acculturation may provide coping mechanisms and resources to resist discrimination faced by the second generation in larger society. Ultimately, segmented assimilation theory problematizes traditional linear assimilation models and, in so doing, highlights the importance of reflexive social processes newcomers experience and enact when being socially positioned within their new environment.

By analyzing these three important facets of a broader and continuous process of acculturation I believe valuable conceptual alternatives to linear models are presented. I ardently believe that the ‘immigrant experience’ is fundamentally a complex social process and to neglect this reality would

misrepresent the interconnected web of social determinants that influence the relationship between migration and health. Like Berry's assertion of universalism I believe there are common human aspects shared by all of us regardless of social environment. How our common psychosocial processes interpret, and are interpreted, within these diverse environments is subject, however, to a myriad of specific variances and contextual mitigators. This makes the study of migration and health, especially from a social determinants perspective, both exceptionally complicated but also primed for valuable future study and insight.

Universalist conceptualizations, of common processes with diverse interpretations, can provide broader theoretical support to the understanding of migration and health. Anthony Giddens, for example, suggests a balance between both agency and structure's role in determining behaviour. This balance, or 'duality of structuration', involves a mutually recursive constitution of both agency and structure. Structure consists of the rules, resources, and physical/social environment in which the agent is developed. The agent, simultaneously, is aware of their structural context and thereby exerts transformative powers through their actions. Rob Stones (2005), describing this relationship, writes that "Giddens sees agents not only as always rooted in a structural context, but also as always and inevitably drawing upon their knowledge of that structural context when they engage in any sort of purposeful actions" (p. 17).

Structuration theory resists giving absolute priority to either agency or structure nor does it denote a linear causal relationship between the two. Rather, as Stones (2005) further relates:

> "agents draw on structures to produce actions that change or reproduce structures. This is the cycle of structuration. It is what is meant by the term 'structuration'. Neither structures nor agents are given primacy. Both require the other. It is not one or the other but both that are involved in social processes." (p. 20)

What becomes important, therefore, is what Giddens describes as the practical consciousness of agents. This is the crucially important "tacit understanding of the 'goings on' in the context of social life. Structure has no existence outside the knowledge that agents have regarding their daily activities" (Frohlich *et al.* 2001, p. 788). The routinized actions of the agent are practical implementations of the social knowledge by which they transform and define their environment. Although they exist and draw their knowledge from their structural context agents simultaneously reinforce or change the environment via their actions. This practical consciousness may be so routinized that the agent is not explicitly aware of its implication and Giddens therefore "distinguishes this from what he calls discursive consciousness, which denotes the ability of agents to give verbal expression to their knowledge about the social conditions of their action and the way that they 'go on' within these conditions" (Stones 2005, p. 28). Stephen Loyal (2003) helps summarize these concepts when saying:

> "practical consciousness represents tacit or 'mutual' knowledge, which is employed in the enactment of courses of conduct

> providing agents with the ability to 'go on'...discursive consciousness refers to the ability to articulate his knowledge...the line separating the practical consciousness from the discursive consciousness is a 'fluctuating and permeable' one." (p. 52)

Immigration can be seen as a sudden and massive change of the structure in which the agent exists and acts. If agency and structure are recursively linked then the experience of immigration will have significant effects on both. Unlike the linear acculturation model that advocates a one-way 'Westernization' of immigrants, structuration theory would suggest a reciprocal formative effect on Canadian society by immigrants' transformative thoughts and actions. Simultaneously, the starkly new structure (i.e. the rules, resources, and physical/social environment of a Canadian community) in which the immigrant now finds themselves will influence the transformative knowledge and subsequent actions they exert as conscious agents. The duality of structuration influences the actions of immigrants but also the nature of their new Canadian environment.

Take, for example, the fairly ordinary concept of buying food. Large scale supermarkets are relatively unique to Western industrialized nations as opposed to how food is obtained in the home countries of many Canadian immigrants. This new structure necessitates an immigrant changing their food provision behaviour by now shopping in a supermarket. But the conscious transformative behaviour, the practical consciousness, of the immigrant who seeks out familiar ingredients has changed the very nature of Canadian supermarkets that now stock many items

that were not available fifty years ago. Both the agent and the structure have reciprocally enacted influences on the other.

In terms of the Healthy Immigrant Effect it is of interest, therefore, to focus on both the practical and discursive consciousness of immigrants concerning their health. The health experiences and perceived self-health of immigrants are an avenue to study the transformative powers newcomers consciously enact in their new environment. How newcomers behave, and what they feel is in their power to do, will be a reflection of the new structure, including health related factors, in Canada. Studying the practical and discursive consciousness of immigrants would provide a clearer picture of the context in which the immigrant experience exists. This can provide insight into the changes in both individual behaviour and structural characteristics that may be contributing to the Healthy Immigrant Effect.

Understanding the Role of 'Culture' in Multicultural Health Research

A salient need, moving forward, is to consider culture within a broader range of psychosocial factors. Culture alone cannot be termed a health factor without exploring the specific context within which it is perceived and enacted by both individuals and groups. The effects of, for example, poverty, discrimination, employment, family, and friends need to be considered alongside, and within, culture when contemplating possible causes of the Healthy Immigrant Effect. A multi-dimensional construction of 'acculturation' could then be built upon more than an isolated and ambiguously defined 'culture' factor. Abraido-Lanza *et al.* (2006) suggest that "Acculturation may be a proxy for other variables, such as prolonged exposure to stressful events or adverse circumstances, including those associated with immigration and eventual settlement, or disadvantaged social status" (p. 1343). If the Healthy Immigrant Effect is a manifestation of socioeconomic disparities then perhaps we can look to Robert Aronowitz for conceptual help.

Aronowitz (2008) introduces the societal 'framing' of disease to help explain the culture/body interface of socioeconomic health disparities. How a disease, and by extension health status in its entirety, is socially defined, named, classified, and diagnosed can have self-perpetuating qualities. Perhaps we can apply this concept to the issue at hand. Firstly, we must ask ourselves how are we framing and defining the Healthy Immigrant Effect? As Newbold & Danforth (2003) demonstrate the major analytical techniques applied to the Healthy

Immigrant Effect are diagnosed conditions, national health surveys, and self-assessed health indexes such as the Human Utilities Index. Aronowitz argues that diagnostic techniques themselves can be dependent on a societal framing of disease. He demonstrates this by citing the example of poorer individuals having a higher proportion of asthma diagnoses relative to the rest of society. Materialist explanations would suggest poorer environmental conditions and resources are to blame and this, in my opinion, is undoubtedly at play. Aronowitz (2008) additionally suggests, however, that physicians may believe "individuals with poor follow up do better with the asthma diagnosis and immediate treatment rather than watchful waiting" (p. 3). The perception that asthma is more prevalent among the poor is itself a self-perpetuating effect on future diagnoses. It is not outlandish that this essentializing effect of disease frameworks could apply to biomedical diagnoses among recent Canadian immigrants. As Johnson *et al.* (2004) learn from their discourses with Canadian health care providers in multicultural settings:

> "Rather than looking at barriers inherent in the system such as the lack of female health care providers and limited clinic hours, the health care providers used women's personal characteristics (e.g., shyness, passivity) that they labeled as cultural to explain lack of participation in health programs." (p. 262)

The essentializing, or 'framing', of particular immigrants' health characteristics to culture can have a self-fulfilling effect on health practitioners' diagnoses within multicultural populations. Generalizations of the relationship

between ethnicity and health may be influencing our observation and characterization of the relationship between migration and health.

Of further interest are self-report techniques and self-assessment scales. These tools are created within a biomedical framework in which respondents are asked to rate their physical and emotional states on a numerical scale. Veenstra (2009) points out in his analysis of the 2003 Canadian Community Health survey that “they are self-reports and might be interpreted differently by people of different racialized identities” (p. 542). The answers immigrants report on these types of tools are heavily reliant on two of the etiological frameworks suggested by Aronowitz to explain socioeconomic health disparities: psychosocial mechanisms and the societal ‘framing’ of disease. The ‘psychosocial’ relates to one’s self-perception, including health and socioeconomic standing, in reference to society as a whole. This is dependent on how one conceives of the self relative to the perceived environment. The societal ‘framework’ in which disease is defined, moreover, can influence both the composition of self-health scales themselves and their subsequent interpretation by respondents. The ‘framing’ of good health in reference to pain, for example, to the researcher may constitute the absence of any physical sensation and yet to the respondent may be a particular emotional response to physical pain which is perceived and reported as no pain at all. For example the discrete category of ‘depression’ that is familiar in Western biomedicine does not readily translate into the traditional Chinese perspective. Rather than being its own medical category, symptoms of depression are

attributed to various sources of *qi* imbalance. How we construct and define health and disease is diverse and subject to various assumed 'frameworks' as Aronowitz suggests.

I think Kleinman (1995) adds strength to the premises of this argument when he states "There is, then, no essential medicine. No medicine that is independent of historical context...Medicine, then, like religion, ethnicity, and other key social institutions, is a medium through which the pluralities of social life are expressed and recreated" (p. 23-24). There is an element of 'naturalization' within the Western research tradition towards biomedicine's epistemology that sees itself as the product of objective truths rather than socially constructed assumptions. I believe this point is important to health research in cross-cultural settings with a diverse population. If biomedicine is not aware of the assumptions underlying its own epistemology it inevitably risks misinterpreting, marginalizing, and belittling other forms of health knowledge when viewing them in contrast. As Airhihenbuwa (1995) exhorts "Health beliefs and actions should be examined within the context of culture, history, and politics" (p. 26). This applies equally to biomedicine as to any other health belief paradigm.

So why should we care about biomedicine's epistemology in cross-cultural health promotion research and endeavours? The main reason lies in the fact that the biomedical method has evolved within a specific system of cultural

meanings and values. This was concomitant with the Western export of said cultural meanings and the legacy of colonialism. Chinn (2007) echoes this when saying "Science as a quest for knowledge developed in the historical context of Europe's search for new lands and economic resources" (p. 1249). Colonialism involved the imposition of Western economic and cultural systems onto those who were colonized. As a result, the cultural beliefs of the colonized were actively suppressed and denigrated as inferior. Cultural norms towards health were no exception. Western conceptions of health revolve around the material elimination of disease from the individual; a perception rooted in a wider societal ontology as Kleinman (1995) demonstrates when explaining that:

> "The idea of a single god legitimates the idea of a single, underlying, universalizable truth, a unitary paradigm...Biomedicine differs from other forms of medicine by its extreme insistence on materialism as the grounds of knowledge, and by its discomfort with dialectical modes of thought." (p. 27-29)

The term 'universalizable truth' here should not be confused with the previously mentioned universalist approach which, quite contrastingly, acknowledges our construction of diverse cultural interpretations of knowledge. Amarasingham Rhodes (1990), furthermore, highlights the underlying positivist character of biomedicine's material ontology when stating:

> "Biomedical theory developed out of the possibility, following René Descartes, of a separation of the physical body from the mental and social. The body, as part of the natural world, becomes knowable as a bounded material entity...biomedicine participates in deep-seated cultural assumptions about what it means to know the body." (p. 161)

The naturalization of this epistemology, furthermore, risks perpetuating systems of power as Amarasingham Rhodes (1990) demonstrates when saying "Medicine can describe events in a value-neutral language that makes them appear to be part of the natural world and thus neutralize what are, in reality, social problems" (p. 168). The waning health of immigrants in Canada can be mistakenly reduced to their individual behaviours rather than systems of power, social exclusion, and poverty.

Our endeavours to improve health in cross-cultural contexts have largely ignored the historically subjective foundations of our epistemologies. They are based in a system that evaluates health with indicators that only make sense in our particular world view. Speed (2006) states that "our representations of others were products of our own social positioning and our own 'situatedness' in relation to those people and cultural dynamics we chose to represent" (p. 66). In addition, Chan-Tiberghien (2004) relates that "Neoliberal globalization privileges efficiency, scientificity, profits, 'development,' and 'progress' and excludes other knowledge systems" (p. 196). There is a continual focus on deficiencies of health in the individual 'other' while ignoring the contextual system of power that perpetuates poor health. Research methods and biomedicine conducted within this epistemological umbrella are thus liable, although well-meaning, to recreate power discourses when describing cross-cultural health. Biomedicine, if uncompromisingly applied, risks evaluating the health of the cultural 'other' in a

light that implicitly reflects a system in which he or she is structured as poor and powerless.

Aronowitz's work helps clarify how our cultural assumptions frame and construct the epistemology on which we rely to develop knowledge. This can never be forgotten or else we naturalize our cultural assumptions and consider them to be the only 'real' and objective truth. An ethnocentric inequity, therefore, would inevitably be applied to the cultural 'other' in any multicultural health interaction.

This perspective can be applied to 'acculturation' theories of the Healthy Immigrant Effect. Rather than adopting a 'mainstream' Canadian lifestyle perhaps newcomers are exposed to new 'frameworks' of health and disease in Canada to which they react. Aronowitz suggests that health, like language, can be a marker of social standing in society. In modern Western society, for example, obesity has become framed as a medicalized 'epidemic' that disproportionately affects the poor. Healthier foods and lifestyles are more amenable to those that have the money to access them and healthy weights have become a biological 'standard dialect'. This standard dialect of health constitutes a perceived 'mainstream' to which individuals reflexively define themselves. Newcomers to Canada are simultaneously bombarded with an abundance of cheap calories and yet starkly contrasting societal messages that valorize weight loss and define 'deviant' body weights in medicalized terms. Rather than adopting an ill-defined 'Western

lifestyle' it's possible that the psychosocial processes of immigrants are re-defining themselves within a new 'framework' of health and disease.

The task, therefore, is to explore and better understand the 'context' in which the immigrant experience is perceived. To provide a multi-dimensional approach would entail a consideration of both the material place (physical resources) and social space (social environment) that immigrants experience in their routinized lives. This approach to understand the nature of context is born from the Frohlich *et al.* (2001) conceptualization of 'collective lifestyle':

> "context is the reflection of both place and the characteristics of people of the place, and that this relationship is recursive and influences disease states. Contexts will be reflected in the collective lifestyles of people living there, both in terms of people's relationship to the attributes of the area as well as to their similitude to each other in terms of their social practices." (p. 792)

I believe an understanding of the social context in which an immigrant lives, the 'collective lifestyle', can elicit causal insights to the Healthy Immigrant Effect. Focusing on only the material context of an immigrant's life would simply provide an epidemiological association between context and health that is stripped of any social meaning. We would be missing the crucially important psychosocial understanding of the individual with their material and social surroundings. As Frohlich *et al.* (2001) state:

> "What is missing is a discussion of the relationship between agency (the ability for people to deploy a range of causal powers), practices (the activities that make and transform the world we live

in) and social structure (the rules and resources in society).” (p. 781)

The role of culture as a social determinant of health needs to be re-examined within this relationship between agency and physical/social structure. Culture can be re-evaluated within a tapestry of social meaning rather than be confined to the rigid categorizations of a contextual vacuum. An immigrant’s personal subjectivity would then become just as important, if not more so, as objective residency times and language skills in determining health outcomes such as the Healthy Immigrant Effect.

Dissolving Theoretical Distinctions - Bourdieu's Theories of Social Relations

The scope of issues surrounding the immigrant experience, acculturation, and the Healthy Immigrant Effect necessitates strong theoretical foundations of analysis to move beyond oversimplified understandings of the complicated relationship between migration and health. The burgeoning uniqueness of Canadian multiculturalism deserves its own assiduous academic inquiry and analytical support. This is why I particularly appreciate the potential applicability of Pierre Bourdieu's theories of social relations to the landscape of Canadian multiculturalism and migration. In particular, I believe that Bourdieu's conceptualizations of field, capital, habitus, and social reproduction can lend valuable clarity and understanding to the social processes underlying Canadian migration and health. As Lynam & Cowley (2007) explain:

> "These concepts help make visible the ways taken-for-granted aspects of social structures, and related traditions and practices, shape experience and structure inter-group relations. Bourdieu's analyses illustrate processes that create privilege and contribute to social suffering while making visible the extra-local conditions, including institutional practices, that structure and reproduce such relations. This perspective has only recently been applied to health." (p. 138)

What draws me, in particular, to Bourdieu is his emphasis on dissolving false dichotomies prevalent in the social sciences. I struggled through the literature trying to reconcile and apply the traditional dichotomies between agency and structure to Canadian immigration. Rather than emphasizing either objectivity or subjectivity in sociological inquiry Bourdieu provides a perspective liberated

from the usual limitations of forcing distinctions between the 'individual' and their 'structure'. This conduit of perspective looks at how mutual relations between individuals, groups, and their environment work in conjunction to form realities. In my analyses I aim to refrain from engaging in discussions of 'objectivity' versus 'subjectivity' but, rather, provide a relational perspective.

Of central importance to this perspective are Bourdieu's concepts of capital and field. Bourdieu introduces any given 'field' as an objective set of dispositions between agents, based on their influence over relevant 'capital', in relation to specific physical and/or social goods. The field is a relational network in which actors must hold a stake and share acknowledgement of its social value. This relational structure means the relevant capital only exists in relation to the specific field. One's position within a particular field, and thus the nature of the field itself, is subject to the amount of relevant capital one possesses relative to others. The field is governed by external rules that presuppose the existence of the field itself by culturally constructing the value and desirability of the given goods. However, avoiding a positivist insistence on fixed social 'laws' like those of the physical sciences, the structure, and thus the rules of the field can be changed if the distribution and nature of mutually acknowledged capital is altered. This highlights the centrally important concept that fields constitute a *struggle*, thereby being subject to change, between agents that are trying either to maintain or improve their relative positions. These transformations are essentially relational because they constitute alterations of social networks in reference to the

overarching field of power. Rather than a prescribed emphasis on the primacy of agent or environment the "principle of the dynamics of a field lies in the form of its structure and, in particular, in the distance, the gaps, the asymmetries between the various specific forces that confront one another" (Bourdieu & Wacquant 1992, p. 101).

Bourdieu, in particular, delineates four types of capital: economic (monetary resources), cultural (ability to draw on, interpret and successfully navigate shared systems of meanings), social (benefit by membership within valuable networks of contacts), and symbolic (level of social prestige and honour). There are multiple types of fields (such as academic, religious, community etc.) within societies that emphasize varying degrees and forms of relevant capital. Overlapping all these fields, however, is the crucially important distribution of power which allows certain actors to dominate various forms of capital. Jenkins (2002) explains that "it is a consequence of the power of dominant fields, particularly the field of power (politics), to impinge upon weaker fields and structure what occurs within them" (p. 86). Reed-Danahay (2005) further explains that:

> "Bourdieu identified...a 'field of power' that refers to situations in which people with a lot of cultural capital are able to dominate in a field. In his later writings, Bourdieu suggested that domination did not occur through direct coercion by a set of agents who could be clearly identified as a dominant class but, rather, indirectly through the actions of the dominant in fields of power." (p. 134)

The power imbued in the actions of the dominant allow them to heavily influence the rules of various fields and thus reinforce their structure. This reproduces the legitimacy of the forms of capital that allow the dominant to retain their position whilst also structuring the subordinate position of those with less capital who have, in turn, internalized the value of said capital. Reed-Danahay (2005) exemplifies this through Bourdieu's concept of lieu, or space, when mentioning that "Physical location comes to express social location because individuals with a lot of symbolic and cultural capital are able to dominate and define the most prestigious locations" (p. 135). Power not only allows one to dominate but, more importantly, define what types of capital are valuable and, crucially, convince those in subordinate positions within a field to acknowledge its legitimacy.

This understanding has borne many criticisms such as those of Frohlich *et al.* (2001) who note that "for Bourdieu the agent is oddly absent, being somewhat passive in the process of structuring perception and action" (p. 790). This simply is not true. The criticism itself reflects the emphasis on theories of rational action and the internal/external dualism prevalent in the social sciences. By rejecting these dualisms Bourdieu does not negate the existence or role of the agent. Rather than discrete biological units agents "are socially constituted as active and acting in the field under consideration by the fact that they possess the necessary properties to be effective, to produce effects, in this field" (Bourdieu & Wacquant 1992, p. 107). Bourdieu offers an escape from old antimonies but, as a result, is

often misread to be removing the concept of agency. The intent, moreover, is to "escape from under the philosophy of the subject without doing away with the agent, as well as from under the philosophy of the structure without forgetting it's effects it wields upon and through the agent" (Bourdieu & Wacquant 1992, p. 121-122). The agent is very much real but the crucial distinction is that "Human action is not an instantaneous reaction to immediate stimuli, and the slightest 'reaction' of an individual is pregnant with the whole history of these persons and of their relationship" (Bourdieu & Wacquant 1992, p. 124). The agent is, through their active relation with the world, sensitized to sets of constructed dispositions. It is not that we are unable to consciously strategize, quite obviously we are, but our ability to rationalize, rather, is pre-emptively influenced by socially constructed dispositions. As Reed-Danahay (2005) states "Bourdieu wanted to show that dispositions were socially produced. Dispositions are internalized, preconscious, and largely determine the actions social agents take" (p. 107). This relational emphasis is brought forth in the famous concept of habitus.

Habitus denotes a socialized disposition, predisposing our reactions to objective stimuli, that is itself structured by the objective conditions we experience in life. Habitus accordingly predisposes individuals to certain lifestyle choices, tastes, aesthetics, and actions. Bourdieu (1977) describes habitus as "an acquired system of generative schemes objectively adjusted to the particular conditions in which it is constituted, the habitus engenders all the thoughts, all the perceptions, and all the actions consistent with those conditions" (p. 95).

Essentially, habitus is an individual's relational embodiment of the fields, and in particular the social constructions that define them, in which they are produced.

This incorporation, or literally embodiment, begins in the earliest days of life. The social structures and cultural norms of our environment are inculcated through our experiences growing up. Structural features such as gender norms, ethnic identity, and socioeconomic status are internalized in this formative period and contribute to the generating habitus. Again, Bourdieu has been misinterpreted to be advocating essentially another form of structuralism. In response to these claims Bourdieu & Wacquant (1992) highlight that habitus is "an open system of dispositions that is constantly subjected to experiences, and therefore constantly affected by them in a way that either reinforces or modifies its structures. It is durable but not eternal" (p. 133). The experiences of the agent, in which they are not passive but instead predisposed, are described as critical to the making and remaking of the habitus. Thapan (2006) clarifies this point when saying:

> "In this understanding of the simultaneous constancy and malleability of habitus, the view is that the habitus is embodied, unthought, instinctual but also reflexive, through understanding and articulation, as well as through embodied work and play, made and unmade in the experience of everyday life...In other words, the habitus clearly constructs their experience in many important and non-subversive ways but their voices also reflect the call for challenging the structuring structures of the habitus through negotiation, contestation, and transformation." (p. 202-203)

As time passes, however, certain experiences and dispositions become so ingrained that change becomes more and more unlikely. Habitus is not a fatalistic

form of structural determinism. It represents a potential socialized reflexivity in the face of given objective structures. The agent is enacted in their coordination and navigation of these dispositions. Bourdieu & Wacquant (1992) explicitly state that "social agents will actively determine, on the basis of these socially and historically constituted categories of perception and appreciation, the situation that determines them. One can even say that social agents are determined only to the extent that they determine themselves" (p. 136).

What becomes interesting then, especially for studies of immigration, is the displaced habitus that is removed from the network of fields in which it was developed. The dispositions to which one is sensitized are misaligned with the new objective stimuli and location within fields. Bourdieu's theories of social theories provide us with an excellent set of tools to reexamine Canadian immigration experiences. Upon arrival in Canada the immigrant experiences:

> "changes in objective structures [that] are so swift that agents whose mental structures have been molded by these prior structures become obsolete and act inopportunely (à contre-temps) and at a cross purposes; they think in a void, so to speak, in the manner of those older people of whom we may justly say they are 'out of sync'." (Bourdieu & Wacquant 1992, p. 130)

The socialized reactions to the practical imperatives of daily life through an experientially trained common sense, or 'practical logic' as Bourdieu puts it, is disrupted by immigration. As time passes one can expect that, to varying degrees and manifestations of acculturation, the immigrant habitus to bridge the old and the new. In effect, the immigrant actually comes to be an embodiment of both

social worlds between which they travel. Trying to conceptualize how the immigrant habitus manifests itself and influences behaviour, can provide another analytical lens to the ‘acculturation’ process. Bourdieu believed that valuable sociological theorization was impossible without associated empirical and practical input. I believe that the socialization of immigration, especially in a Canadian context, is an excellent venue to apply this input. The immigrant is abruptly thrust into a completely new set of fields whilst simultaneously experiencing a wholesale change in the forms and amounts of capital they possess in their new environment. Academic inquiry into the social processes underlying this interaction can focus on how the field is influenced by the introduction of the immigrant but, also, how the immigrant adapts in response. The immigrant will find themselves positioned according to the rules and relative positions of others in this new series of fields whilst, in turn, re-establishing their identity and position. This analysis of practice can perhaps be insightful to the improved understanding of newcomer health and well-being in Canada. Additionally, the positions of immigrants relative to the crucially important ‘field of power’ can also tell us a lot about the nature of Canadian society, identity, and multiculturalism. Adopting Bourdieu’s analytical tools for understanding social processes may yield insight and important conceptual support to the relationship between migration and health in the Canadian context.

Method

Transitioning to the empirical case study from my theoretical analysis, I now describe the research methodology employed. Data analysis techniques are described by which I try to understand participants' discourses and experiences. I then begin my presentation of findings with a case study encompassing all the prevalent themes interpreted from the data. Each theme is subsequently presented, in its entirety, in order to fully describe the range of conceptualizations informing participants' self-health.

Background

At first, when I was initially considering how to approach this study, I considered the analytical approach of phenomenology. Phenomenology shares an emphasis with the Frohlich *et al.* conceptualization of 'collective lifestyles' wherein both objective realities and perceived subjectivities work in conjunction to constitute the 'context' in which one lives. Peter Rothe (2000) gives further support to this feature of phenomenological studies when saying:

> "Phenomenology reflects the assumption that we live in a given and ordered world. Our everyday world is a social reality comprised of cultural objects and social institutions, a world that we accept without question because we were born into it as it exists...Phenomenologists focus on how we internalize the objective world into consciousness, how we negotiate its reality in order to make it liveable and shareable and how we construct social reality within the confines of the world's constraints." (p. 40)

I believe the way immigrants construct their lives, in response to a new cultural and physical reality, has salient effects on health and, by extension, observances of the Healthy Immigrant Effect. Finding a way to explore this relationship lay at the heart of the initial research question I was contemplating. Moustakas (1994) further elaborates the ontology of phenomenology when stating:

> "...inevitably a unity must exist between ourselves as knowers and the things or objects that we come to know and depend upon...Although phenomenology is concerned with ideas and essences, there is no denial of the world of nature, the so-called real world." (p. 44-46)

I believed a phenomenological design could complement the research question and my interest in personal experiences. The usefulness of self-expression is outlined by Hyden & Overlien (2004):

> "Namely how individuals perceive, organize, give meaning to, and express their understandings of themselves, their experiences, and their worlds...In both telling and interpreting experiences, narrative mediates between an inner world of thought-feeling and an outer world of observable actions and states of affairs." (p. 250-251)

However, as I developed my reading of the literature I became determined to apply more personal insight as a researcher, forcing a divorce with phenomenology, to my interpretation of the data. I also wanted to bring theoretical perspectives, especially those of Bourdieu, that I find personally interesting to an area of Canadian health promotion research. I felt I needed to move away from ontological debates surrounding objectivity and subjectivity that

set about answering everything, in some sort of order with confusing boxes and arrows, in a 'grand theory'. I appreciated Bourdieu's suggestion that social research requires rethinking in every situation rather than applying a positivist stencil that must explain all phenomena. Applying a relational interpretation would help me better understand Bourdieu's advocacy of "a coherent system of recurrent questions that saves us from the theoretical vacuum of positivist empiricism and from the empirical void of theoreticist discourse" (Bourdieu & Wacquant 1992, p. 110).

Not only can such an approach provide novel analytical insight to this application but, more crucially from a personal point of view, also help me develop my current theoretical understandings. As a result, I was drawn to the more appropriate, for my purposes, approach of ethnography. My reasoning is reflected by Merriam's (2002) description of ethnography when asserting that "it is not enough, then, to describe the cultural practices of a group; the researcher also depicts his or her understanding of the cultural meaning of the phenomenon" (p. 237).

I found that my research objectives had evolved into a theoretically and empirically informed personal journey of Canadian multiculturalism through a qualitative understanding of the Healthy Immigrant Effect. This journey took on the form of an auto-ethnographic reflexive analysis of my experiences in order to inform an interpretation of the 'immigrant habitus'. Being myself a second

generation Canadian this study represents a personal exploration of identity, borrowing ethnographic research tools, rooted in the specific analysis of how my theoretical understanding of Canadian multiculturalism relates to empirically sourced accounts within a specific immigrant settlement program.

Participant Observation Informed Research

To begin this inquiry I participated as a volunteer with the Kitchener-Waterloo YMCA Cross-Cultural and Community Services' Host program English Conversation Circles. K-W YMCA Cross-Cultural and Community Services offers centralized support and services to newcomers in the Waterloo region of Ontario. The centre is funded by Citizenship and Immigration Canada, Employment Ontario, and additional federal support. A variety of programs are offered including the Immigrant Settlement & Support Program (ISAP) which provides tailored support, counsellors, and information in 15 languages. The Language Assessment Centre refers newcomers to appropriate Language Instruction for Newcomers in Canada (LINC) and ESL programs in the region. The Newcomer Employment Centre offers skills assessment, referral to work training, job search workshops, and a resource centre with internet, fax, printer and job postings. The Settlement & Education Partnership in Waterloo Region (SEPWR) in conjunction with local school boards works with students, families, and teachers to ease the transition of newcomer children into the Canadian school system.

Of particular note is the Host program which aims to match newcomers with Canadian volunteer peers to foster friendships, support, and diverse ways to learn about life in Canada. The Host program also offers a mentorship program that matches recently arrived professionals with Canadian peers to help them adapt to the workforce. English Conversation Circles, an aspect of the Host program, are organized to give newcomers a relaxed and informal environment to practise their conversational skills with other participants and Canadian volunteers. The circles foster friendships and help develop English skills. On the suggestion of Host Program coordinators I participated as a volunteer in two of these circles from October 2009 to June 2010.

The principal research tool I developed for this study is a semi-structured individual interview guide. The ultimate goal of the interview was to provide participants with the space to freely elaborate their perceptions and experiences. The interview guide was designed to establish basic structure and an interviewer-interviewee rapport rather than serve as a strict protocol. The interview process, moreover, was intended to be flexible wherein probing questions are derived from participants' discourse. The main emphasis of the interviews was to convey participants' inner logic and expressed meaning. The development of the guide, moreover, was subject to an ongoing process that included both influences from the literature and a period of participant observation by the researcher.

At first I made a preliminary interview guide (see appendix, Fig. 1) with considerations garnered from the literature. The three themes prioritized were the ‘definition of health’, ‘health and well-being before coming to Canada’, and ‘health and well-being while moving to and settling in Canada.’ In this design participants would be prompted to begin interviews by expressing their conceptualization of ‘good health’. They would then be asked to describe how experiences from both before and after immigration have influenced their perception of self-health. This order of questioning was to allow participants to compare and contrast their developing narrative of self-health, throughout the immigrant experience, with their initial personal definition of ‘good health’.

I initially participated as an English speaking volunteer in 5 informal discussions over a two week period in which we covered a variety of topics such as finding a doctor in Canada, winter weather tips, food, politics, Remembrance Day, geography, and the media. Through these informal discussions I noticed that when the topic of health was brought up the conversations often focused on immediate and practical concerns such as doctor shortages, confusion over health coverage, long wait times, and trying to understand the mechanisms of health services in Canada. From these informal discussions I determined that perhaps these immediate first hand concerns would be a better entry point for interviews. Rather than beginning with the more abstract definition of the nature of ‘good health’ I decided that the interview guide should begin with the immediate concerns of participants themselves (see appendix, Fig. 2). I then reworked the

order of the interview guide to begin with a description of one's self-health at the present moment in Canada before moving towards the ontological nature of good health itself. The middle of the interview guide remained centred on participants' experiences before and during immigration. The tail end of the interview then returns to experiences here in Canada with particular focus on access to health services, information, and resources. Ultimately, however, the course of the interview would always be at the discretion of the participant.

I included a mixed gender sample of adult newcomers, who have either Canadian citizenship or permanent resident status, in the age range of 23 to 46 years old. The sample criteria included any user of the Host program English conversation circles and, as a result, consisted of individuals entering Canada as refugees, standard principal applicants, and family sponsorships. The age range represented was a consequence of those who agreed to participate however the majority of standard principal applicants (SPA), who represent the largest Canadian immigrant category, are between 25 and 49 (Kustec & Dempsey 2003). This age range represents an important target group of individuals who are in their early adulthood when they experience their move to Canada. Individuals of this age have completely spent the formative years of childhood and adolescence in a foreign context to the Canadian environment in which they are now building a new life, early careers, and young families. The health subjectivities that arise within this particular experience are of central importance to my study. I

emphasized a mixed gender sample because I feel the literature has predominantly focused on exclusively female sample groups. As Portes (1997) suggests:

> "Instead, like class and race, gender represents a master dimension of social structure and a focus on this dimension can yield novel insights into many phenomena. For this to become reality, the analytic focus cannot be exclusively women (or men for that matter), but the socially patterned relationships between the sexes as they influence and, in turn, are influenced by the process of immigration." (p. 816)

Additionally, participants must have arrived in Canada within the last ten years since this has been observed as a critical time period over which average health outcomes change within the Healthy Immigrant Effect (Newbold & Danforth, 2003).

An equally important aspect of the research design is the inclusion of a multicultural sample. Since the research is exploratory, involving a small sample of preliminary descriptive interviews, I thought it appropriate to include multiple ethnicities. Being limited to a description of the thematic self-health experiences prevalent within the English Conversation Circles, and specifically those I participated in, the relatively small sample size is intended to generate a theoretical saturation. A multiethnic sample, thereby, incorporates the pluralistic nature and many backgrounds represented at Host program English Conversation Circles. This research does not seek to establish population level generalizability but, rather, describe the particular experiences present at the English Conversation Circles I participated in as a volunteer. As Lynam & Cowley (2007) state:

> “The criteria for appraising the adequacy of the sample in research of this nature is determined by the depth and detail the data provide for understanding the phenomenon of interest. The goal is not to seek representativeness but to gather data in sufficient depth to illustrate ‘systems in practice’.” (p. 130)

A multicultural sample can help direct future research by providing examples of similarities and differences across ethnicities experienced in the Canadian immigration landscape. The emphasis, however, is to provide diverse examples of ‘systems in practice’ and not to compare cultures. This project, through its sample and design, pointedly limits itself to exploratory inquiry.

Through the course of the English conversation discussions I approached individuals who I had established ongoing rapport and familiarity with through the course of my participation as a volunteer. Thus, participant observation is the major research structure trying to ensure rigor by building mutually trusting relationships over time with participants. In addition to newcomer participants I also conducted a discussion with two senior managers at the YMCA Cross Cultural and Community Services. They discussed topics, drawing from their extensive experience as community level settlement workers, surrounding the health and health care experiences relevant to Canadian newcomers in Kitchener-Waterloo.

Ethics

This study was reviewed and approved by the University of Alberta Arts, Science & Law (ASL) Research Ethics Board. All participants’ identities are kept

anonymous. Participants were privately invited to participate after we had developed a mutual familiarity through the course of conversation groups. Participants were repeatedly advised that participation was voluntary and that refusing had no bearing on their relationship with me. Written informed consent was given, after a comprehensive explanation of participants' rights, before commencing any participation with this study (see appendix, Fig. 3).

Table 1: Participant Profile

Participant ID	Country of Origin	Sex	Age	Time Since Arrival
PKW1	El Salvador	M	25	3 years
PKW2	Sudan	M	46	9 years
PKW3	Iran	M	27	2 years
PKW4	China	M	40	6 years
PKW5	China	F	30	3 months
PKW6	China	F	23	8 months

Table 2: Settlement Workers

Settlement Worker
SW1
SW2

Data Analysis

I prepared transcriptions of each recorded interview with both participants and settlement workers. Raw individual transcripts were thus prepared for an initial set of readings. During these preliminary readings, after each interview was completed, I noted broad themes as they came up throughout the discussion. From these themes I then developed, and defined, precise codes pertaining to what participants were expressing at each particular moment in their respective interview. A new code was created, as needed, whenever a new thematic element emerged from participants' discourse and consequently given a definition characterizing the essentialized meaning expressed. The following list constitutes the final master list of codes, and respective definitions, generated across the full sample of participants' interviews.

Table 3: Codes Developed from Participant Interviews

Code	Definition
1. Defining Good Health	Defining the criteria of 'good health'. Establishing what it means.
2. Language	Reflecting on how language impacts one's life as an immigrant to Canada.
3. Language and Employment	Impression of the relationship between personal language abilities and employment in Canada.
4. Language and Health	Reflecting on how language has/can impact personal health and well-being.

5. Employment	Experience and impressions of finding and holding employment in Canada.
6. Accreditation	Relating experiences of trying to get accreditation to practice one's profession in Canada.
7. Education	Reflecting on one's personal ambition and attitude to furthering education in Canada.
8. Comparing Health in Canada and El Salvador	Comparing one's present health in Canada to that remembered in El Salvador.
9. Comparing Health in Canada and Sudan	Comparing one's present health in Canada to that remembered in Sudan.
10. Comparing Health in Canada and China	Comparing one's present health in Canada to that remembered in China.
11. Comparing Health Care in Canada and Iran	Comparing the features of health care services in Canada and Iran.
12. Comparing Health Care in Canada and China	Comparing the features of health care services in Canada and China.
13. Health in Canada	Reflecting on one's personal health at this moment in Canada.
14. Health in Iran	Reflecting on one's personal health, before moving to Canada, in Iran.
15. Health in China	Reflecting on one's personal health, before moving to Canada, in China.
16. Communicating and Interacting with Doctors	Perception of one's ability to communicate and interact with doctors. Reflecting on one's experience and self-perceived role as a patient in the relationship.

17. Communicating and Interacting with Family Doctor	Perception of one's ability to communicate and interact with their family doctor in particular. Reflecting on one's experience and self-perceived role as a patient in the relationship.
18. Getting Health Service Information	One's experience and impression of getting information regarding Canadian health care services.
19. Getting Timely Service	Perception of wait times to get health service in Canada. Perception not from firsthand experience.
20. Service Value/Insurance	Perception of health insurance fees in Canadian employment.
21. Staying Healthy	Describing methods one uses to maintain good health in Canada.
22. Finding a Family Doctor	Experiences and impression of searching for a family doctor in Canada.
23. Walk-in Clinics	Impression, knowledge, and use of walk-in clinics in Canada.
24. Emergency	Knowledge and opinion of health services available in an emergency.
25. Traditional Treatments from Sudan	Reflecting on non-biomedical treatments from Sudan.
26. Traditional Treatments from China	Reflecting on non-biomedical treatments from China.
27. Treatment for Old Ailment	Seeking treatment in Canada for an old health ailment.

28. H1N1	Experience and impression of the public health response to H1N1 in Canada.
29. Smoking	Personal experience and attitude towards smoking.
30. Improvements for Health Service Quality	Personal opinions of how Canadian health care can be improved.
31. Returning to China for Expedited Health Care	Describing instances of Chinese immigrants returning to China to pay for quicker treatment rather than waiting in Canada.
32. Immigration to Canada	Impression and personal experience of initially moving to Canada.
33. Reasons for Immigration	Reflecting on why one decided to immigrate to Canada.
34. Expectations of Life in Canada	Reflecting on the expectations one held of life in Canada before immigration.
35. Cultural Community	Perception of the community from one's home country/culture in Canada.
36. Canadian Multiculturalism and Society	Reflecting on the makeup of Canadian society and the interaction between different ethnic and cultural groups.
37. Comparing Multiculturalism in Canada and Iran	Comparing one's experience and impression of the relationship between different cultures in Canadian and Iranian society.
38. Family and Community	Reflecting on the role of family and community in one's life.

39. Friends	Perception of the friendships and relationships formed with non-family members in Canada.
40. Getting Settlement Help	Perception of the sources of help and resources personally available to help one's settlement in Canada.
41. Host Program	Perception as a participant in the Host program offered by YMCA Cross Cultural and Community Services.
42. Comparing Lifestyle in Canada and China	Observations of daily lifestyles in both Canadian and Chinese society.
43. Food and Diet	Perception and evaluation of satisfaction with personal diet and access to food.
44. Exercise	Discussing concerns about personal fitness and ability to exercise.
45. Relaxation	Discussing methods of relaxation and recreation employed in Canada.
46. Car Accident	Reflecting on the experience of being in a car accident in Canada.
47. Getting Help from Car Insurance	Experience of dealings with car insurance after an accident.
48. Cannot Work Due to Health	Experience of being unable to maintain employment because of health in Canada.

I then summarized each transcript, retaining their structure of codes, in my own words. I thereby created a second set of briefer transcripts with summarized accounts emphasizing the essential sentiments, feelings, and opinions of

participants. From these essentialized transcripts I analyzed the distribution and character of codes across the series of interviews. The codes, which were derived from participants' interviews, fell under the four following general themes: the definition of good health, language and employment, health and health care, and the immigration experience. I focused my analysis on these four thematic elements, in their turn, as they give insight to the larger topic of health and well-being in the context of Canadian immigration. I have structured the following discussion around these themes as they were developed through participants' own discourse. This approach emphasizes an analysis rooted in expressed meaning and the subjective experience of the individual. I give prominence to how participants characterize their Canadian experience and try to present, with as little researcher interference as possible, their precise conceptualizations. The entire project is, and specifically limited to, a clear portrayal of the social phenomena experienced within the set of Host program English Conversation Circles in which I participated.

Following the analysis of participant discourses, structured around the four aforementioned thematic categories, I drew insights from my discussions with senior settlement managers at the YMCA Cross Cultural and Community Services. To begin a presentation of this analysis, however, I have chosen to begin the discussion with the poignant experience of PKW2. I believe his narrative of interacting with the Canadian health care system must be presented on its own,

starkly distilling all the highlighted thematic elements, as a natural bridging point to my entire analysis.

The Experience of PKW2

PKW2 relates, in particular, a personal experience that illustrates the extent to which Canadian health care services can potentially fail an increasingly multicultural population. PKW2 came to Canada, on his own, from war ravaged Darfur in Sudan. His determination to support his family and earn a living in Canada allowed him to proudly hold two jobs and an eighty hour work week.

PKW2
Lines 2-11 "When I first came here I was thinking I'm going to have a good life when I come here. Yes to work, get a good job, support my family because my family from Darfur the region is now in a war. So I'm thinking I got to work hard to support my family. I have idea to bring my family here in the future…And then I start to work two jobs. Sometime I work eighty-three hours, sometime eighty hours."

At first his industry led to success and he accumulated savings while also sending remittances to his family. Unfortunately, he was then involved in a serious car accident.

PKW2
Lines 16-28 "I have been in an accident, car accident so when I come from work…that person just come right away and hit my car and spin more than five times…Yes rolling and went to the other side. I was completely conscious. I didn't see anything but after like fifteen minutes the police arrived. [Knocks on table] Knock on the door windows. When I open my eyes the police are here. I saw my car and say oh what happened, did the police bring me here!? And then my body was very very stiff. And then I realized it was an accident. And when I saw my body there is nothing broken, and no blood out I'm thinking I'm ok because no blood, nothing broken. I'm thinking I'm ok but police ask are you ok? I say yeah I'm ok. I wasn't ok, my body is not ok, but I felt nothing broken. Ok guy you go."

After initially leaving the accident, feeling he was relatively uninjured, PKW2 noticed he was feeling unwell. At this point PKW2 relates that he had

absolutely no idea what to do in this situation. When speaking with his car insurance company he repeatedly voiced a concern that he was not feeling well. He was under the impression, from when he bought car insurance, that their coverage included your personal well-being.

PKW2

Lines 43-46 "Then I sit home one day, the second day I call, the morning after I call my insurance company. They say ok we'll send for you a car. I say I'm not ok, my body is not ok. We send for you car. I'm saying I am sick! They hang up the phone."

Lines 50-65 "Again I call and they say ok we send for you cars. I'm sick! What do you mean you sick? Because I do not know where to go. I don't know how the situation works here. Nobody explain it to me before. Somebody explain to me ok you go to the hospital check yourself if there's something wrong they will tell you. But nobody say that to me. Insurance company after another day sent a rental car…Yes car company, rental company. And we rent for you car and you go to work. I say I'm not ok. They say take the car and go to work…Yes I don't know what I'm going to do! [laughs] I took the car and continue working. My body getting worse and worse."

Lines 90-97 "Yeah I don't know how to say I'm hurting. Yeah I'm saying my body is not good. That means I'm hurting but they don't want to hear that. Just they want to get the money and the person who you are just shut up. That's what I know now. But if I'm saying my body is not good. I'm paying as a rule everybody have insurance when you have a car. I have insurance and I'm driving. And you telling me before when something happens you're going to cover it right? And the same time I have one translator before in the insurance company when I was starting with them. And explain to me everything and then every month they taking the money from my account."

Fortunately, PKW2 is one of the lucky newcomers with a family doctor. Having been in perfect health before the accident he began visiting his doctor for the first time because of his increasingly poor health. Unfortunately, his inability to communicate his situation, and his doctor's inability to bridge communications, resulted in an ongoing misunderstanding. PKW2 never mentioned the accident, in

particular because he was not sure, having no obvious injury immediately after the accident, why he was beginning to feel increasingly fatigued and unwell. His doctor, moreover, through the course of multiple examinations and visits somehow never managed to learn PKW2's history.

PKW2
Lines 122-124 "In three years and five months I never visit her even once. After the accident happened I started visiting every week, every week, every week, every week."

Lines 128-141 "After the accident yes. And just telling me ok take advil and go. I take that pill and I'm working. Another day she just say ok maybe you are eating wrong food. I say what? What you talking about? Wrong food what you mean wrong food? My food only one I ate when I was growing up until today is the same. Food have no problem but my health is no good. There is something wrong in my body… And she said no maybe just take aspirin you can use this aspirin…From advil to aspirin. Week, months, after years."

As a result, PKW2's frustration grew as his doctor continuously sent him home with advice to take aspirin or advil for over a year. He felt powerless because he knew his health was deteriorating but that his doctor failed to listen. Eventually his health affected his ability to work and he could no longer maintain his formerly industrious schedule.

PKW2
Lines 149-153 "Yes and then completely stopped, I can't do my job. I'm thinking maybe at the job I was working there is a chemical, maybe that's affecting my life or what's going on? I'm very tired. I couldn't sleep my body all in pain and my family doctor telling me no you don't have to say your body is in pain, tell me where it is exactly. I don't know my body in pain I don't where it is exactly. I have pain all over."

PKW2 tried approaching specialists but was always told to see his family doctor. His frustration having culminated, PKW2 decided to confront his doctor

and demand the service he wanted. Finally, through this demand his doctor agreed to send him for an MRI.

PKW2
Lines 165-172 "And then my answer I said I don't know why am I here all the time? Coming and see you and you say to me take advil and go. Coming to see you and I'm saying I'm sick and you say where is your pain exactly…I'm visiting you every, every week, send me somewhere. And she said I don't know. So really I become really, really upset, very angry. Just I decide to fight because there is nothing to do. Nothing to do. I not get any help. What should I do? Family doctors keep people by the files and they don't allow you to go nowhere."

Lines 185-190 "Just I try to do something to be better. After that I can't do anything. When I decide to fight with her and she said you don't have to talk to me like that. I say I have to, I have a right to talk to you like this because you tell me you are doctor and I'm coming to you day by weeks by week by week. You do nothing for me, why you keep me until I die or what? So you, you should do something. Everywhere when I go for help they say do you have a family doctor? I say yes. Ok your family doctor should look after."

Lines 197-200 "I say today this is the last day. I'm not going nowhere until I find out something from you. She said what, what are you talking about? I say yes that what I said, you heard that I'm not going nowhere. And then she went to her secretary and they talked together and say ok we will send you to the MRI."

Finally, over a year after the actual accident, PKW2 was able to get a diagnosis from the Canadian health care system. Unfortunately he had been enduring the effects of fractured vertebrae with no more treatment than some aspirin and advil.

PKW2
Lines 204-207 "So why do I have to fight like this with my doctor? I am coming to you today and tomorrow, this means I have a problem. If you have no idea send me to someone who maybe has more ideas or they have the technology to check it out and can see what is the problem exactly before the person is finished. And then they told me you have damage. S1 L4 and 5."

Lines 211-215 "Have you been in a car accident? I say yes. When? [laughs] Just it come out in my mind I say yes it's now one year and two months ago. Uh oh doctor's surprised uh oh. What, what is doing your family doctor? I say I visit there many times but I couldn't know this is from the car accident. And nobody explained to me and she didn't send me nowhere, just keeping me there."

Lines 215-224 "And she explained you know you can't do anything because this is real damage, real damage. So we don't know we can send you somewhere else and they can look after physio or something. And then they send me to Hamilton to one doctor in Hamilton there. And one day he ask me when I have a cd from my results and when he looked at it he said ohh this is a very dangerous place…This is ninety-nine percent people getting paralyzed and dies. Maybe one or two of them is getting better."

Lines 225-230 "And when I come back to my family doctor when they send the results for us she said to me sorry…I said ohh this is too late. I lost my job. I lost my job."

Being alone, PKW2's economic independence was completely vested in his health and ability to work. As his condition worsened he eventually took all his vacation days and then had to leave. Despite this, having formed a good relationship with his employers, he has a job waiting for him should his health ever improve.

PKW2

Lines 276-278 "That time [initially from the accident] I didn't really feel hurt, just I feel tired, tired day by day. I don't know just I say I'm very much tired. People asked what happened? I don't know. After that just getting worse. And from that day until today I lost everything."

Lines 260-265 "My job is very cool and I like my job. More than three years and five months never late, never absent one day. And my boss, supervisors, everybody like me very much. And I do a very good job. They are really happy. So when I'm hurt I can't do my jobs. I took a short vacation and then the supervisor told me whenever you're able to come back your job is here. Three months, four months no problem, five months even no problem because you never had a day off."

Lines 270-272 "They called me and I said I'm still sick. They call me I'm still sick. So where did you get hurt? I say from the car accident. Oh we remember the one that happened before? I say yes from that accident but nobody explain to me what to do."

Being unemployed, PKW2 has lived off his savings and is ineligible for welfare until his account is depleted. The savings he put in to support and eventually sponsor his family are now being used up.

PKW2

Line 234-236 "Yes because of this. I went to unemployment and the unemployment told me you have damage we can't take you. Only just three weeks they give me the money and then they stop."

Line 241-252 "Ontario workers, uh it's called welfare…When they check it out they said oh you have a lot of money in your account…Yeah yes. I say this is my money. I was working all my time here in this country. And I was working all my time that's why I save it. I'm not stealing the money from nobody and this is the record. And they say no you go eat your money until it's finished. When you finish your money come back and we'll look something after."

Through these experiences PKW2 has developed a strongly negative view of Canadian health care. He has lost faith in doctors here and feels that they simply do not care about his situation as a person. Having a single system, he states, deemphasizes competition and, as a result, the quality of care he received as a patient. He especially laments the fact that he could have afforded treatment at the time of the accident, had he been diagnosed early, in a private system. Instead, as a patient in the Canadian health care system, he has both lost his savings and not recovered. He wonders at the perception that his doctor would not believe him, as if he was lying, when he continually claimed he was ill and needed help.

PKW2

Lines 455-462 "Ah for me what's damaging people more here are family doctors…I don't know how to explain in English. They need like private hospitals so if you have money just come and pay and they can give you the results right away and say ok problem is here and here. And we need this kind of knowledge so you can fix your problem."

Lines 489-502 "They don't care because money is coming. Like family doctors just they need the names of how many people I have. They come in and sit, they sit like this and say ok I have maybe three or four hundred people is enough, government give me money. That's it but if there's open place [private option] we can see are you a doctor or not? If you do something right then people will keep coming to you…Yes they pay you and people at least they have to get their health. But they don't care. This is the one thing because when I had my accident if somebody told me this is your problem, if you have money you can fix it. Right away I had money and could have fixed it… My money yes my money is now finished and my house is finished. I don't know what to do."

PKW2 is also experiencing difficulties with the medication he has been prescribed. He compares the effects of his treatment, and his by extension his experience of Canada, with the lifestyle he remembers from Sudan. In so doing, he characterizes his Canadian experience negatively and believes that life was, in fact, better in Sudan.

PKW2

Lines 378-392 "Nobody helped me, sometimes I couldn't do anything. Just stay like this five minutes and eat sometimes because my health isn't good I don't feel like eating. And I can't clean my place for like five days, don't do anything. Just I keep taking more medication. When I take more medication, medication also is one disease. Medication just killing your body and you get numb all over your body and you don't feel very much… Yes when you, when you take the medication you feel lazy or dizziness or some kind of stuff. So that is not normal."

Lines 396-404 "Yeah but natural medication like in Africa they bring from the trees…They boil it and they give you to drink…Yes nothing but pure. Medication use chemical."

Lines 624-625 "I have planned to get married before the accident but the accident happened and now everything has stopped."

Lines 700-701 "Ah it's very interesting when I look back from Canada to here when I compare life is much better there."

PKW2's experience highlights the fundamental obstacles facing multicultural health care. The first question I raise is one of responsibility. In Canada, to whom is the responsibility placed to ensure newcomers' understanding of health care systems and access? The experience of PKW2 would seem to suggest that it is, for all practical purposes, up to the individual newcomer. PKW2 clearly had no idea, despite living in Canada for over a year, where to seek help after his accident. The fact that he was demanding medical assistance from his car insurance company demonstrates the extent of his confusion. At no point did he relate an instance where a systematic initiative, put in place by the formal health care system, served to bridge his understanding. In fact, as I will later discuss, most health care information gleaned by newcomers is from informal social networks and grass root volunteers. This non-uniform and highly variable reality leaves gaping holes for individuals, such as PKW2, to fall through.

The second broad theme that PKW2's account brings up is the potentially deleterious consequences of mutual cultural misunderstandings. This refers directly to the respective assumed roles the Canadian health care practitioner and immigrant patient place on each other when interacting. The Canadian health care provider, at least in the case of PKW2, treats the newcomer as they would a native English speaker with no added provision. If the newcomer is unable to

communicate their experience effectively, again as I will later discuss, there is no formally conceived provision to assist them. Simultaneously, the immigrant patient expects their physician to provide an empathetic approach to treat their health concern. The inability to effectively communicate leads both parties to misinterpret the other. In PKW2's case, his doctor finds him an unhelpful, and at times rude, patient that needs to be repeatedly sent home with nothing more than over-the-counter analgesics. PKW2, however, interprets his doctor's actions as callous indifference in the face of his desperate frustration. He now views his doctor as only economically interested and having no empathy towards his personal well-being. This mutual misunderstanding was allowed to continue for over a year to the severe detriment of PKW2. Again, to whom is responsibility attributed to bridge this communication gap: the health care system, the newcomer patient, or some third party mechanism?

Finally, the experience of PKW2 gives insight to the social structure of Canadian health care. How is power and agency attributed to various actors in Canadian health care? PKW2's account is one of personal frustration and a desperate search for solutions by his own initiative. He tried contacting specialists but literally felt trapped by his family doctor. It was only through his own insistence, by confronting his doctor, that he found any results. Despite navigating a foreign language and system, PKW2 had to desperately fight to be effectively diagnosed and treated. His only form of agency is described as personally confronting the doctor who has much more 'capital' in the 'field' of Canadian

health care. PKW2 expressed that not having his doctor’s economic interests aligned with his satisfaction as a patient, as he was accustomed to with Sudanese private doctors, afforded his family physician much more power than him. His experience provides a stark example of how the Canadian health care system can construct a newcomer patient and their subsequent reaction, as per their restricted agency, to this social structuration.

Defining Good Health

When asked to define the nature of 'good health' participants answered in three broad ways. Good health was framed as a combination of access to health care services, physical health with the absence of illness, and emotional/mental well-being.

Access was typified through concerns about wait times and the ability to see a family doctor. Having these services available when needed was seen as a requirement for one to be healthy.

PKW2
Lines 92-94 "Good health, I think good health could be getting the health you need on time all the time. Because it's, it's something that it's really important for everyone. Doesn't matter if you're an immigrant or Canadian you know?"

Physical health was termed most often by the absence of disease and illness. Having the energy to physically pursue one's goals and be free of long term physical ailments was characterized as important.

PKW4
Lines 294-296 "What is good health? It contains two like physical and mental. Like so physical health you know is very hard to say you know, physical health is like you don't have long term disease. It can bother you right. And so you can enjoy your life."

PKW6
Line 30 "feel full of energy every day. That's healthy."

Finally, emotional and mental well-being was often cited as an important factor in attaining and maintaining good health. These statements often touched on issues surrounding acculturative stress and identity. The need to relax was

cited in the face of anxiety and constant worry that could be, otherwise, overwhelming when adapting to a new environment. Also being able to achieve personal employment and educational goals was a significant concern associated with mental well-being. Ideals of identity and personal expectations were compared to daily life in Canada in order to point out the significance of psychological well-being.

PKW3
Lines 16-21 "And the other things that I think is related to have health, to have a healthy body, is to have fun. It does not matter even if it's the worst condition that you can imagine, you cannot imagine worse than that. I think people should have fun somehow because one of the things that makes you feel sick first of all are the things that you have inside. Inside your mind that you are thinking about them. The problems, the future, the stress, and all of those things."

PKW4
Lines 298-315 "Right so for the mental part I think it's less a concern for the people but maybe they do not pay attention to it. That's much more dangerous. It can affect physical health also right. But people didn't realize that normally. So mental problem I think is more, more need for concern right…Some of the people like they were engineers but they come here and because of language problems or something like that you know similar problem. And then they have to support family they have to go do newspaper job and for a long time. They don't feel good, they don't feel good you know. So it's better to give something to do right, give something to do."

PKW5
Lines 161-164 "That's maybe because I heard someone during their first few years in Canada they cannot get used to this society, to this culture, to this weather. They feel very upset and think always thinking about their home or their culture. They miss their family members so maybe they are not, they are not in a good emotion."

Interestingly, the range of responses incorporated more ideals of good health than would be expected from a standard Cartesian perception of Canadian biomedicine. The absence of disease and the mechanical function of the body was

described as required but not sufficient for a full assessment of good health. The definitions of good health enveloped the social determinants of health rather than being limited to an exclusively biomechanical view. Social determinants were not abstractly described but, rather, pointedly explicit and forefront conceptualizations in participants' discourse.

<u>**Language and Employment**</u>

<u>Language</u>

Language was, unsurprisingly since the entry point for my research was an English conversation group, a recurrently important topic for participants. The sudden frustration at being 'less than able' to communicate in mundane daily tasks carries a heavy psychological toll on adults. Participants passionately emphasized that difficulty with new languages is universal and that immigrants should not be considered, as a result, intrinsically deficient.

PKW2
Lines 102-115 "also if you don't speak English it doesn't matter, everybody has their own language. We not come here only speak English or French, they can speak Spanish or in my language Arabic or any other languages. But if you personally speak English when you go to other countries sometimes you can have difficulties…Yeah you don't know the language and the communication is getting harder. So nobody can understand what you say if you speak English and I'm speaking Arabic it's very hard to get to know what the problem is."

Perceiving oneself as deficient, however, in the simplest of social interactions has a powerful effect. It shocks one's identity and feeling of personal confidence.

PKW3
Lines 149-159 "once I went to Tim Hortons and I stood in the line. And I was thinking how to say that I want a cup of coffee. And in the middle of the line I just thought that I cannot do that. I just turned around and came out of the Tim Hortons and I went home. You know it's, it's really awful when you cannot even, when you cannot say that you just need a cup of coffee! You have money and the coffee is over there and you just need to say that I need a double double. You know it's really funny...And these small things when it happens to you, when you collect them together you feel like you're nothing."

There is also some diversity within discourses about interacting with an English speaking population. On one hand, the need to willingly engage others to practice and improve conversational English is highlighted as important.

PKW4
Lines 233-235 "Or they try to go out to be with people and then to increase their English level and then they will feel more confident to find a job."

On the other hand, feelings of embarrassment are shown to cause a reticence from interacting with the rest of Canadian society.

PKW6
Lines 553-555 "when I go to the street, go to the store, go to the restaurant there are a lot of native speakers who speak really really fast. So I can't say every word please talk slowly pardon, pardon, pardon so it's a problem."

Although participants vary in their experience and levels of English proficiency everyone expressed dissatisfaction with their current ability and a desire to improve. Language is seen as the foremost obstacle to accessing desired educational and employment opportunities. It is also the primary conduit through which immigrants engage the rest of society and, thereby, governs feelings of belonging, self-efficacy, and identity in Canada.

Language and Employment

Language was frequently mentioned in relation to employment. Participants often related it as the most important asset they needed to realize personal goals and ambitions in Canada.

PKW5
Lines 138-140 "I'm thinking about practising my, practising optometry. I have to have very good English communication skills. So [laughs] language first I think!"

It was even pointed out that one should take English classes before even trying to find employment in Canada. This places immigrants in a difficult position where they might sacrifice an improvement of their English skills for the immediate need to gain income.

PKW1
Lines 671-687 "I don't want to go back and search for work. Because I know how to do a lot of things but I don't want to do anything. So I think I don't want to go back to work unless I have at least, at least finished one English course…I'm trying to man. I'm trying to and I've never been in school before…Well I went but I went for maybe a week and then I quit because I knew that I need to work. So I said I need to work and I quit school."

The conflict between the need to find employment and English skills was met with remarkable resilience and determination. There was a pointed feeling that one had to prove themselves capable, as compared to native Canadians, since employers would assume them to be incompetent because of language.

PKW2
Lines 560-576 "When I come here I didn't have English. But I got a job because all the time I go to the agents. I go there and when they asked me what can I do for you I said I need a job. They said you don't speak good English. I say no but I know how to do the jobs. And then every day I returned and another day one agent says ok we have one job for you…I say ok, when they take me there I say I don't speak English well, I don't understand but show me. I say show me first and then they show me this way [gesturing with hands] you put this way and this way. You put this way and this way. Alright and then I started doing…They say you are a very good worker. And then again they get me another job. And then from that job I make another job, I've been working two jobs. I don't have English."

Lines 580-588 "My mind is ok inside, is working. I learned how to do my job from watching. So people say you know what I have a high school certificate. Some of

them say yeah I have college degrees. For me I say no I have zero. This is my first life here. Because I do have education but my background is Arabic, it doesn't help me here but I know how to do. All the time those people make mistakes but for my side nothing. Supervisor is surprised and says to others you speak English, you are Canadian you do mistakes all the time, man this is not good. Says see PKW2 look at PKW2 he never makes even one mistake. How long has he been working here? He says oh man don't talk about PKW2 even he doesn't know how to speak English! [laughing]"

Language, despite being an obstacle, was used as motivation to prove oneself as a valuable employee in the Canadian workforce. In this regard, participants treated language as a double edged sword. On one hand, it provided a driving determination to establish oneself in Canadian society. On the other, however, it could also be viewed as the source of deep anxiety and apprehension about the future in Canada.

<u>Language and Health</u>

Anxiety caused by living in a society where you do not speak the language was related as a significant factor determining self-health. This was experienced in terms of both emotional and physical health. The extra burden of the emotional stress experienced was expected to have physical consequences.

PKW3

Lines 88-99 "Language is one of the important things that can depress someone, that can make someone depressed and can hurt him very badly. It happened to me when I came here in first two months, I was thinking like those two months were like a nightmare for me…But when you come here as an immigrant you don't know anybody. You don't know what to do, you don't know who you should go and talk to. Whom should you go and hang around with? These are all the things that are important. And so I think these things all together are enough to make you nervous, stressful, worried"

Lines 104-130 "When I have something in my mind that bothers me and I cannot solve that problem it makes my body weak…it makes my immune system too

weak…You know the body is like this. When you spend your energy in something that happens to you suddenly it has a very powerful effect on you. So you want to fight with it you want to just keep going. But when you when you lose your energy it can destroy you."

The stress can become so encompassing that the only path back to good health is considered to be learning English as quickly as possible.

PKW6
Lines 151-156 "I think it's very complicated because my English is not enough so I need to go to English school every day. Because if you don't know English in Canada you feel much more stress in everything. So you can't stop learning English in Canada, you must learn it. So I can't stop. The only thing I can try to make myself more healthy I think is to learn everything very fast. To learn English very well and then maybe find a good job, maybe I can relax."

Lines 174-176 "Yeah [laughs] so much stress. Because you can't understand everything people say to you. It's a bad feeling. I know I'm unhealthy but I can't stop or life will continue on the same, the same thing."

With learning English as quickly as possible becoming such a priority, and perceived avenue to better health, frustration with slow progress reinforces the anxiety already experienced. All participants expressed dissatisfaction with their standard of English and cited it as a foremost priority in their lives.

<u>*Employment*</u>

For recent immigrants, especially in the age range of the sample, employment was an important and pressing topic. It was the immediate concern for most upon arrival and provoked significant stress. Often one found themselves immediately searching for work without being aware of any services available to them as an immigrant.

PKW1
Lines 653-661 "See when I first came here I didn't do anything other than trying to find a job. Live with nothing, basically nothing. And now that I'm here at the YMCA I enjoy its benefits, enjoy to get them right. I feel like I just arrived to Canada…Yeah yeah because I was living in a completely different world. Yeah that because I had a very bad feeling about living in Canada. I thought it was a suck country to live in because it was hard to find a job."

This initially harrowing experience provided an advisory perspective in retrospect. The benefits of taking the time to get Canadian qualifications and language courses was extolled as invaluable.

PKW4
Lines 124-130 "Actually, in my experience I think the immigrant needs to take a couple years to adapt to live life. To make yourself rest and comfortable. Don't rush to go do a labour job. Right because if you do a labour job for long time. I don't mean I look down at labour jobs. I don't, I just mean that if you have like a master's degree and if you're doing this job it kind of feels uncomfortable. Right because you think I can do more than that right. People would think this way and then they feel frustrated this way. And then the stress is one of the parts to get immigrants the worse health."

Lines 189-190 "You know it's better to go back to school and then review and then see if there's another chance you may go back to school. And then you have time to think, you feel you can relax."

Lines 425-431 "And then you have to follow the Canadian way. Step by step no rush. Just like learning English you cannot rush, step by step. Relax yourself, relax your heart. And people maybe they just think the other way. They rush thinking I have to do better than others just like in China. You know in Asia oh I was the best I come here I have to be best of the best. And then if they cannot find a chance or they find language problems they have a big trouble finding a job. And then they will, they will get lost you know."

Participants saw themselves at a particular disadvantage, compared to native born Canadians, in the job market and needed to make up this difference with education. Employers were expected to distrust immigrants' qualifications

and require Canadian retraining. Trying to find employment without this experience was often characterized as an exercise in frustration and stress.

Accreditation

For one participant, in particular, accreditation was a major concern. PKW5 was a practicing optometrist in China and is trying to resume her career in Kitchener-Waterloo. She researched the process, before coming to Canada, through internet forums and official government websites. Knowing in advance that it would be difficult she expressed dismay that the government advertises the need for skilled immigrants who are then not recognized once they arrive. The government information she accessed advertised bridging programs but didn't provide any other details. She initiated correspondence with the particular university but, unfortunately from a service point of view, found the most helpful information from a friend whose husband had participated in the program. Informal networks of personal contacts and internet forums provided PKW5 with more information than official sources. She also felt more comfortable learning about the accreditation bridging program from Chinese sources because of self-doubt over her English ability.

PKW5

Lines 70-81 "And when I, when I noticed that I cannot continue my job immediately after immigrating here I felt upset. And you know for the immigration and the Canadian government have some requirements for the technical immigration. Because they say they have thirty-eight jobs which is most needed in Canada now and it includes the doctor field. But after these doctors immigrate to Canada they cannot do their job because they are not re- how to say...recognized by here. So it's weird you need, you need them and enroll them to your country

and then you do not, you do not accept their knowledge. And they have to spend a long time to restart their job so."

Lines 113-114 "Yes the governmental or the immigration organization they don't tell you this. They don't tell you we need you but we won't accept you."

Lines 130-134 "when I came here and I met a classmate whose husband is studying in that program I got more information about that. That helped me a lot so I think it would be better to have someone who is very familiar with this and they help you. Because you know some, sometime you are just afraid to talk to the school or talk to those people because your language not good enough. You are afraid to talk to them sometime."

These discussions, centred about language and employment, give insight to newcomers' perceptions of identity in Canada. First person accounts relate how the individual constructs themselves and, implicitly, the 'structuring structures' in which they now live. There is a comparative view between the fully functional former self and, now, the immigrant struggling to learn English. As adults, our perceptions are strongly contingent on self-efficacy and a sudden inability to communicate, especially in the 'public space', forces a jarring reevaluation of identity. Until this gap is bridged, so as to be fully engaged as an independent adult in larger Canadian society, participants continuously categorized themselves to the transitional social space of the 'newcomer'. This liminal self-perception within society does not allow the individual to consider themselves to have fully 'socially arrived' in Canada until they have improved their language abilities. The longer newcomers attribute themselves to this psychologically turbulent space of uncertain identity, I suspect, the more likely they are to experience diminished self-health in Canada. I find it difficult, however, to delineate to what extent this

transitional subjectivity is structured and reinforced by Canadian social environments.

To answer this question, within the framework of this study, I have found some insight in participants' discourse of employment. In this field, moreover, the cultural and social capital contingent with language is described as especially important. Language is continuously described as an obstacle to overcome, or valuable skill to possess, in order to achieve employment aspirations. Newcomers emphasize the need to prove themselves as worthy despite their English proficiency, relative to their native speaking peers, to potential employers. Failure to span this divide forces the individual to remain psychologically in the liminal space of the newcomer as opposed to being a full member of larger Canadian society. PKW1, for example, describes himself as only now, two years since his immigration, feeling like he has arrived in Canada. The extent to which this is structurally reinforced can be further exemplified by experiences of pursuing Canadian accreditation. PKW5, for example, was surprised that Canada tells skilled workers they are needed only to subsequently not recognize their credentials, or have available job opportunities, once they have arrived. The individual is forced to remain in a liminal space of transition because of accreditation rules, the 'objective structures' of Canadian society, governing the relevant fields of employment.

Health and Health Care

Comparing Health Before and After Immigration

When participants contrasted their impressions of health in Canada with their home country the responses varied depending on personal conceptions of health. PKW2, for example, attributed a lot to family structures and their influences on health determining behaviours. This helped him explain his perception of higher disease and addiction levels observed in Canada.

PKW2
Lines 338-346 "Oh I have no problem before because everything there is natural. Yes even I never heard of some disease names here in this country. And we eat foods everybody knows. If something damages your future everybody knows so you're not allowed to try, if you try that's your choice. Now until today many people think that Canada is the best country…personally I say no. For me is the worst. I can say in front of anybody for me is the worst."

Lines 700-703 "Ah it's very interesting when I look back from Canada to here when I compare life is much better there. If you ask one person working they feed like fifteen or ten, one person work they feed all together. They eat there's no problem. And they have most of them they have houses to live."

Lines 749-752 "Ahh for me personally the parents is the first place, first place. My child I'm responsible. If I smoke I don't smoke in front of my child. I go away and I smoke. I come to sit with them normally. And when my children come from school we need to sit in one table to sit and eat together. And I can tell them to eat the food together."

Lines 773-777 "Yes yes if they try to eat something wrong tell them please I don't mean you don't eat but I cannot let you eat something that is hurting you. I'm not letting you eat in front of me. Please please my child listen to me...When they become fifteen or thirteen they listen to you more and you become very close friends. This is all about knowing Africa but here is different. Here is different."

PKW2 emphasized social determinants as an important cause for differences in health observed between Sudan and Canada. The cultural norms

surrounding family structure and roles were directly linked to health outcomes. Social pressures and responsibilities in Sudan are attributed to better health behaviours and why PKW2 believes Canadian health suffers in comparison.

Other participants compared health in Canada and their home country in the physical terms of bodily illness. Participants from China especially noted pollution as a significant difference affecting their personal health. Public health policies such as smoking bans were also cited as positive influences in Canada.

PKW1
Lines 151-153 "I just feel now, I feel more confident about my health. I think I don't have any concerns because at least I went to my doctor for a physical. And he said it was ok, it was just my press- pressure?"

PKW4
Lines 9-16 "Actually I feel a little better than before…before that means I was in China because you know the air quality is not very good. And you have a lot of pressure, a lot of work to do. And actually physically I think I get healthy, healthier here. You know because I always try to be happy you know. But I don't think most people you know they feel the same thing as me."

PKW6
Line 12 "Right now here in Canada is very difficult to catch a cold because the air is very clear."

Lines 67-69 "Here a lot of people smoking but I never smoke. I don't know the feeling of the smokers. I think here is more healthy than my country because here when you smoke you can't smoke in a public space."

There was no consensus as to whether Canada was generally a healthier environment or not than one's home country. Generally, though, participants' perceptions on the nature of health greatly influenced their comparative discourse.

Comparing Health Care Before and After Immigration

Participants often compared health care services in Canada and their home countries. An important facet of this discourse was the perception of power relations between patients and health care providers. The public Canadian health care system was often portrayed as disempowering for patients as compared to private systems experienced in home countries. In private systems the patient was thought to have more agency to make demands on the quality of service they receive. This is corroborated by PKW3 as a patient and PKW5 as a health care provider.

PKW3

Lines 537-542 "In Iran I knew when I'm sick and if I have money I can go to doctor and he can treat me and he can spend his time with me. Like trying to make me better. And he couldn't do anything, like he couldn't do anything. Even if he knew that I was Afghani it does not matter because I paid for visiting him, I paid for the visit. And because I used to pay for that visit I could punch that doctor in face, yeah if I saw anything would happen to me I could punch him."

PKW5

Lines 632-634 "But here if it is an urgent situation you still have to wait if it's not emergency. But in China if you wait more than two hours you can complain. You can ask complain to the hospital some supervisor, and then the doctor and the hospital will be charged."

Lines 662-671 "I think the Canadian doctor are more powerful. Only compared to my experience because…Yeah because I met some patients and their relatives. They, they stand above you know? Even they are patient they don't actually, they don't understand their disease very well. They only got some information, not the complete from some books or internet. But they think they know everything and then they just want to test you if you are correct or not [laughs]! So yeah doctor in China will be more difficult than here."

The discussion frequently compared private and public systems that participants are bridging through immigration. Although the concept of universal coverage was viewed as a positive it was also seen as responsible for long wait times and doctor shortages. The concept of family doctors was particularly criticized by Chinese participants who lauded the system of directly visiting specialists in China.

PKW4
Lines 571-617 "Because there's no family doctor system in China. No such system. And then so people if they have a small disease they just go to drug store and buy what they need…We don't want to go see family doctor. Actually if you can solve this problem by ourselves so we never go see the family doctor. But when we need to see the family doctor normally we just go to emergency right. But what we complain about the emergency, the emergency system, the emergency system is [sighs] like kind of slow."

PKW5
Lines 10-17 "I think the health care system for all people, the free system it's good at this point. Because everyone have the equal rights to be cured, be treated. Yes and then no matter who you are, rich or poor you have the health right. But it is also because of this public free health care, so they bring some problems to this because too many people want to go to the hospital, see the doctor and they don't have enough doctors or nurses for them. So usually people have to wait a long time and sometime if I want to see a specialist I cannot go directly to him. I have to wait for my family doctor to refer me so it's not very convenient at this point."

Lines 629-632 "Yes because compared to China if I have some emergency or I want to see a doctor I can go directly to the hospital without any appointment. And you will be treated maybe if it's emerge-, very urgent you will be treated immediately not just let you stay there waiting for such a long hour."

PKW6, in summarizing this comparison, makes the astute conclusion that Canadian health care is better for serious illnesses whereas Chinese health care is more efficient in less urgent situations.

PKW6

Lines 449-462 "Here in Canada if you are sick, like somebody's get a terrible hurt like cancer you don't need to pay the fee. But in China you must pay the money. If we have the very horrible sick you must pay the money. And then they will fix the problem very fast. But in Canada I've never been there and I don't know in Canada…If I have the small problem I think China is better than here. But if somebody has the big problem I think Canada is better because you don't need to pay the money. Maybe in China you, you are very poor but you have cancer and you don't have money maybe you can't fix your problem."

<u>Health in Canada</u>

When discussing their immediate health in Canada participants gave a variety of responses. Even if dissatisfaction with health care services was reported there was often a confidence in one's personal health at the moment.

PKW3

Lines 5-7 "I'm in a, I'm in an acceptable condition. I don't have any serious problem thanks God because of that! [laughs] And so I'm good, I can work, I can do my job, I can go to school so that's enough. Yeah I have that much that I need."

PKW5

Lines 805-807 "Up till now I feel very good [laughs]! Because although I don't have any family doctor I think I have some protection like the health care centre and the free health care."

This satisfaction was not uniform and a sense of poor health was also related. PKW6 attributes a continuing lack of energy, beginning in China but that continues today, to stress and time constraints on exercise.

PKW6

Lines 34-35 "No. I don't know, it's me, it's not from Canada I don't think. I need more exercise so I feel like I'm sleepy every day."

Lines 127-137 "When I move to Canada everything is busy. Have a lot of things to do…Yeah I think I'm unhealthy right now."

During interviews I found that inquiring directly about one's present health would yield these types of abrupt responses. Although they provide some preliminary insight they do not entail a great deal of contextual detail. To enhance this perspective they can be considered alongside complementing background discussions of personal health in participants' home countries before immigration.

The reported state of health in Canada was influenced by interesting personal interactions in participants' lives. PKW3, for example, cited isolation and smaller social networks, as compared to his life in Iran, as a significant effect on his well-being. Social interactions, however, were also noted as the major reinforcement for smoking cigarettes. As a result, he has reduced the amount of cigarettes he smokes per day in Canada. This complicates, therefore, unequivocal claims as to whether his health is being improved or diminished in Canada.

PKW3

Lines 368-386 "I know because those days I didn't care. I was with my friends but sometimes right now when I smoke alone I think that it's just wasting time…Usually all of my friends were smoker. And a few times I decided to quit but because of having smoker friends I couldn't do that. Because sometimes once I even tried and I quit for six months, for six months I didn't smoke any. Even when I was with my smoker friends I didn't smoke but after awhile, after six months I don't know it happens or something. Saw one of my friends gave me a good cigarette and I smoked that and I go smoke the second one and it just started again. But right now I mean right now I smoke like six or seven, seven in a day. But I'm still thinking that's too much. Like not because of the money but because of the, because I feel I don't enjoy that."

Food and Diet

The availability and quality of food was a repeated concern in discussions of health and well-being. Trying to match quality and affordability as efficiently as possible is an immediate question for newcomers.

PKW1

Lines 134-144 "I was just touring, I was just comparing last time I went to the Sobey's and Price Choppers that's two different stores but man I can see the difference. For like maybe two pounds of apples oh man they were like almost four dollars. If you go to Price Choppers it is like maybe a dollar something or two, no more than that. And I think that really affects people who have large families you know?...You can't buy because it's expensive you have to eat whatever is in your hands, that you can afford."

There is a concerted effort to eat a healthy diet that is not restricted by food preferences but, rather, affordability. Another concern about food quality, and its effect on health, is strongly voiced by PKW2. He laments the use of preservatives and frozen food in Canada when compared to his former diet in Sudan. He attributes the freshness of food in Sudan to better health outcomes than those he has observed in Canada.

PKW2

Lines 636-648 "Yes most of the food with the chemicals. So chemical is not good for health. And when I said the pollution or what do you call?...Yes because here many factories and many cars all the time smog. Smog is from the ground is go to the sky and come back again. We breathe this, our body gets burned. And we get most sickness. But in Africa even food is natural. Is organic food. Even sometimes all of the fruits without chemical. Without chemical. So when you eat nothing. Just you feel good and very very healthy. People like seventy, my father now he's eighty years old but he's still working very hard. If you, if you look at him you never believe. Even my mother. Most of the generations if you seeing you c-, you wouldn't believe. But here somebody say I just forty five years old like this."

Lines 687-700 "So that's one we have in Africa, food like meat here it has like three days or five months or six months they call frozen. Always the bacteria in…It's fresh [in Sudan] there's no bacteria in. Just they kill the animals right away, they make barbeque and eat…And fresh what did you call um vegetables and like tomatoes and everything is fresh. You eat fresh. And still your body is not big, you not fat. But you feel strong, you feel very very strong. And you can run and whatever, do anything."

PKW6 also finds the dietary transition to Canada a difficult one to bridge. Firstly, she finds cooking herself difficult, both in terms of time and ability, as opposed to affordable take out foods she ate in China. She also finds the Chinese food in Canada to have been adapted to Western tastes but, additionally, acknowledges that many specific ingredients are available here.

PKW6
Lines 370-381 "I think it's more healthy than China, like the vegetable and the meat. But the thing is I don't, sometimes I'm not good at cooking. I can only cook the easy food, the simple food. Like in China you can go to the restaurant everyday because the food is more suitable for you. But here no. They all change it to sweet sweet flavour…But here I don't like the sweet I like the salty. Traditional Chinese food."

Lines 403-413 "Yeah I can find the things. This is good I can find everything I want. And there are a lot of Chinese restaur- Chinese supermarket like in Toronto. I and my husband will go to Toronto…Twice a week or once a week. They all Chinese foods."

Exercise

PKW6 relates, in particular, that a lack of exercise has left her feeling tired and unwell. She expresses a desire to recapture an active lifestyle while acknowledging that newcomers often do not adequately exercise because of time and economic constraints.

PKW6
Lines 79-85 "Oh when I was young. I can't say when I was in China. When I was young I was full of energy, never feel sleepy but this two years I think every day I feel sleepy…Yeah it already started because I didn't take a lot of exercise."

Lines 112-113 "Yeah here I have to study English every day. I don't have enough time to go to gym. Only one day a week."

Lines 653-655 "Yeah they don't, if they have money they don't want to spend it for the exercise. They are lazy, a lot of people are lazy I think like me [laughs]. I want to do but I don't have a lot of time."

<u>Health Before Immigration</u>

Descriptions about health before moving to Canada were varied amongst participants. Again, social determinants were cited as an important influence over health. Being busy, working, and doing the things one enjoys, in contrast to the disempowered boredom experienced in Canada, were described as causes for good health.

PKW3
Lines 317-328 "before coming to Canada I was absolutely in a good condition. Once the first thing, the first reason was because of my job. My job was kind of like I was, I was journalist I had to write, I had to talk, I had to fight, and I had to move, and I had to travel. You know and it's important especially traveling around not staying, not staying in a place…And so because of my job I had many things to do. I have no time to be worried about anything. I have time to hang around with my friends. I have time to, I had time to have fun. And I was doing my job and I was making money too. And my job was kinda of like uh, I really liked that kind of job because I like reading books. And right now in Canada when I came here I couldn't read."

Immigration constitutes a shock to one's identity. The shift from being a functionally independent adult to an illiterate, in English, and unemployed newcomer is a powerful health determinant. PKW5, in contrast, felt her employment in China had a negative influence on her health. By rebuilding her

career in Canada PKW5 expresses the hope that the stress she experienced in China will not be reproduced.

PKW5
Lines 201-210 "I think I'm not in good health. They have a word to say this, sub sub-health?...Yeah that means you don't have any disease but maybe you are under some pressure. Under some stress. And maybe you work too long and don't sleep very well."

Lines 218-229 "Yes because in China everyone is very competitive. I think especially in my hometown I come from Shanghai. People struggle and you, you can see on the street everyone the speed is very very fast [laughs]! You cannot keep up with them maybe. So you also maybe worry about something and you want to stay in the same level with the people. And you have, like for me I'm a doctor I usually have one hundred patients a day. And I have to deal with every patient and so maybe I'm in the stress…Yes sometimes I have some physical, like my back have some problem, stomach have some problem. It's not a big problem but sometimes when I was very tired I can figure out my back hurts because I sit too long or something."

<u>*Communicating and Interacting with Physicians*</u>

I asked participants about their experience and impressions of patient-doctor relationships in Canada. PKW1, having first-hand experience in both the US and Canada, expressed dissatisfaction with a medical exam he received here. Although the doctor was not performing what he thought to be an adequate evaluation he felt, despite having many questions, it was not his place to discuss his concerns.

PKW1
Lines 350-359 "when I came here as soon as I got my doctor I asked him for a physical. But the physical I get with him was nothing compared to the one I had in the States. That one in the States made me feel more comfortable about my health you know?...But it's true that I don't think I'm that well. Like I feel great but I don't know if there's something wrong."

Lines 425-431 "I didn't want to say anything to him because I don't want to look like a fool in front of him. If I ask him why are you not doing the examination the way I know it's done? Like it's not that I know but that's the way the other doctor did it. So you're not doing the same, why are you only asking me questions and taking my blood pressure and that's all? You know what I mean because he was going to be like oh who's the professional here you or me? Some people are like that so I just feel afraid to get that answer from him and so I didn't ask him anything."

Lines 457-459 "They think that because some people, I'm not saying that my doctor's like that, but some people they think that only because you don't speak English very well that you're a fool, that you don't know shit you know?"

PKW1 pointedly relates his perception that, as both a patient and a newcomer, his role is not one to question the authority of a Canadian doctor. He has not received the medical assurance he seeks and, unknowingly to the doctor, continues to harbor concerns about his health. As a result, born simply from a lack of communication between doctor and patient, his self-health has declined in Canada.

Hesitancy over language ability was a recurrent subject when communicating with doctors. Even if participants expressed no shyness, or perceived subordination, as a patient they cited English medical terminology as an obstacle.

PKW4

Lines 476-492 "And I found when I got sick and went to see the doctor it's hard to describe my situation [laughs], it's very hard to use the word because I always use the dictionary to find some word and so try to explain clearly…People need training, maybe a few weeks of class and train them when you get disease and your family get disease how to express your situation. The symptom something like that right in professional words."

Lines 498-502 "Yeah because you know the official language is always English right. So you're supposed to speak English with doctor, you need to learn. You have to learn or else if you have a disease you won't know how to express yourself right. Because only you know your own situation right. No other can like replace, take over or something like that."

PKW5

Lines 376-380 "I think they will not feel shy for health care but they will feel it's hard to communicate with the doctors. Because they cannot explain their feeling, their symptoms very well. And maybe they will misunderstand what the doctor or the nurse said. So yeah I heard that a lot my class mates, Chinese class mates they said how they wish they will have a Chinese doctor here."

Participants' explanations suggest that hesitancy to interact with Canadian doctors is a reality for newcomers. Be it a cause of language, shyness, embarrassment, or a perceived lack of agency the lack of communication can have negative consequences on immigrant health in Canada. PKW6 relates a combination of these experiences in her perception.

PKW6

Lines 355-359 "And I have the pressure stress for the language. Maybe I can't speak English very well to say what problem I have. Maybe the doctor she or he didn't have the patience for me so I will feel bad, so I never go there. But I want to go to the hospital to check myself because I feel I am unhealthy right now."

Lines 593-599 "I don't think I can exactly say my problem. I don't know how to say a lot of words for the health. It's a big problem...And I'm afraid if I explain something wrong it's a big problem yeah. So I suggest maybe Canada can find more like Chinese doctor."

PKW3 goes further with a description of his experience with family doctors. He criticizes the relationship as dehumanizing and too impersonal. Rather than taking the time to understand and communicate the doctor is described as quick to prescribe medication and move on. The single payer Canadian system is again characterized as disempowering for patients as it removes direct financial

accountability. He also describes the frustration he feels towards the doctor for prescribing his mother medication, for back pain, that leaves her without any energy. This makes him feel that the doctor is only interested in quickly treating symptoms rather than really helping his patients get better.

PKW3

Lines 557-569 "But here we don't pay, like OHIP pays. And they pay them good. I mean it's not just a little money it's good, it's good money. At least it's thirty-five dollars per hour. Like as much as I know it's thirty-five dollars per hour. But when I go to him, I just went to him a few times…When I went to him a few times he was just like you know it's [laughs] I don't know just first time when I went there I think I got a cold or something. But I was sick. When I went to him he said ok go get tylenol and stay at home a few days and then go to school. When you get better go to school. I thought to myself so why did I come to him? And it was like I could do that too, I could do that myself, like I didn't need a doctor."

Lines 593-606 "You know your family doctor is someone who is responsible for you. Like a situation that my mom has right now. My mom has some problem. Like she has some pain in like she has pain in different parts of her body. Like back pain, like she has pain in her feet, in her legs and many different kind. But last time when my mom went to him he gave some tablets. And I don't know why because when my mom use that kind of tablets she cannot do anything, even she cannot talk, even she cannot talk to anybody. Like sometime when I ask her she cannot stand saying one word…Yeah it's because of the side effects of those medication or medicine or whatever. [laughs] And I'm just thinking that does he want my mom to get better? Or does he just want to make her calm?"

PKW3 compares the frustrated impressions of his current family doctor with those of his previous one. The contrast highlights his perspective of what the patient-doctor relationship should entail.

PKW3

Lines 583-586 "He sat down, he talked to me, he said what did you do? What did you eat? What did you drink? Where did you go? Anything else? Any kind of any, any kind of like any different kind of pains? Or anything if you would? Like he was trying to find he was trying to find out everything."

PKW3 makes it explicitly clear that simply showing that one cares about the patient's well-being is an important facet of treatment. The perception the patient develops of how they are being treated, namely if they feel they mean anything to the doctor, is crucially important to avoid the frustration with a seemingly impersonal Canadian health care system as PKW3 describes.

PKW3
Lines 625-631 "Like if I go ten minutes late, if I be there ten, five minutes late I will lose my appointment. But if I go there and wait for half an hour or forty-five minute it does not matter, it bothers nobody. No because you're ill, you're sick and who's doctor? A doctor is someone that he's doing his job, it does not matter if you stay or not. If you're alive or not. There will be someone else that he will make money out of them. You know it's talking to someone like this that just listen to you and doesn't do anything. What's the point of that? Like I don't know just open the window and try to talk to, I don't know try to talk to a tree!"

<u>Getting Health Service Information</u>

Participants listed a number of different personal, official, community, and media sources of information concerning health care access. Official government information sources, such as television segments or multi-lingual pamphlet publications, were described as appreciated and credible sources of information.

PKW1
Lines 542-546 "Yeah government stuff like and especially in the news right? They have all the sections right? Sport section, so I like to watch the health section, health section yeah. And they give you like pretty important steps, what's appropriate to do in cases of flu, how to live a healthy life. You know what kind of meals you should be eating."

PKW5
Lines 336-339 "Yes I think they have because I saw some brochures. They are not only in English but in several different languages including Chinese. I think the government or the organizations they are thinking about the language obstacle. So they try to help people in different languages."

PKW5 expresses her dismay, however, that despite these official efforts she did not get the information package for newcomers upon landing that she expected. Being computer literate she was able to find the relevant information about obtaining a health card on the internet as well as from personal networks she has developed at the YMCA.

PKW5
Lines 574-578 "And I heard when you first immigrate you will get a package of information for all the things like the insurance card or driver's license but I didn't get this package. I heard I was supposed to get this at the custom in the airport but I didn't get it. I think maybe you can get information from there and also I think people can be informed by YMCA. I think they did a very good job here."

Participants familiar with computers named the internet as the most frequented and important source of information. Online informal Chinese language forums are sources where newcomers can pose questions and benefit from the experience of others.

PKW4
Lines 513-521 "Actually maybe I look at the website you know. The main source for me is the website, always website. And then you might have question, I always use google…Google yeah, always google and then try to find the answer. You know that's my way. I don't know maybe some of the people who don't know how to use the internet maybe they just don't know how to do things here."

Lines 542-549 "I believe for the Chinese community most people they have a high education, they know how to use internet. They usually go to the forum and then pass on how to do things in Chinese. Yeah I can, I can see a lot assembled over there. Yeah they have forum over there and then they help people you know like I want to have a driver's license and how to do. They tell you how to do that because always some old immigrant has that experience. Like they can, they can write in Chinese and just tell people how to do. This is what I'm understanding in my situation."

PKW5
Lines 574-589 "I got almost all the information from the internet…like if parents they just come here for their children's education maybe the parents' English is not very good. And they don't know how to use the computer very well maybe they have some problems."

Community level settlement services, and especially the YMCA in the case of this sample, were also noted for providing health care information. ISAP counselors provide multi-lingual sources of information concerning all public services in Canada. Health care information sessions run by volunteers and YMCA staff are also organized to help notify newcomers of the resources available to them.

PKW4
Lines 527-529 "Maybe they just go to the YMCA seminar, like they have some institutions at the YMCA immigrant service. Like Chinese they have some Chinese community centre like the YMCA and they can go there and ask them to how to do things."

PKW5
Lines 326-330 "you have a lot of organizations like YMCA or some community health centre. And a lot of volunteers here to talk about health care. I think it's very good compared to China because in China we don't have such information, such health care centre like something like that. And what is better is most of this information, all this help is free for everyone. Yes that's what we don't have in China."

PKW6
Lines 499-503 "From the YMCA [laughs]. From YMCA I heard about that because when I came here as a newcomer the people gave me a lot of information and you could see how to find a family doctor. Like and a lot of people will go to my school to give out presentations. Give more information for us. I know the information but it doesn't [laughs] it doesn't work you know. I haven't found the family doctor yet."

PKW5 lauded the Canadian public health response to H1N1 and thought she was well informed by the information campaigns to receive her vaccination.

She cited newspaper, television, and online sources of information while noting Canada's ability to provide free vaccinations to the entire population.

PKW5

Lines 811-833 "Yeah H1N1 and I think uh it cannot happen in China for everyone to get the vaccine for free...Oh I think the information is given very sufficiently. And every day I heard the news not only in the television, also on the newspaper and even the school. Yes I think I got enough information…Yes I saw the newspaper they listed the place almost every day. And they also have, I know that there is a website they will give every information about the H1N1 on the website. And also I saw the news like CP24?...Yeah they have some information on the television every day."

Getting Timely Service

Many participants expressed a fear that they would have to wait very long times to receive health care when needed in Canada. These beliefs were based on anecdotal accounts of long wait times and patients being ignored. Participants expressed this is due to a significant shortage of doctors and nurses in the Canadian health care system.

PKW1

Lines 24-38 "So they said that there was a lady who had a really sick friend, like flu I think. She was vomiting and headache whatever. So she went to the emergency room. But I think this is related to the service too because she says that she saw a nurse walking around and she saw the lady dying and all she says was aw a drama queen!...That's one of the things that's happened. I see that very often everywhere I go like especially in the hospitals. It's not enough people working there they need more nurses more doctors."

PKW4

Lines 275-286 "I just heard a lot of complaints about the health system. Last time I read the news, you know it's on the Chinese website I [laughs] as the lady said waiting for long time. There's a guy and this lady and then die in the hospital because of lack of care. You know emergency and wait for a long time. And the lady got like sharp pain in the stomach so rare and then and the doctor didn't treat well…So yeah it's actually not the first time. It's not the first time so you

know. People complain about that you know some people even like just some old guy just give up on the service you know."

PKW5 further relates this sentiment with the added insight that this is not exclusively experienced by newcomers but, rather, the entire Canadian population. She notes that, because of this, newcomers are unlikely to complain when seeing the long wait times that extend to everyone.

PKW5
Lines 596-597 "I think if it is an emergency I will go to the hospital emergency room. But maybe spend five hours waiting there [laughs]!"

Lines 643-657 "I heard many times my friends said their child have very high fever, or hurt, or broke their legs or arms but they all have some trauma that they had to wait, nothing can do. And they see the nurse talking but they don't look to their diseases…I think it's for everybody because not only the newcomer they see other Canadians they are also waiting there. They don't see anyone else complaining so how can I complain [laughs]!"

<u>*Service Value and Insurance*</u>

PKW1 also had frustrations with health benefits he had to pay into at work. He felt the obligatory monthly payments, including for certain benefits he never used, were not worth the savings when making claims. Additionally, he felt that having to pay up front before being reimbursed prevented him from accessing the services. He suggests this money could be better used by the health care system to expand services that are currently only covered by employment benefits.

PKW1
Lines 55-61 "When I was working I was paying too much money. And like I said some people use that right but some people don't like me. I don't get sick

often…Maybe I don't know once a year. And I think we are paying too much money for that."

Lines 231-235 "But the thing is I know my insurance will pay for that money for my treatment but I didn't do it because first of all my insurance won't cover everything. They only will cover like eighty percent or something like that. And before that I have to pay from my pocket, I had to put the money down from my pocket and then after two weeks they gonna send that money back to me."

Lines 281-284 "So I think that's crazy. I think it would be a better idea if we pay the money to the government and the government put the money into the health system so we can get everything on the health card, you know what I mean? Like the dentist, medical and so that way we don't have to get ripped by those companies such as Co-operators life Sun Life."

Staying Healthy

PKW4 believes the attitude towards life newcomers hold when coming to Canada is central to maintaining good health. He states that it's important to balance employment with efforts to relax and taking the time to adapt. Often, he states, newcomers, especially those supporting a family, put themselves under constant stress and pressure. PKW4 believes his emphasis on attitude has allowed him to be an exception to the trend of newcomers having health and well-being difficulties.

PKW4

Lines 23-27 "You know get less pressure and you know when I have nothing to do I try to go outside and meet people. And you know try to do something to keep my health like happy and relaxed and get less pressure and something like that you know. Or some activity because I like to do some sports you know. Actually I feel a little bit better than before. Not like maybe, not like a statistic not getting worse [laughs]."

PKW4 advocates the importance, to newcomers, to make the effort to engage the community and become involved in activities. Learning about your

new environment is described as an active process than can greatly help newcomers' personal well-being.

PKW4
Lines 145-160 "The community service and activities are always available when you try to find out. Yeah I think in Canada I was satisfied with this part you know, the service when you're trying to find out, look around there's always something around you. But you have to be active…Yeah because whenever I go to a new place wherever if I have money I try to go out to find some activity. Try to find something new in this city. Try to understand more about the city. You know so in my situation you know I actually I feel comfortable in Canada. You know because we know how to, we know how to save the money. How to like put the money in the good use."

Finding a Family Doctor

For the most recently arrived participants, PKW5 and PKW6, the search for a family doctor continued to be a source of anxiety. Both have used services available at the YMCA to help newcomers find family doctors but, like many in Waterloo region, are frustrated by the widely experienced shortage. PKW5 had also registered on the Ontario government's waitlist registry and tried getting information about potential spaces from informal social networks.

PKW5
Lines 433-438 "So I'm thinking about finding a family doctor here and I try to some some ways like with the YMCA. They have a program to help you but they say there are no family doctors right now. And I also ask some of my class mates if their family doctors are enrolling new patients. And also I got a website on the Ontario government. I forgot the name but you can sign up and if they know some family doctor enrolling new patients they will inform you."

Lines 521-524 "Counselor yes. And when I met her she explained all their services including to find a doctor. But she said they don't have any information on that but she got my email address and my telephone and promised if she had some information she will inform me."

PKW6
Lines 472-475 "I don't know exactly but I think they should contact the newcomer like me. I came here already eight months but I and my husband are trying to find a family doctor. But we haven't found it because they are all full. We don't have chance to find a family doctor."

Both participants expressed the opinion that they might have a better chance finding a doctor, especially one who speaks Chinese languages, in Toronto than in their home region of Kitchener-Waterloo. PKW5's husband and in-laws travel to Toronto to see a Chinese speaking doctor.

PKW5
Lines 455-489 "I don't know, I don't know if I can see the same doctor as him because I don't ask. I don't want to go to Toronto. But my parents in-law every time they want to see a doctor they travel to Toronto…I don't know the situation in Toronto but I think it's also difficult. But maybe easier than here because Toronto has a large population. Maybe more doctors want to practise there."

PKW6
Lines 511-512 "Yeah but I know in Toronto in the big city they have the chance. Maybe very easy to find the family doctor. But here we have few doctors."

PKW5 goes on to surmise that, because of the extreme shortage and long search times, newcomers may just give up and use walk-in services whenever they need to access health care.

PKW5
Lines 551-552 "Yes I talked to with my class mates one is from Japan. She said she spent one year to find a doctor. And some people they just uh give up. They just walk in."

Traditional Treatments from Sudan and China

PKW2 laments that there are traditional African methods that could have helped him much better than his Canadian doctors. He describes traditional

African treatments as effective but, because Sudanese practitioners don't have an education, that the government doesn't give it a chance. He believes this opposition is because health care acts as a business that does not want the competition.

PKW2
Lines 845-871 "No I don't know here because the government doesn't give opportunity to other people. Some people they have no education but still they have very good ideas. People they have no education but they know how to fix some things much better than doctors…Yeah because it's a business. Yeah it's not allow you to practise without any education."

PKW6 also describes the availability of Chinese traditional practitioners in Canada. She describes them as a quicker option, compared to the health care system, for small problems. Some Chinese newcomers may prefer this option over long wait times in public services.

PKW6
Lines 704-708 "Uh like I twisted my ankle and my cousin at the same time twisted his ankle. So my cousin went to their Chinese hospital and the doctor gave him the stitching and gave him the medicine. But he twisted harder than me. I can walk by myself but he can't. He can't touch the floor so he must go see doctor. He didn't go to the Canada hospital he go to the Chinese people small hospital."

Treatment for Old Ailment

PKW1 had trouble reconciling the health care system covering his diagnosis but not the treatment for an old sports injury. He could not justify spending the sports medicine clinic treatment fees and, partly to avoid embarrassment, told them he could not take the time off work. He now continues to leave the injury untreated.

PKW1
Lines 166-179 "And um last time I tried to get treatment for my knees because I got a dislocated bone long time ago. And I trying to get something to cure it but I couldn't make it because my health card like OHIP covers everything except for the therapy…and I think that's not good, that's one of the parts that I don't like because what's the point if your health card will cover the MRI yeah?...And the x-ray and they get to see your doctor and everything except for the treatment. I think it's the more important part you know what I mean?"

Lines 184-202 "Because if you have the money the doctor can say oh this is wrong with you knee so this is what you need, go to this clinic and the sport medicine doctor will tell you what you need to do. And that will cost you this and that. If you don't have the money, that's what happened to me…My first visit to my therapy will be a hundred and fifty dollars. And in order to continue the treatment will be two hundred and fifty dollars so I said no way, not doing that."

Improvements for Health Service Quality

When providing advice on what improvements could be made to health care services, especially for newcomers, participants presented several items. An important concern was the feeling that newcomers are left on their own to figure out the health care system and how to access services. There is a feeling of being left adrift and ignored if you are not able to learn the role of a patient on your own.

PKW2
Lines 879-890 "I can say as like all immigrants when they come here like me many of them, too many of them involved in the same situation. They don't get enough help and they destroy their lives. So at least they have to have they say multiculture. They need if accidents and those kinds of situations happen somebody to send, they train the people here and they just send and train them to say ok you're in this situation you should do this and this and this until you get better. And they can get the same treatment like everybody else is getting. That's much easier but other than that immigrant people most of them they don't know where to go…Yeah they don't know the information and just keep sitting home and become worse and worse."

PKW5
Lines 763-769 "I think before they came to Canada when you give them the visa the government maybe if they can give them some information about this to learn and prepare. That will be better and after they arrive in Canada they can get some information maybe by the mail or at customs in the airport. They have some information about where you can get the service, the health care service and what if I cannot find a family doctor. Something like that maybe will be better. Not for the newcomer to find the results, find the answer by themselves."

The need to increase the number of doctors and access points for health care was also a prominent suggestion to reduce long wait times. Also, the limitation of what medications are covered is cited as a financial burden that can leave you in a helpless situation.

PKW6
Lines 622-633 "And then I think maybe open more hospital. Because if you want to go to the hospital there are a lot of people. No one wants to waste your time waiting whole day or whole afternoon…Maybe open some more access place."

PKW2
Lines 823-829 "Ah for me personally I see health care is good in one point but in other points it's not good. Because when they give you health card it's very limited. Very limit money. When you go sick, say I'm sick even the good medication they say ok your health card does not cover it. What should you do? They not giving you this. You not getting this money. That means the problem is not solved…What you do? So you stick with your disease until you die. How are you going to fix it? You have no money."

The frustration of not getting satisfactory service from the public system, and not having any other option to turn to, is difficult for newcomers familiar with privatized systems in their home countries.

PKW2
Lines 833-839 "Ah for me personally I can say they have to have some private. Yeah open some private clinics. Yeah if person have money they can go right there and they can fix their problem. Or you can go anytime there for MRI and

you pay your money and you get the result. And you know what to do after result. That one I think is much better. But here they say no there is no private clinics. All is public, one same thing and you just going and coming and get nothing. You get nothing. And then the problem is growing, growing, growing and after the person is finished."

<u>*Returning to China for Expedited Health Care*</u>

Some participants mentioned that some Chinese newcomers, faced with long Canadian wait times, may return to China and pay for quicker treatments. The expense is justified in the face of being frustrated by long waits or doctors saying their required treatments, such as those for non-life threatening cases, are not prioritized.

PKW4
Lines 284-287 "Some old guy just give up the service you know. They just prefer to spend money in China and then to get the service you know."

PKW6 additionally relates the personal experience of her aunt which leads her to suspect she would need to do the same if faced with a similar situation in Canada.

PKW6
Lines 717-723 "Oh one thing I want to talk with you is my aunt. My aunt had a hurt back and hurt neck because during the six years she opened a restaurant here. She's very hard working so she has a lot of very hard problem with her back and neck. But when she go to the hospital the doctor said it's not very serious so they didn't want to operate for my aunt. But my aunt was suffering a lot. She wanted to fix the problem immediately so she went back to China to pay a lot of money to fix the problem and then she came back to Canada."

Lines 747-749 "I hope I'm never sick. But but for me if I am really suffering I will go back to China immediately. I can't be patient for my pain. If I'm in so much pain I can't."

Perception is coloured by our personal emotional states. None of us can objectively assess our health in a vacuum of personal judgment and experiences. I believe this is why participants were better able to describe their self-health in terms of, for example, stress, work, identity, family, and attitude towards life in Canada rather than when directly asked to objectively report their health. I think this is the fundamental understanding we can take, at least from this project, towards explaining the existence of the Healthy Immigrant Effect. It has been an established statistical trend based primarily on self-report data. I believe the nature of self-reporting suggests the Healthy Immigrant Effect reflects a representation of Canadian multiculturalism and, in particular, the lived experience of immigration. It is not limited to an objective assessment, purely in public health's epidemiological terms, but rather describes a broader social phenomenon. It is encompassed by the personal construction an immigrant undergoes, in effect a dynamism of the habitus, as they exist in the previously described 'social space' of the newcomer transition. Uncertainty of one's identity is a fundamentally 'unhealthy' experience affecting the perception of self. Previously fundamental personal beliefs are forced to be seen as subject to reevaluation and deep certainties to be potentially illusory. Not being sure where you socially exist, as immigrants often do over the period in which the Healthy Immigrant Effect has been described, is the overarching social determinant at play. Offering a singular definition of health, through which we can theoretically assess and compare newcomers over time, will never be able to explain the

observance of the Healthy Immigrant Effect. It is, rather, a public health reality born from a larger social determinant: the personal challenge to one's identity that all immigrants inevitably face.

Participants did reveal certain extents to which Canadian health care reinforces constructions of the uncertain newcomer identity. Discourses of disempowerment, shyness, embarrassment, and a perceived lack of agency were repeated in reference to interactions with health care practitioners. Newcomers, at least in this study, felt they did not hold the social power, especially as non-native English speakers, to question or make empowered requests of their health care providers. This structured experience reinforces the liminal 'social space' newcomers find themselves in that I posit is the most significant determinant of the Healthy Immigrant Effect. The question, therefore, is how can health care experiences help break, rather than reinforce, this structuring process? Seeing the doctor in Canada cannot be an alienating and marginalizing process for newcomers.

A relevant example of where health care systems can help bridge this transition is in terms of information distribution. Participants expressed that the majority of their information regarding health care came from informal social networks, volunteers, and settlement agencies such as the YMCA. Rarely did anyone mention formal methods of multicultural bridging put in place by health care services. Participants unfamiliar with the internet, in particular, were at an added disadvantage since formally available information, at least that known to

participants in this study, seems to be predominantly through online media. As previously mentioned, this knowledge gap leaves large cracks for newcomers, as exemplified by PKW2, to fall through when in need. There seems to be a current emphasis on the individual to figure things out on their own. For all practical purposes this seems an inefficient, and unlikely to succeed, method to inform newcomers who are arriving from starkly contrasting cultural and medical traditions. The inevitable result is that many newcomers are unaware of the services available as well as how to effectively access them as social agents.

Immigration

Discourses on immigration and settlement experiences help further analyze how the transitional 'social space' of the newcomer is constructed. These expressions were often developed, in particular, through themes of both employment and family. Participants held certain expectations, centred about ideals of personal identity, to which impressions of their life, and by extension their well-being, in Canada were comparatively formed. Being able to economically support one's family and have a sense of control over the future were important facets to avoid an experience of social marginalization. One's assessment of how personal and social expectations of life in Canada are met, and thus the extent to which feelings of marginalization versus belonging are experienced, greatly affects the evaluation of self-health.

This self-assessment is heavily structured by the experience of Canadian multiculturalism. Every participant related, to an extent, feelings of isolation and loneliness. They also expressed a desire to become a part of this country and have greater engagement with larger Canadian society. This crucial evaluation of belonging, I believe, constitutes the central social determinant of the Healthy Immigrant Effect.

Immigration to Canada

When participants discussed their thoughts of immigration to Canada the topic varied from personal stress to population level effects experienced by

newcomer groups. PKW3 pointed out that immigration is an especially taxing experience for young adults as compared to children.

PKW3
Lines 43-49 "So children usually don't remember anything and they can grow up in every condition very soon and they don't care. But for adults it's important because adults they like they spend some period of their lives in another culture, in some other country with a different way of thinking. And different things that they need in their lives. But when they come to Canada they will see many different things that they might not have before, that they might not have in their country. Like it's first time that they I don't know they they see something new. Like when I came to Canada."

As a result, PKW3 in particular, worried about every facet of his life as a young man including education, employment, language, and marriage. He perceived his entire future as being in an uncertain state and was, initially upon arrival in Canada, continuously stressed by a feeling of helplessness over his life.

PKW3
Lines 71-87 "Yeah like when you come from my point of view when I came to Canada I had many things to be worried about. First of all was how can I match myself with a society, with a society that I don't know their languages. And I have to spend time to learn that language but what should I do during this time? The other thing is education. What should I do? Where should I go? How can I manage if I decided to go to university? How can I manage that? Because the system is different. And the other thing is finding a job. Like how can I work here? What is working in Canada like? What people, what people expect you to do, what people expect you not to do…So if you're single someday at least you want to get married. But even thinking about that, what should I do in a new society? You know it makes it makes problem. Like you don't know if you go back to your country even if you want to get married with someone from your country, from your culture you don't know if she will come here or not. You don't know if she, if she can match herself in Canada in society or not. And all of those things are problem."

Others, curiously those who had only recently moved to Canada, described their initial immigration experiences as rather seamless and reported a feeling of quick adaptation.

PKW5
Lines 253-257 "Ah because [laughs] for me my husband made this pro- process. Like he hired a lawyer to do this for me so I didn't prepare anything. So for the application, for the immigration I don't have any problem. But I know because if you, for the other people they apply for the immigration by themselves from from China. Usually they have to wait maybe three or four years and maybe they have some worry."

PKW6
Lines 317-320 "But at the beginning when I move in Canada I think it's interesting and I can see various kinds of people everywhere. They dress differently. But right now I don't, I don't know. Maybe I already suitable for this society. I have no feeling no feeling."

PKW4, instead, described immigration in terms of the opportunities available to groups of newcomers based on their settlement patterns. Rather than focusing on himself he noticed that, generally, by moving to large urban areas newcomers were subject to stiffer competition and poorer conditions. He notes that this competition places an exceptional pressure on men from cultures where they are expected to be the primary financial supporters of their family.

PKW4
Lines 41-55 "most immigrants first land in the big city. You know and then maybe they find another chance to go another place. But most of them don't. They stay in the big city…And then getting poor. And because of the big city you can get a chance but at the same time there's more competition because there's a big population over there right…Because big city means everything is expensive. Especially the house and the rent. When you don't have enough money to support your family and then you feel especially for the man they feel like how to say, I want to use the one like, one word for it, for this situation. Is they feel bad you know they feel bad"

Reasons for Immigration

PKW3 mentions the discrimination he endured in Iran, due to his Afghan heritage, as the reason for moving to Canada. Although he was born in Iran his parents were refugees from Afghanistan and he was never afforded full citizenship. He was barred from state universities and had to hide his heritage from his employers. Despite similar cultures in Afghanistan and Iran, racism is both institutionally and socially directed towards Afghan refugees and their Iranian born children. PKW3 describes how he tried resisting the discrimination and social alienation from his native country.

PKW3

Lines 440-451 "Actually the main reason was that we we didn't have a good situation in Iran. Beause I was born in Iran I grew up like others but they didn't treat us like others. Because my parents were from Afghanistan originally. And we were born as refugees [laughs]. That's what they used to say…And that was the thing that they said. Like they said you're refugee and it's not our problem. If you have anything to complain go to God. You know it's the thing they used to say. You couldn't ignore that I mean I cannot ignore that. Because it's you know it's absolutely racist."

Lines 480-488 "And I saw many things, I heard many things. Sometime when I couldn't stand that I used to fight with them. Not to represent that I was Afghanian because I knew if I said that I would lose my job…Yeah like many places that my brother and I used to work we couldn't say that we're Afghanian. Because we knew that if as soon as we say we will lose our job and it's like when you lose your job and you don't have money to split [laughs] so you better die soon."

Multiculturalism in Canada

PKW3 compares his experience of multiculturalism in Canada with that of Iran. He attributes Canada's history as a nation of immigrants to the lack of

discrimination, as compared to his experiences in Iran, he now observes in Canadian society. The breadth of cultures encountered here has allowed him to learn and correct misconceptions he had growing up in Iran.

PKW3

Lines 493-500 "No no because I mean it's something that I feel it in my bones [laughs] but I don't have any good reason for that. One good reason may be that the majority of people in Canada are immigrants…Yeah it's an immigrant country. And so in this situation nobody can say that we are first or we are second. What's the point of being first and what's the point of being second?"

Lines 504-509 "And who want to say we are high, we are much more high class than you. Wow why do you think that? We have like many Chinese here, have Indians, many European, many people from Africa, many people from Asia, Iran, Afghanistan, Indonesia, even the countries that I didn't know. Like when I came here I used to learn about countries, like some countries I didn't know. When I was in Iran I didn't know that people, some people in Africa can speak English or they have French language."

PKW6 also makes observations of the Canadian multiculturalism to which she now contributes. She finds this new society both friendly but also, at times, rude in her service industry experience.

PKW6

Lines 241-253 "Oh I think different cultures have different people. They are, they are all different but they are mostly very friendly. But less of them are very rude [laughs]…Yeah because I work at a restaurant I know the customer sometimes they are really rude…I know native like you are very good. The native speaker are very friendly. They are always trying to help us."

Expectations of Life in Canada

Participants sometimes described what their expectations were of life in Canada before actually migrating. PKW2 described his personal ambitions of

supporting his family back in Sudan to the end of eventually being reunited with them in Canada.

PKW2
Lines 2-6 "When I first came here I was thinking I'm going to have a good life when I come here. Yes to work, get a good job, support my family because my family from Darfur the region is now in a war. So I'm thinking I got to work hard to support my family. I have idea to bring my family here in the future."

He contrasts his hard working ambition with the prevailing view he believes people in Sudan have of life in Canada.

PKW2
Lines 420-425 "People say if you don't like to work and if you don't like to have a future Canada is good very good. Just sit and complain, welfare give you money for food and they give you shelter. So if you don't have a family or you don't have nobody you can easily live yourself. But in my experience it's very difficult. Because I never ever forgot my mother and my father and my brothers always in my heart."

Lines 513-514 "That's it that's it. So people most of the people think this is a good country because they don't like to work."

The perception of a proverbial 'land of milk and honey' is further elaborated upon by PKW3. He describes the perception in Iran of the 'Hollywood' life in the West where all your needs are easily met.

PKW3
Lines 404-411 "Because when I was about to come to Canada I used to think that ok when I go to Canada I can go to school. The government will give me good money. I can finish my education in university and the government will give me free money [laughs]. When I came this was the pictures or imagination that I got from movies. You know when you're in a country in the East and when you watch Hollywood movies, when you watch the other movies that they made. They were made in West of the world. You know you think that everything that you see on that movie is true here."

This perception extended to health care systems and PKW3 relates that he never expected to encounter any problems in a developed country such as Canada.

PKW3
Lines 413-415 "I was sure that if I come to Canada I will not have any kind of problem with health. Like when I was there I used to think that Canada is a developed country and in a developed country they have a different kind of system and you will not be short of anything."

PKW5 however, as a health professional, was hoping to find a better work-life balance in Canada as compared to her stressful work experiences in China.

PKW5
Lines 235-240 "Yeah I think if I have the same job in Canada I would not need such stress because I heard that the doctors here don't need to have as many patients. And patients respect doctor, they follow the direction of the doctors. Because you know in Shanghai sometime the patients they will challenge you. They don't believe what you told them because they search on the internet about their disease and they think you diagnose them in a wrong way. But here I think the doctors don't have such problems."

She also expressed an interest in Canada's multicultural society and hoped to have greater interactions, in her personal life, with people from different ethnic backgrounds. She relates a strong desire to be involved in the country.

PKW5
Lines 263-268 "I think the first thing is I want to be involved in this country. Because I don't have friends here. My only relatives are my husband and my parents in-law and I don't have much networking here. So I think no matter for the jobs or for the language. So you have to know someone else not only some Chinese friends but also I wish I can make some friends with the Western people and from all over the world because Canada is an immigration country I think."

Cultural Community

Discussions of one's cultural diaspora in Canada were not the exclusively positive reinforcement that I had initially suspected. Some participants felt isolated from their respective communities simply because they had not formed significant networks.

PKW2
Lines 443 "Only three families here and they are all new, they don't know nothing."

PKW6
Lines 230-231 "The only Chinese people I contact are in my English school. I don't know if there is a Chinese community. I know but I've never been there."

The relationship with one's cultural community was also described as a stressful and negative experience by PKW3. He felt patronized and rudely treated by Iranians who had been in Canada longer than him.

PKW3
Lines 176-180 "Because I don't know at least it happens to a majority of the Iranian community. I'm not talking about all of them but the majority of them. Like when they come here when they think that you're new, they are sure they know something more about you. They know something more that you know. So you have to beg them."

Lines 185-194 "Yeah like the first time when I was talking to an Iranian girl. And like I just said that I'm new here. And she was thinking like she's a god. But she said yes I've been here for five years, I have many friends, I have many thing to do, I don't have a time and those things. And at the end I said I don't want to date you I just wanted to know if you ever you have any program like every weekend or once in a while to just at least stay closer with part of my culture. To stay closer with part of people that I used to know them. And just keep going with the Iranian community. And she answered me like I don't know what [laughs] I mean that day I just felt like what a mistake I made. I mean I felt like why did I do that? Why did I talk to her? Why did I ask her? Why did I tell her that I'm new?"

As a result of these early experiences PKW3 has been reticent to seek out association with local Iranian communities. In contrast, he has found friendship with a multicultural group of non-Iranian friends here in Canada.

PKW3
Lines 225-230 "But non-Afghanian and non-Iranian, like I have many good friends from Africa, I have many good friends from Europe, I have many good friends from Asia...my relationship with others is good, like I still have good friends. Like I have a good friend from Arabic countries."

PKW6 also describes multicultural friendships as a welcome addition to her life. She finds, however, that they cannot be the deep friendships she left behind in China.

PKW6
Lines 328-331 "There are people like me from China, maybe others Spanish we are friends but we can't be the best of friends. We just say something and chat with each other but never know each other deeper. Like in China I have best friends. Here I can't find best friend because you are adult. It's hard to make best of friend here."

PKW5, moreover, demonstrates that her Chinese classmates in Canada are a source of relaxation and familiarity. She considers this cultural support as an important countermeasure to feelings of homesickness.

PKW5
Lines 173-179 "Yes that's why every afternoon we have dinner here…Yeah because usually Chinese people like to bring lunch for rice or vegetable, meat. And we sit together here and talk in our own language. I think it's a good way to deal with our homesick feelings."

Family

A sense of family and community played an important role in all participants' perspective of life in Canada. PKW2 placed a strong cultural and personal emphasis on his familial responsibilities despite being alone in Canada. He regularly sent money home to Sudan and despaired at broken family structures observed in Canada.

PKW2
Lines 595-603 "I really need to take care of my mom and my father and my youngest brothers…I keep my saving here and then I send them money monthly. So even in Africa like your mom or father's family even if they have money you still give them something. They say ok thank you, we don't need but still this is something from our son or from our daughter so we have to accept. That is all about our family, they always live together."

Lines 608-620 "I see many people who say who cares about mom or father?...Make me cry. Make me cry. If anybody say to me who cares about father or mother it makes me cry really. Because I can never ever be in this world without mother and father…How come I'm going to say I don't really care about my mom or my father? Never ever ever ever from my mouth. I really care about my mom and my father even my brothers and sisters because this is my family. We are human beings."

PKW3 describes his family as the crucial support that allowed him to withstand the initial stress of moving to Canada. At the most trying points, where his life seemed to be in an uncontrollable flux, his family provided the familiarity and support to cope.

PKW3
Lines 163-164 "Yeah. Yeah if my family weren't here I would have gone back in the first month I'm sure."

Despite having a significant amount of family in Canada PKW6, however, explains that time constraints prevent them from seeing each other very often.

PKW6
Lines 222-225 "I have a lot of relatives here. But they are very busy. Yeah we don't have the time to get together very often because my aunts opened a bread store. They need to bake the bread every day and my cousin opened a restaurant. The restaurant open every day. I'm free but sometimes they are busy so we can't get together."

PKW5 relates, similarly, that she felt isolated at first in Canada while others worked. She found support through the LINC program where she was able to form friendships and a sense of attachment to something in Canada.

PKW5
Lines 281-289 "Yes I think um before I came to this school I spent one month in my home. I don't know other people and I don't know my community or my neighbours. Yeah so that first month I feel lonely that's why I came to this school. Not only for improving my English but also I want to know someone here…Yeah and I think [laughs] that everyone new to this country, newcomers have the same feeling I think."

Getting Settlement Help

The importance of finding and accessing settlement assistance programs was made clear by PKW1. He mentioned that his arrival in Canada was more stressful because he did not know about the resources available. He felt he had no way of knowing and that the only information he ever received was from the initial immigration package given to all new Canadians upon arrival. Only now, two years later, after becoming unemployed has he been able to benefit from newcomer assistance programs.

PKW1

Lines 584-587 "I didn't know about the YMCA until last month. Yeah because I don't know my ex-wife she didn't say shit about how you can get help if you are not working. I had to live with very little, I remember that. The reason why I know about the YMCA now is because I lost my job."

Lines 612-621 "When I came here it was friggin hard for me to find a job. But some people I heard that they came from their country and they come to the YMCA and they get the help you need to find a job. They got financial support to get on their feet you know? Like housing or whatever but I wasn't able to receive all that kind of help because I didn't know nothing about it. I didn't know nothing about this country. Only thing I knew about this country was what they told me in my resident envelope where they put the card inside. There's a lot of information inside that. First thing you need to do is get your health card. And with the health card you can get this and that but they don't give you like much information they just give you like the basics."

PKW1, having been divorced from his wife, felt he had a limited social network from which to get information. He relies on new networks he is forming here for information about services and programs that can assist him.

PKW1

Lines 588-606 "so I get more not from family because I got no family here but from people around me. You know like co-workers, people who I live with like roommates yeah…Yeah and most of them at church too…Yeah at church I get a lot of information from people who came from my country…Yeah and different countries too like South America, Mexico."

The importance of family is highlighted, in contrast, by PKW5 who has relatively quickly accessed the YMCA and LINC programs on the experienced recommendation of a relative.

PKW5

Lines 344-347 "My aunt told me because she was in America and she told me that when she went to America for the first time she got a lot of help from the YMCA. And then she recommended it to me here. And also because I want to improve my English I know there's a LINC program. So I know this place [laughs]!...Yeah I

think it's very very good because I never imagined before there's such a service for immigrants. And it's free and they are very helpful, very warm hearted."

PKW3 has also benefited through his family's involvement in the YMCA's Host programs. He cites the cultural bridging program as an important aid against feelings of isolation and marginalization in Canadian society. The program's emphasis on social interaction is invaluable to mental well-being.

PKW3
Lines 256-282 "Yeah Host program. Yeah so we went outside a few times. We went out a few times to play pool, to have like I met one of [Host program volunteer] cousins…At least in some period. In some period of your life when you're an immigrant and you come here as someone that cannot speak English fluently it's important for someone who does not have anybody, any kind of relatives, anyone to talk to, anyone to listen to, anyone to hang around with, it's important. Because imagine that you stay at home. I think it's something that every single person can just test it for once. Go to your bedroom. Turn off your light. Close the door and close the curtain. And just stay in your bed. How long can you, how long do you think you can stay on that like without talking?"

The participants who described the greatest comfort obtaining information about specific settlement assistance programs were those regularly accessing the internet. Having this computer literacy gives you a significant advantage and breadth of information over those with no previous computer familiarity.

PKW4
Lines 174-178 "The internet is the big one like we said. And the other source is the library. And also the YMCA you know, I know there's always something there to help people so I try to use this source actually all the time. You know when I get a problem I will try to ask them what to do. So actually right now I just feel comfortable. You know I feel comfortable."

Comparing Lifestyle in Canada and China

PKW4 broadly compares lifestyles in Canada and China when considering his immigration experiences. He relates that Chinese culture places large financial pressures on men, as opposed to Canadian culture where men and women share responsibilities, to be the predominant breadwinner for their family. He states this leads professionals, such as engineers like himself, to frantically accept any job they can find.

PKW4
Lines 53-65 "When you don't have enough money to support your family and then you feel especially for the man they feel like how to say, I want to use the one like, one word for it, for this situation. Is they feel bad you know they feel bad...And yeah so they feel like frustrated...like depressed and maybe something like that. You know especially frustrated you know."

Lines 65-74 "They don't have a good job and then they need to support their family. And then when you get home your wife, your family might complain oh you not good you know. You're not very good, you're not good man, you not good enough to support your family and we need money. They rush to work. And then those people originally had a good job as maybe a engineer and manager where they come from…And then they rush to out to work and then they have no choice. And then maybe they do some labour job that doesn't need skill and they will feel frustrated and keep doing this job for a long time."

Lines 110-116 "Yeah because for us, for those people who come from Asia the man is always the the main support for the family. And then they will feel they're responsible for the family. But for the lady they have less pressure because if the family have some problem that's the man's responsibility. That's the culture. It's not like a Western country you know where man and woman each take their own side right. Their own responsibility. They don't complain, they don't only put pressure on the man but they do in the Asian culture, that's part of Asian culture."

Using this perspective as a backdrop, PKW4 surmises his experiences of adaptation to a Canadian lifestyle. He feels that if you take the time to settle,

especially if you are single, the Canadian lifestyle can be more relaxed than that in China.

PKW4

Lines 387-395 "In China everything is rush, rush, rush. Here you don't have to rush. You don't have to rush. Actually everything is step by step, so you go slowly in this manner. So this is why if you're just one guy and you don't have a family to support you feel comfortable. You feel comfortable especially if your English is good enough to communicate with people, you feel good you know. So actually in the first three years I didn't feel good you know. But when I passed the English barrier then I felt more comfortable. And actually the job is not very hard to do. Actually it's easy to do. It's easier than in China because in China the boss always pushes you to do [knocking on table] this thing, that thing."

Lines 625-632 "Being job-oriented is the habit in China. People are job oriented you know [laughs] job oriented. I don't know if this expression is good or not?...Yeah job oriented. Like here it's family oriented right and I understand this is very different you know."

PKW6 however, when comparing lifestyle differences between Canada and China, focused predominantly on cultural norms of social etiquette. She felt acutely aware that she must quickly learn these 'new rules' for life in Canada.

PKW6

Lines 270-289 "But I have no idea, I need to learn a lot of things. Like last week I was wearing a skirt and I didn't shave my legs but my class mate said in Canada you must shave your legs…Shave your legs because they will think if you don't shave your legs that you're a guy or something…But in China we didn't."

Lines 293-303 "I need to learn a lot of things. And there are a lot of rules here you need to listen to…Acchh [pretending to sneeze] when you do this you must cover…Yeah sneeze but in China we never do this. Nobody pays attention when you do this. And here the people will say bless you and you must cover. They're afraid you will pass the cold but not in China."

Through these participant discussions of immigration and adaptation we can apply Berry's previously mentioned theories of acculturation. When

considering Berry's 'bicultural model' I find that not a single participant expressed rationalizations compatible with exclusively 'assimilation' or 'separation' strategies. Perhaps unsurprisingly, since participants were recruited through a Host program initiative, everyone expressed elements of the 'integration' strategy that Berry describes as most favourable for reductions of acculturative stress. I believe that participants' descriptions of 'marginalizing' processes, such as poor language skills and accreditation difficulties, in the backdrop of their desired integration strategy is what produces the previously described 'liminal social space'. The construction of this social space, that I suspect is the primary social determinant of the Healthy Immigrant Effect, constitutes a struggle, by both the individual and newcomer groups, to achieve Berry's integration strategies while overcoming the marginalizing processes inherent to immigration. I believe that the Healthy Immigrant Effect is actually a 'social gauge' of Canadian multiculturalism in that it represents the extent to which, and at what 'acculturative stress' costs, the desirable integration strategy can be pursued, at the expense of marginalization, by newcomers to this country.

<u>The Perspective of Settlement Workers</u>

> "Little is published about the role of immigrant-serving agencies and ethnocultural organizations in promoting the health of immigrants over their life span and across the migratory experience, but it is commonly understood that these are essential services for some groups." (Thurston & Vissandjee 2005, p. 238)

I conducted a recorded discussion with SW1 and SW2, senior managers at the YMCA Cross Cultural and Community Services, concerning the issues raised from participants' discourse. They have both worked extensively throughout their careers as settlement workers, at all levels, while also having personal experiences of immigration to Canada.

In over thirty years of experience as a settlement worker SW1 relates that she has not seen an effective bridging between multicultural newcomer groups and Canadian health care. She points out the failure to incorporate newcomer health professionals into Canadian health systems for this continued inability to adapt. She relates that concerns over medical standards have been used as an excuse, rather than an obstacle to be overcome, allowing power to be held within the field of Canadian biomedicine by a relatively select few.

SW1

Lines 164-165 "Unfortunately unfortunately after seeing this for more than thirty years. This is what I see here in this country. I cannot say that the division between these two worlds is less."

Lines 166-168 "You have to understand that this is power, there is a lot of power over there. And it's not easy for a group of people that has all the power all the time to relinquish it you know to share a little bit of that power."

Lines 168-177 "One of the reasons that they always bring to the table, they talk about standards. We cannot allow these are Canadian standards. We cannot

allow these doctors from who knows Malaysia you know he was practicing for thirty years over there. So they afraid that those standards are going to be lower than the Canadian standards. So I think that that reason over there it has to be brought to a table and really addressed. What is behind that? Of course I'm not to look for lower the standards...But I don't think it's just that, there is something else over there."

In their front line experience, SW1 and SW2 realize that newcomers come with an array of cultural health knowledge and expectations. Providing venues by which cultural meanings and knowledge are valorized, rather than systematically 'othered' and ignored, could improve newcomers' perceptions of Canadian health care.

SW1
Lines 200-204 "But also there are practices, there are approaches to illness that are different. And now if you start reviewing the practices that other groups, other ethnic groups, other you know in other countries you are going to feel is less intrusive. That are practices that are even healthier or bring health quicker. That there are less margins of produced damage you know second, third level damage. Because there are more natural things."

This extends to the emic knowledge, and cultural specificity, immigrant health professionals could offer to respective diasporas in Canada. This expertise would cover knowledge gaps that may exist in exclusively Canadian trained work forces.

SW2
Lines 240-247 "Yeah and maybe the doctors their education is on tropical diseases not diseases from this part of the world. So you have you have to know the background of where the person is coming. Possibilities of what people who live in that area whatever diseases they have. I remember when I was so lucky I got an Indian doctor so he was able to, I mean I was being given you know antibiotics and he said no we have to do a culture to see what you have, worms from somewhere else or you know. Which students who are maybe from a Canadian university won't know this type of worms"

SW1 and SW2 realize that the population of Waterloo region, and by extension all of Canada, is changing. They warn that not adapting health care systems, to the needs of an increasingly multicultural population, risks diminishing the aforementioned standards of care.

SW1
Lines 259-263 "And and now you see we have in this area at least just for region of Waterloo that the numbers of immigrants are increasing in just such a quick manner that the systems are feeling the effect of the change, the shift in the population. But they are the same doctors, the same school of thought, the same behavior, the same thing. So how do you solve this problem?"

Lines 263-270 "The most revolutionary thing is oh bring an interpreter right. So this is the way of solving the problem and the interpreter sometimes is a doctor with studies in Vietnam. I worked with one but he was a specialist in blood diseases, he was a hematologist. So he had a degree in blood disease and he was the interpreter for this guy that didn't know what to do with this Vietnamese patient. And I look over there and I thought this is really crazy. What are we doing with this? This guy could not practise. The patient was from his country. He understood what's going on over there and he knew that the Canadian doctor was far away from the problem."

At the moment, because of this slowness to adapt, SW1 and SW2 feel that settlement workers are exclusively bearing the weight and responsibility of cultural bridging. They feel isolated, as the only form of social glue, trying to bring these 'two worlds' together in Canadian society.

SW1
Lines 284-289 "Well settlement, settlement workers become everything as I say sometimes joking we are nurses, we are midwives, we are priests, we are nuns, we are everything, we are journalists, we are everything right. Lawyers, advocates you know everything. It's a group of people that have to dance and do everything in a kind of music over there. What is the only thing that allows us to do that? A second language to translate and try to put together these two worlds that are apart over there."

In this isolated role SW1 and SW2 point out the difficulties intrinsic to medical interpretation. They elaborate how it is not a practice that should be approached simply as direct 'language to language' translation.

SW1

Lines 296-305 "You have the language and also there's some knowledge of these other culture. I said some because for my case I did the settlement of all Central Americans and I am from the south of the continent. We are kind of close but we have some differences so I have to learn when they said I have a chivola in my eye. I didn't know what the hell is chivola? You know I have never heard that word...So I have to get in the same level with this person you know. I have maldillolin. What the heck is maldillolin I have never heard that? So the person has to explain to me in Spanish. What was maldillolin? It was just an infection in your kidneys. But they call it maldillolin. I've never heard that."

Lines 313-321 "Then it gets even worse. When I the interpreter I went to school only three or four years. So I don't know all the words for my body. I don't know that I have here an organ that is called a spleen. How often do you talk about your spleen? Tell me how often. Not right? Or you have a double personality you know disassociated you know. If you go to a psychiatrist you hear things you've never heard of before. And for Canadians oh she speaks Spanish but how much vocabulary you have to go and translate for a two, three hour session with a psychiatrist with somebody that has paranoia?"

Lines 321-326 "the silence in you know with the psychiatry, those silences are a lot of information. But the patient stops and everything is stopped you shouldn't break those things you know as an interpreter. If you don't know that, you never went to school you never went to university, you never took any courses like that you won't know these kinds of things. So the interpreter is, I mean you can we can write chapters about the pros and the cons of interpretation and the big red flags about the role of an interpreter."

Also the need to bridge cultural meanings, rather than simply translate words, is highlighted. In their experience as medical interpreters SW1 and SW2 found themselves having to moderate starkly contrasting ontological perceptions, and cultural referents, that are colliding in Canadian health care settings.

SW1 and SW2

Lines 340-361

"SW2: There comes you know in some cultures when they think they are possessed or something you know. And I remember I was interpreting and...And I remember when I was interpreting someone saying she was back at home I was eating and a woman who was hungry must have seen me her eyes immediately and that's why she's sick. So how could I interpret that? [laughs] Even now saying it doesn't sound correct when interpreting from my own language. Because they believe that someone's eyes.

SW1: Of course and what you do for that, for a baby you put a little red whatever

SW2: Yeah or wear something.

SW1: So of course you know so

SW2: That's a belief. That's a thing...And then they will give them sleeping pills that's all."

In this regard SW1 and SW2 suggest that Cartesian emphases of Canadian biomedicine, such as sophisticated technology and pharmacology, have neglected an element of 'human connection' that they believe is important for multicultural interaction.

SW1

Lines 113-118 "It's a big time cultural insensitivity I think that our professionals here are not given that in university. You know when they know a lot about pills and chemistry and all that stuff. About how you use machines and things like that. But the the human part you know the communication with people, I'm not talking about language communication I'm talking about other things. You know sensitivity how to listen, all that is not there. And it's not, it's not given."

SW2, in response, highlights how a cultural diaspora can react in response to this stunted interaction. She describes concerns within her own Somali community to the Canadian use of Caesarean births for women that have undergone female circumcision. The community, averse to Caesarean sections,

reverted to home births since Somali physicians, familiar with the situation, could not practise here.

SW2
Lines 139-147 "So when we have a patient that is pregnant. When she's about to deliver we swear that you know we had a doctor who was here but he was not allowed to practice and could have helped them because they were doing c-section with all of them. You are pregnant oh then c-section, then c-section. Then as a community we said this women had four children and why is the fifth being in caesarean? But for them they were just pregnant. Something will happen and they will be sued so this is the best way, just have c-section. And it was also it was not cost effective. So thanks God there is that choice of midwives. So now they go with midwives and have home deliveries and all that. But that's when everyone will try to inform them you know use those Somali doctors with experience."

SW2 further describes the mistrust engendered within Somali communities towards North American medicine, because of the limited communicative moderation between the differing cultural perspectives.

SW2
Lines 437-450 "There is a mistrust with doctors I know. Especially with children you know, Somali community they suffered children had all this autism. And they don't know it's something new in this environment they never used to have it back in Somalia. Never used to see that autistic child but here you will see a mother with two children. And I think it's here, in Minnesota, and I think Philadelphia, those three communities. And there was I think a reporter that said you know she saw a yellow bus taking like twenty students from Somali community. So they said why don't we find out what is causing this? But in Minnesota they are trying to find out. In Canada they don't even ask ha! So now some of the parents stop you know, I don't want to have vaccinations for my children it's coming from this...But then if they don't vaccinate them they cannot attend schools so many are trying to home school or do other things. So mistrust when you don't, when you can't trust the system."

Ultimately, SW1 and SW2 advocate an increased emphasis on the social determinants of health, including culture, to be valorized in Canadian medical

training. They feel this is important not only to newcomer populations but, also, to the mutual benefit of all Canadians.

SW1

Lines 533-544 "Many things they are doing are not, is not fitting even the Canadian born. So when you open it and review it everybody's going to benefit...Everybody. I'm not doing this because I want just special services for new Canadians. No we're going to learn from and for all. There is so much information over there in countries like China for example. What are we doing? Practices and procedures or whatever that have been there for thousands of years when Canada didn't even exist. So this is the thing you know when you open these situations and problems and look into it. It's just for the betterment of everybody right. And use better our resources and monies."

Lines 484-494 "We need to do something. We need to address something. I don't think or am asking for immigrants to be better treated than the native population. I think there are two groups that whatever happens to one I think is very close to what happen to the other. It's not good news for any of the two groups, our immigrant people and the native population. I think somebody has to address also the education the doctors are receiving in university. Somebody has to go and review what they are taught in university. How are they formed this group of professionals?...So in order to make some changes I think you have to go to the root. Where are these people going to receive their education? I don't know. And I don't know if it's only the government but also somebody has to regulate the the doctors' associations right. Somebody has to go over there and ask until when are these people going to be this very closed club."

SW1 and SW2 suggest a democratization of what is valorized and legitimated in Canadian health discourses. This would necessitate a change, they feel, from a health care system in which a relatively small group control the dialect, form, and framework of socially legitimated health knowledge.

Multicultural Health Moderation: Applying the Social Determinants of Health

On the suggestion of both local settlement workers and newcomers, who I met through the course of my volunteer and research work, I tried to conceptualize methods by which insights, drawn through this type of study regarding the social determinants of health, could be applied to practical improvements of multicultural health care. Drawing from my work I feel that so called 'aberrant' actions of immigrant patients are attributed, by the Canadian practitioner, to a ubiquitous cultural influence. Essentializing statements such as 'it's against their culture' or 'their culture encourages/discourages the individual's behaviour' not only risk over-generalizing individual characteristics but also mark a discourse of othering that imply an 'us and them' perspective within Canadian health care. Browne *et al.* (2009) provide a precise definition of this process when presenting that:

> "Culturalism refers to the process of viewing people through the lens of culture, defined narrowly as shared values, beliefs and practices, and often conflated with ethnicity. In this process, 'culture' thus defined operates as the primary explanation for why certain people or groups experience various health, social or economic problems such as, for example, poverty, substance use, or low birth weight." (p. 168)

Cultural descriptions are used in lieu of considering health care barriers rooted in socioeconomic inequalities and social exclusion. As Johnson *et al.* (2004) surmise "Although cultural descriptions can be useful to health providers in terms of providing guidance when working with ethnocultural groups, they can

also create groups as outsiders." (p. 255). Being a native-born Canadian, albeit second generation, and educated within the Western scientific health research paradigm, I am fully able to understand the rationalization process underlying the essentializing of the 'other' within biomedical culture. This familiarity with the biomedical culture, however, also allows me to acknowledge the largely assumed emic perception that biomedicine is a completely impartial system, dealing with only an objective reality, that is free of any social influences and bias. Despite good intentions, being unaware of one's place within larger systems of values, such as a biomedical culture, predisposes one to discourses and interpretations of othering towards those that do not fit within the predisposed model. This is not limited to multicultural health care but is a common feature of all human intercultural interactions. Again, holding a universalist perspective, I contend that human beings possess common psychosocial processes that are variably interpreted, enacted, and experienced in culturally specific ways. This can be made clear by understanding the intrinsically human relationship between the conscious and unconscious mind. Our unconscious minds are trained by conscious habituation and training. Through daily conscious experiences of one's native cultural norms we are unconsciously conditioned to react to various stimuli according to the sociocultural environment in which we have grown up and become accustomed. I believe this interpretation to be not far from what Bourdieu meant with habitus. This internalized socialization causes our conscious minds to contemplate the behaviours of 'cultural others' according to the unconsciously

instinctive frameworks to which we are accustomed. The ‘cultural other’, meanwhile, similarly enacts this same process, thus the universalism, according to their habituated cultural framework in contemplating our behaviours. Common human psychological processes, therefore, cause us to mutually misunderstand and socially position the cultural other according to frameworks they do not share.

A concrete example of this can be seen through PKW2’s frustrated relationship with his family doctor. On a wider level, moreover, just consider the recent ruling by Quebec’s human rights commission, in reference to full Muslim veils being worn in formal public interactions, that the “health insurance board [RAMQ] has no obligation to satisfy religious or cultural preferences...civil servants and RAMQ users are expected to act neutrally, and neither party should expect any accommodation based on particular religious or cultural beliefs” (*Canadian Broadcasting Corporation* 2010). The justification of this ruling, which is based in a culturally specific emphasis on a perceived neutrality of civil services like health care, shows the unconscious conditioning and perceived naturalization of one’s subjective values in comparison with the other. Quebec’s emphasis on a neutral and secular service, ironically in the name of equality, ignores the fact that this ‘neutral’ system structurally excludes any individual who does not assume the social positions it favours. It implicitly privileges those who embody its framework and system of meanings; those who possess the cultural subjectivity to freely navigate the Canadian health care system both linguistically and culturally. This privileged group, inadvertently, is overwhelmingly white and

middle class. In the well-meaning name of secular equality Quebec's human rights commission is unnecessarily empowering a structural 'othering' process that actually impedes Minister of Immigration Yolande James' profession of "Our vision has always been one of inclusion, and diversity, while making sure Quebec's values are respected" (*Canadian Broadcasting Corporation* 2010). To bridge this gap the conscious mind has to actively contradict, by acknowledging the subjective existence of our cultural beliefs and institutions, the unconscious instincts we experience when interacting within multicultural populations.

Analysis of this phenomenon in multicultural health services has realized that "Cultural competence is defined as the ability to understand and work effectively with patients whose beliefs, values, and histories differ from one's own...One established construct that may be closely associated with cultural competence is ethnocentrism" (Capell *et al.* 2008, p. 121). Ethnocentrism can be structurally enacted by well meaning individuals and groups within the context of health service delivery. Johnson *et al.* (2004) point out their empirical findings that "South Asian women did not easily fit into routines and the culture of efficiency that characterizes the mainstream health care system. In this institutional context, health care providers often constructed women as difficult to deal with..." (p. 266). The inability to mutually understand one another and the subsequent unfulfilled expectations of patient/provider roles are often attributed, by Canadian health care providers, to the culture of the patient. The attribution of perceived 'idiosyncratic' behaviours to a vaguely generalized 'cultural influence'

by the self-perceived objectivity of biomedicine, ironically, legitimizes the importance of social determinants to immigrant health outcomes. However, if we are to be honest with ourselves we have to pursue this line of thought with further questioning and rigour. We need to, at least for the present moment, deconstruct the ubiquitous term ‘culture’, delve deeper into the social determinants of health, and thereby reconstitute our understanding of culture and its role in the understanding of immigrant health. Only having done this can we subsequently identify loci for interventions towards the practical benefit of health care provision within multicultural populations.

The relationships between gender, culture, and health, for example, are of significant importance in multicultural health interactions. From a Canadian health care perspective well-meaning arguments rooted in Western feminism may be detrimentally applied to multicultural populations. By focusing solely on gender, and ignoring its intrinsic relationship with ethnicity and culture, health care providers may emphasize the Western perception of female individuality to persons from cultures with various patriarchal elements. Rather than helping immigrant women it may cause them to withdraw from public health services and become increasingly reliant on their husbands/male family members. Blackford (2003) makes this crucial insight when saying:

> “contradictions existed between nurses who expressed desire to free women from a perceived inequitable relationship and their failure to ensure non-English speaking (NES) women had access to an official health interpreter...Feminist critiques of a liberal feminist position saw that the demands of equality for women were

> constructed from a privileged position based on their race, that is white, and class and excluded ethnic minority women because of their class and race." (p. 240-241).

The well-meaning intentions to liberate women from patriarchal systems becomes, in fact, a form of institutionalized ethnocentrism precisely because it ignores the relationship of gender constructs with culture and ethnicity. The fact that there is an implicit privileged position structurally located within health care services, that is white and middle class, demonstrates the error in attributing 'aberrant' immigrant behaviours to their culture. Moreover, health care practitioners cannot feel they are liberating 'poor and powerless' women from their cultural chains by simply taking decision making into their own hands. Meddings & Haith-Cooper (2008) emphasize this point when illustrating that:

> "how society views autonomy will become significant when an individual is faced with making personal decisions...Consequently, the importance of respecting a woman's autonomy (from a western understanding of the term) is not considered relevant because health care practitioners take on the role of decision makers for their clients." (p. 54)

By trying to liberate culturally 'other' women from their patriarchal family structures, without adequate cultural competence, health care practitioners risk further marginalizing individuals who need their help. Autonomy and agency is not transferred to the patient who is, rather, left in a liminal and powerless position. Immigrant women are negotiating the structural constructions of Western biomedicine and the traditional gender norms in which they are socially positioned. As Menon (2002) relates "the health care setting tries to impose its

values without regard to cultural origin, the individual is likely to feel less empowered" (p. 37). Multicultural health care settings, therefore, need to foster a space for this negotiation so that the patient is not left feeling marginalized and powerless.

Similar insight can also be provided through the immensely important influence of language and communication in multicultural health care settings. The root of almost all cultural misunderstandings have language and communication implications. In the biomedical perspective much emphasis is placed on the individual agency and assertiveness of the patient. If language barriers impede this expected role the patient may inadvertently be considered timid and unhelpful by health care providers. Within a 'culture of efficiency' this misinterpretation may be attributed to the patients' culture which is seen as reticent and stubborn. Menon (2002) highlights the detrimental consequences of this misunderstanding when saying:

> "From a minority individual's perspective, difficulties in communication and inability to comprehend written and oral information lead to feelings of powerlessness. The problem may be compounded by the tendency to 'save face'...in which the individual tries to avoid embarrassment to oneself and to others. Thus, psychological health empowerment is adversely affected..." (p. 37)

As a result, many health care facilities that serve significantly multicultural populations have enlisted the help of professional interpreters. Although this undoubtedly helps the communicative process it still presents some challenging issues as my discussions with SW1 and SW2 suggest. The patient's

perception of the interpreter must be trusting and not one wherein they feel they are being evaluated and judged by a member of their own community. Moreover, even if direct interpretation is provided there might be cultural meanings that are, to risk a cliche, lost in translation. As Newbold & Willinsky (2009) learn from their interviews with health care providers “there may be communication barriers even with immigrant clients who speak English because many do not see or talk about health the way most Canadian healthcare workers are accustomed to. Thus, the patient and provider may not fully understand each other” (p. 374). Similarly, if an interpreter simply speaks the same language, and cannot provide any cultural interpretation, the same failure to fully understand one another may arise. Multicultural medical interpretation cannot be simply language translation but, rather, provide a bridging of different cultural ontologies concerning health and well-being. It’s more importantly a form of conceptual translation in addition to bilingualism. A multicultural health moderator needs to not only speak the same language but also empathize, develop trust, and mutually clarify the respective perspectives of patient and provider to one other. Cioffi (2003) clearly summarizes this insight when relating that:

> “The behavioural strategies, the communication skills, involve flexibility in verbal and non-verbal communication styles, ability to speak slowly and clearly without excessive slang, ability to encourage others to express themselves, ability to communicate sincere interest and empathy, patience and ability to observe and intervene when there is misunderstanding. These strategies show that language is only a part of the communication process and indicate that cultural referents and the patient’s reality are also involved.” (p. 300)

The multicultural health moderator, therefore, is much more than a professional interpreter but, rather, represents a sophisticated and invaluable component for health care services in Canada's increasingly diverse population.

The potential for multicultural health moderation can also be construed as having social justice connotations. The Canadian health care system is one that has historically egalitarian roots that influence the previously mentioned 'culture of efficiency'. Having to provide high quality health care to all Canadians, regardless of socioeconomic status, places an enormous workload on a service with limited resources. However if patients cannot assume their expected roles within the biomedical culture of efficiency, or are not assisted in doing so, can they really access the services to which they are entitled? Meddings & Heath-Cooper (2008) also recognize this potential and state that:

> "in reality, being able to read and write in the majority language is an important facet in enabling users to learn about and then access health services...Utilization of such a service demands a reasonable command of the English language, including the understanding of and ability to communicate descriptive words and some medical terminology. Without this, one could argue that these women's rights of access to this service are not being respected and therefore they are being treated unjustly." (p. 55-56)

Should the burden of adaptation be placed largely, as it is now, on the shoulders of newcomers to Canada in the health service context? Frustration on the part of heavily burdened health care providers with language barriers is a legitimate concern but we must also empathize with the even greater frustration of the newcomer patient. After all, they are trying to navigate a completely new and

confusing system, often in a language they do not fully understand, whilst also experiencing all the larger challenges of life as an immigrant. This, moreover, is occurring at a particularly stressful time when they require health care services and cannot communicate with, or feel they are not being listened to by the Canadian health care system.

This question of who is responsible, and to what extent, for multicultural adaptation speaks to issues of power within the health care context. If the immigrant patient is expected to make all the effort to adapt in the health care context then this suggests they hold a powerless and subject position within the biomedical system. The 'standardized normal' to which the immigrant patient must adapt themselves represents a structurally constructed position of power that, by majority, is assumed by middle-class native English speakers. This institutionalized relationship between social role and power is at the heart of the 'othering' experienced by immigrant patients. Mahalingham (2008) points out this association between power and 'othering' when mentioning that "Immigrants who live at the cultural contact zone internalize, but also resist and disrupt the process by which they become the other. Power plays an important role in the need and desire to construct and control the representations of the other" (p. 369). The health care setting is an excellent example of a locus where immigrants must negotiate 'othering' processes imposed on them by systems of power that imbue structured social positions. Rather than apportioning exclusive responsibility to either the immigrant patient or the health care system emphasis can be placed on

the potential for multicultural health moderators. Multicultural health moderation can fill a formalized position that bridges the negotiation of identities and expected roles between patient and practitioner. This could help remove structurally imposed power differences that are inadvertently enacted upon multicultural client populations accessing Canadian health services. Mulgan (2009) highlights the need to bridge patient and provider perspectives when advocating the importance of:

> "Everyday public services that are of the people as well as for the people. In rural societies, police officers, health professionals, and teachers live in the same communities they serve. The patterns in cities are less clear-cut, and the mismatch between public services and communities creates tensions..."

This mismatch is reflected in health care services that are unprepared to handle multicultural populations in ways that do not create othering discourses and detrimental misunderstandings. If you cannot empathize with the realities of the people you serve then you risk misinterpreting their behaviours and socially positioning them in a powerless role.

The impact of cultural competence to maintaining a healthy Canadian population will only grow in importance as this century progresses. The extent to which multiculturalism is being stamped on to the Canadian identity means we cannot afford to neglect changes in the population's health needs. Immigration is an inherently taxing experience both physically and mentally wherein every aspect of one's life is being redefined in a new sociocultural environment. Accessing health services must exist as a locus of facilitation, that helps bridge

and ease the taxing experiences of immigration, rather than be overwhelmingly confusing, daunting, and disempowering for Canadian newcomers. This bridging must be a two-way process that involves action on the part of health care providers rather than demanding newcomers completely assimilate to a structurally expected patient role. This bridging can be made real through the continued development of cultural health moderators. Moderation involves more than simple translation but, rather, requires a facilitated negotiation between disparate cultural ontologies in the effort to bring together different world views. Such an intervention can help avoid mutual cultural misunderstandings that cause both newcomer reticence in accessing their entitled health services and othering discourses on the part of well-meaning health care providers. Dispelling these othering discourses, moreover, represents a reevaluation of how culture is considered within Canadian public health and medical research. It involves an acknowledgement of broader socioeconomic factors such as gender, language, and power alongside shared cultural meanings that constitute the social determinants of health. In so doing, we can enact interdisciplinary and multicultural perspectives for the common goal of promoting health amongst Canada's entire population.

Limitations and Indications for Future Research

The major limitation of this study is the limited sample size. It is not possible to make any general claims on the health of larger immigrant populations as a result. Being a theoretically and empirically informed personal exploration of Canadian multiculturalism, the research was purposefully limited in its scope to my experiences as a participant within a local settlement program. From this very personal perspective, however, more diverse research endeavours can be based. A mixed methods approach can supplement qualitative inferences, such as those from this study, with wider statistical analyses of immigrant self-health over time in Canada. Also the emphasis on the local in this study leads me to believe that future research can look at regionalization and its effect on immigrant self-health and well-being. Analyzing the interplay between local and urban, through the perspective of public health, across various regions of Canada can provide interesting comparisons as to how multiculturalism is diversely enacted and socialized. My study provides a very personalized explorative inquiry that, despite its limited scope, demonstrates the vast potential for future insight available to this field of research.

Conclusion

Through a personal exploration of Canadian multiculturalism, driven by both theoretical and empirical insights, I have challenged public health conceptualizations of culture as a social determinant of health. My study provided two larger periods of personalized inquiry. Firstly, I tried to provide an element of theory development, pushing the boundaries between antimonies of agency and structure, to further flesh out conceptualized meanings of the concept 'culture' as it relates to the increasingly unique Canadian experience. Then I partook in a period of empirical inquiry that, somewhat unanticipatedly, diverged from my theoretical outlook on the interplay of 'health and culture'. Rather than focusing on my ontological considerations, as my immersion in theoretical questions had generated, newcomers immediately evoked, when asked about the term 'health', issues and themes around service and health care access. By adopting an emphasis on a participant observation informed research design I subsequently adapted my personal inquiry of Canadian multiculturalism. The end-product is a combined theoretically and empirically informed reflexive interpretation of the 'immigrant habitus' based on my personal experience of Canadian multiculturalism.

As a result of this combined inquiry I believe the Healthy Immigrant Effect demonstrates a health phenomenon exclusively determined by social interactions. It is structured by a liminal 'social space' within the new society that newcomers intensely experience over their first Canadian decade. The sense of personal identity is simultaneously subject to all the Canadian social 'fields' in which it is

now enacted and being readjusted. All the social, economic, and cultural capital one previously possessed is categorically reassessed within a new network of 'objective structures'. The incorporated social aesthetic of one's previous society, the 'ancient' habitus, is necessarily made malleable through this period of intense transition. In effect, the Healthy Immigrant Effect is a byproduct of the nascent and forming 'immigrant habitus'. This forging of new personal and social structures is inevitably taxing both mentally and physically. I suggest that this dynamic, extracted to a population level, lies at the heart of Healthy Immigrant Effect observances. It is an example of how the personal experience, essentially the 'subjective' and the 'social', has very real biomedical consequences of Cartesian import.

The nature of Canadian identity has always been, and most likely always will be, an enigmatic one. This is precisely because the demographic constitution of what is a relatively young country, has always been, and continues to be, in a state of flux. It has been suggested that many European nations, with long held assumptions concerning nationality, view immigration as a problem to be solved. Just consider, for example, German chancellor Angela Merkel's recent assertion, amid widespread anti-immigrant sentiment, that her nation's attempts to build a multicultural society have failed (*British Broadcasting Corporation* 2010). Canadians, however, inherently place immigration at the heart of national character for the simple reason that we are intrinsically a migrant nation. There is a certain curiosity about the cultural other and a willingness to exchange that I

feel is deep within the modern Canadian experience. Long may this continue for it is our greatest strength. If anything, a definition of Canadian identity must be tied into this indelible trait of cultural porousness. Our ability to publicly enact multiple cultural subjectivities without, crucially, feeling threatened must, in fact, deeply reflect what Canadian identity truly represents. The extent to which immigrant othering processes are minimized, and marginalization avoided, is a salient barometer of this country's health. The Healthy Immigrant Effect is truly a finger on the pulse of Canada's social health. We must support the capacity to adapt, in health care as in all fields, to ensure that the 'Canadian', whatever his or her cultural dynamic, is an identity blessed with good health.

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Appendix

Figure 1: Preliminary Semi-Structured Interview Guide Derived from the Literature

General Question Guide for Interviews

The following questions are used to help commence, guide, and give basic structure to individual interviews. The interview structure serves to facilitate discussion and allow for participants' personal narrative.

Definition of Health

What do you think 'good health' is?

Please tell me about the kinds of things in your life that have affected your health?

Health and well-being before coming to Canada

How did you feel about your health before moving to Canada?

What factors in your life before moving to Canada were important influences on your health?

Health and well-being while moving to and settling in Canada

Can you describe how you felt about your personal health when moving to Canada?

Figure 2: Final Semi-Structured Interview Guide After Participant Observation

General Question Guide for Interviews

How do you feel about your health here in Canada?

What, in your opinion, is ‘good health’?

How did you feel about your health before moving to Canada?

What factors in your life before moving to Canada were important influences on your health?

Can you describe how you felt about your personal health when moving to Canada?

What is your experience of accessing information about health services in Canada?

What do you think could be done to improve knowledge of health resources and access to services for new Canadians?

Figure 3: Informed Consent Form

Study:

Culture and the Healthy Immigrant Effect: A Multiethnic Phenomenological Study of Canadian Immigrant's Self-Perceived Health.

Research Personnel:

Sheel Chaudhuri (University of Alberta MSc. Candidate – Centre for Health Promotion Studies): [contact information was listed here]

Dr. Helen Vallianatos (University of Alberta professor, Department of Anthropology): [contact information was listed here]

Task Requirements:

This study is an investigation of the self-perceived health of newcomers to Canada. We are trying to find out what health concerns recent immigrants have as they settle in Canada. You will be asked to participate in an interview where you talk about your health and health care experiences in Canada. You will be asked to share your opinions concerning what you think is good health. You will also be asked to talk about what in your daily life has important effects on your health.

Duration and Compensation:

The interview will last approximately 1 to 1.5 hours. Participants will be offered a $25 grocery gift certificate to compensate for their time and in appreciation for their contribution.

Benefits, Risk, and Discomfort:

Your participation in this study will help contribute to our understanding of health for newcomers to Canada. This can also contribute to providing better health care for all new Canadians. There are no potential physical risks with participation. If you feel anxious and/or uncomfortable at any point in the interview please tell the interviewer immediately. The investigator will provide a list of local health services and will try to provide appropriate referrals if requested.

Confidentiality:

Your identity will be kept strictly confidential throughout the study and whenever we report the findings of the study. Any tapes, notes and interview transcripts will

be labelled with a code number and/or false name, and locked for storage. Your name will be recorded only on this consent form and on one master list that links your name to your code number and/or false name. The consent form and master list will be locked and accessible only to members of the research team. Any computer files relating to this research will be stored on password protected computers only members of the research team can access. When we report the findings of this study, we will not report details about you or your family that would allow others to identify you.

Right to Withdraw:

Your participation in this study is completely voluntary. You may stop your participation at any time and will not lose your gift certificate of compensation. Any data you have provided will be destroyed. You do not have to answer any question or talk about anything you do not want to. You are also free to withdraw your participation after the interview by contacting the researcher.

Protection of Privacy:

The personal information requested on this form is collected under the authority of Section 33 (c) of the Alberta Freedom of Information and protection of Privacy Act and will be protected under Part 2 of that Act. It will be used for the purpose of academic research and providing you with a final report. Direct any questions about this collection to the research personnel at the above contacts provided.

Results from this study will always remain anonymous and only be used to better understand personal opinions of health. Your interview will be recorded and transcribed by the research personnel and read to summarize expressed meanings. The audio recordings and transcripts will be retained under lock and password by the research personnel for 5 years.

I have read the above description of the study and I understand the conditions of my participation. My signature indicates that I agree to participate in this study.

DATE:

PARTICIPANT'S NAME:

PARTICIPANT'S SIGNATURE: